Evaluating baseline knowledge of HCAHPS Awareness as a method to improve quality of care training in St. John Providence Park Hospital Associates in Novi, Michigan

Ashley Page

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First Reader

Dr. Shan Parker

Second Reader

Denise McLean, CNO
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Abstract

Background: St. John Providence Park Hospital is developing an HCAHPS Awareness orientation, as a quality improvement method to improve HCAHPS scores and increase CMS reimbursements. This project seeks to help the organization develop and shape the HCAHPS Awareness orientation content by developing a survey to assess baseline knowledge of HCAHPS in various hospital associates.

Methodology: Using a cross-sectional approach, a non-validated survey was used to assess employee’s knowledge of patient experiences. The collected data were used to determine methods to improve communication skills and shape education content for an HCAHPS orientation.

Results: HCAHPS Awareness were frequently reported in associates with clinical positions, longer durations of employment, and those with higher levels of education. Survey participants had high reports of effective communication and low reports of cultural awareness and responding to call lights. Access to health care and health insurance was identified as a common disparity seen in patients.

Discussion: HCAHPS Awareness Survey responses were comparable the National HCHAPS scores. Areas in need for improvements include responding to call lights, cultural awareness, health literacy, and family inclusion.

Conclusion: The recommendation made for this project may be effective in increasing knowledge towards HCAHPS practices and promoting patient experience. By implementing methods to improve responsiveness of staff, cultural awareness, and family inclusion the hospital may see enhancements in the quality of care provided, promote patient safety, and reduce hospital errors.
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Chapter 1. Introduction

Introduction to the Problem

The healthcare industry is continuously evolving. Recent changes in the hospital changes involve hospital mergers, staff reduction, and technology advancement. Often, these changes have a common goal of developing methods and implementing programs that can improve the standards of patient care. Proper patient care is essential to hospital systems as it directly affects patient’s health outcomes. Most commonly, poor quality of care has been linked to hospital injuries, hospital-acquired infections, medication errors, failure to adhere to medical treatment plans, hospital readmission, and death. These preventable adverse health outcomes can lead to extensive and unnecessary hospital expenditures. Medical errors contribute to nearly 20 billion dollars of annual spending in the United States healthcare systems (Andel, Davidow, Hollander, & Moreno, 2012).

Over the past few years, incentives have been a popular method used as an attempt to improve the quality of patient care. The practice known as Value-Based Purchasing (VBP) seeks to hold inpatient hospital providers accountable for the treatment and quality of care provided to patients. Centers for Medicare and Medicaid Services (CMS) offers monetary incentives to hospitals and providers who actively make improvements in hospital standards and productive changes (Andel et al., 2012). Additionally, penalties are put in place to discourage poor performances. Hospitals are at risk of losing substantial amounts of CMS payments, simply due to overall reports of poor patient experiences.

The practice of Value-Based Purchasing is currently being used with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. The HCAHPS survey was first introduced in 2006 with the goal of providing a method that would adequately
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measure patient’s perceptions of their quality care received during their recent hospital visit. The HCAHPS survey became the first large-scale national standardized survey that provided a measure of patients’ perspectives of inpatient care. Prior to this survey, there were limited methods and sources used to measure levels of care provided by hospital associates. The HCAHPS survey seeks to produce comparable data on patient perceptions that would enable comparisons between hospitals, allow public reporting of survey results to create incentives for hospitals to improve the quality of care provided, and increase the quality of hospital care transparency as a method to enhance accountability and investments.

Statement of the Problem

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is conducted nationwide to assess the quality of care received by patients during their hospital stay. The survey is delivered randomly to adult patients who have been discharged from the hospital between 48 hours and six weeks. The four modes of survey administration include mail only, telephone only, mixed use of mail and telephone, and active interactive voice response. The HCAHPS survey consists of thirty-two questions, which examines ten areas of patient care. The ten domains include communication with doctors, communication with nurses, the responsiveness of hospital staff, pain management, communication about medications, care transitions, cleanliness of hospital environment, the quietness of hospital environment, discharge information, overall hospital rating, and likelihood to recommend the hospital. These areas primarily focus on how well the hospital staff has been able to communicate with the patient and respond to their needs during their hospital stay.

HCAHPS survey results are reported publicly on the Medicare website. Individuals can compare the HCAHPS scores received by hospitals in their local community, as well as
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throughout the country. The ratings can influence where patients choose to seek medical treatment. Additionally, scores can potentially dictate if individuals seek medical treatment at all. Low HCAHPS scores can put a hospital’s reputation at risk. Hospitals may be faced with the inability to attract and maintain patients and may have trouble recruitments and retaining staff members and health care providers (Richter & Muhlestein, 2016).

HCAHPS survey scores are essential to the St. John Providence Park hospitals, as Medicare and Medicaid reimbursement rates are dependent on survey scores. Research suggests there is a strong correlation between the quality of care provided and levels of patient satisfaction. Lower HCAHPS scores can be reflective of low satisfaction due to the poor quality of care provided. Low satisfaction scores have been linked to adverse health outcomes, as patients are less likely to comply with medical treatment plans and may be inattentive to relapse signs or symptoms (Richter & Muhlestein, 2016). This is a concerning issue as adverse health outcomes can result in increased hospital-acquired infections, hospital readmission, and higher mortality rates.

Background of the Study

As a method to reduce spending due to hospital errors, St. John Providence Park Hospital is continuously working to improve their standards, practices, and policies within the hospital. One valuable method to enhancing the quality of care is to ensure all associates are aware of the HCAHPS survey and understands what the survey is measuring. The agency is currently working to develop and deliver an orientation to current and new hospital associates to raise awareness of the HCAHPS domains of care. Their goal of the orientation is to increase survey scores by improving communication skills, safety measures, patient care, and patient experiences during their hospital stay.
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In order to properly develop the content for the orientation, it is crucial to gain an understanding of what associates currently know about the HCAHPS Survey. This will allow the agency to focus the education content on areas in which associates are lacking knowledge, rather than teaching already known information or irrelevant information. The purpose of the project is to assist the St. John Providence-Park Hospital organization in developing an efficient education program to deliver to hospital associates in all departments.

In collaboration with Toni Tackas, the project began by developing a survey that helped to assess baseline knowledge of HCAHPS among hospital associates, across disciplines. The survey completed by hospital associates is referred to in this paper as the HCHAPS Awareness Survey. Questions determined if associates know about the HCAHPS survey, whether or not they can list the survey domains, and examine their current practices affecting patient care. We predicted those who are aware of HCAHPS would provide better patient care and patient experiences. Additionally, we were looking to see if HCHAPS awareness increases with employment duration and education levels. We expected to see that employees with higher levels of educations and longer duration of employment with the organization are more likely to be aware of HCAHPS than those with shorter employment durations and lower levels of education. The HCAHPS Awareness Survey allowed us to determine which departments have a greater awareness for HCAHPS. It was expected that clinical staff members would have higher levels of HCAHPS knowledge. Furthermore, the survey sought to gain an understanding of associates knowledge pertaining to patient experiences and what may hinder patients from receiving proper care during hospital stays. This allowed us to determine if cultural competence and cultural awareness are associated with improved patient care.
The survey was conducted by selected participants on a volunteer basis, using face-to-face interviews. Results were analyzed and used to make recommendations for necessary education content for the HCAHPS 101 orientation. The survey took place in both Novi and Southfield hospital campuses, which allowed for the identification of hospital needs and health disparities amongst patients. We were looking to see if one location is more aware of the HCAHPS survey. Additionally, we were looking to see if the location of the hospital affects the types of disparities seen in hospital patients. By identifying potential differing disparities, we were able to determine if different educational content is required, based on the needs of each hospital location.

**Purpose of the study**

The purpose of this capstone project was to gain a baseline understanding of hospital associate’s knowledge of HCAHPS and patient care. A primary goal of this project was to understand the reasoning behind low HCAHPS scores and provide methods to improve reports of patient care and patient experience. This data helped to produce a more functional orientation for hospital associates. By providing associates with proper education, they may be able to improve the way hospital associates communicate with one another. Additionally, they may learn and develop skills that will help to enhance communication in patient/provider relationships.

The improved communication skills are expected to improve patients care, patient safety, and patient perceptions of the hospital environment. As a result, the hospital may see a reduction in patient errors, reducing the occurrence of hospital-acquired infections and hospital readmission. These events are likely to influence HCAHPS survey scores positively. Higher HCAHPS survey scores are associated with increased patient treatment compliance, maintenance
of follow-up appointments, and uses of provided educational materials (Hekkert, Cihangir, Kleefstra, van den Berg, & Kool, 2009). Improvements in HCAHPS scores are essential and can produce higher reimbursement rates from Medicaid and Medicaid services, securing hospital finances.

Public Health Significance

The HCAHPS survey plays a vital role in public health, as the survey strives to hold hospitals accountable for quality care and patient safety. Patient safety in hospitals is often referred to as the providing quality health care that aids in the prevention of any harm to patients. Unfortunately, the incidence of hospital errors and avoidable patient harm are growing public health issues in hospital systems throughout the United States. In the 1990s, deaths resulting from hospital errors accounted for 44,000 to 98,000 individuals in the United States (Card, 2014). That number has since increased tremendously. The Journal of Healthcare Risk Management estimates that preventable adverse events account for over 400,000 deaths each year, in the United States alone (Card, 2014). Thus, suggesting avoidable patient harm may be equally important as other public health issues like heart disease which is currently the leading cause of death in the United States (Card, 2014).

Apart from increased morbidity and mortality rates, patient errors can have a grave impact on overall population health. Patient errors can result in various adverse health outcomes including increased length of hospital stay, hospital-acquired infections, permanent disabilities, loss of wages, and increased medical expenses. Furthermore, clinical practices can be impacted because of patient errors. Physicians and clinicians commonly report increased stress and fears of committing the mistake again (Elwahab & Doherty, 2014). These feelings may lead to higher
rates of burnout and depression, potentially causing cyclical incidents of inadequate patient care and patient dissatisfaction.

Patient and medical errors are currently the third leading cause of death in the United States (Makary & Daniel, 2016). In order to develop methods to minimize the burden of medical errors, it is essential to understand why they occur. Injury or harm to a patient from medical errors may be a result of simple human mistakes, diagnostic error, poor judgment and inadequate levels of skill (Makary & Daniel, 2016). Significant factors contributing to preventable patient harm may a result of improper communication and medication errors.

Poor communication can occur between physicians and other physicians, between physicians and nurses, between hospitals and other hospitals, and between patients and medical provided (Taran, 2011). Proper health communication between hospital associates and patients is essential for promoting health care and health behaviors. Public health communication has the power to raise awareness, increase knowledge, shape attitudes, and change behaviors regarding health issues (Bernhardt, 2004). Miscommunication between a health care provider and a patient not only affects health outcomes but can potentially act a barrier to receiving proper medical care. Individuals may avoid seeking medical attention because they fear their provider does not hear what they have to say. Additionally, patients may have a hard time adhering to medical plans when they do not understand what their provider is trying to communicate to them. Providers must use jargon and language that can easily be understood by the patient. Health communication plays a sizeable public health role as it helps to protect the safety of the patients and reduce potential hospital errors.
Value to Community Agency

This project helped the organization develop a stronger HCAHPS 101 orientation for all associates within the hospital. With adequately designed education content, the hospital is likely to see an increase in patient care and improved patient satisfaction. Associates may see an improvement in coordination and communication between departments. All of this could aid in decreasing rates of hospital-acquired infections and hospital readmission. These events may help to promote HCAHPS scores, which would be an incredible benefit to the St. John Providence Park hospitals as higher HCAHPS scores are linked to higher reimbursement rates from Medicaid and Medicare Services. Additionally, improved reports of HCAHPS can help recruit community members when they need medical attention.

St. John Providence Park Hospital is a non-profit organization, meaning they heavily rely on community members for financial support. Significant sources of funding are based on donations, grants, and reimbursements from insurance companies. By improving patient care and HCAHPS scores, it is likely that the hospital can see an increase in CMS reimbursements. Increased payments from the Centers for Medicaid and Medicare Services can serve to be a very crucial source of funding for the organization. This is especially important as CMS no longer reimburses providers for preventable hospital readmissions (CMS, 2017).

This project benefitted the agency as the research conducted had been provided to the hospital without the necessity of paying employees or consultant fees. Furthermore, the resources developed for this project can be replicated for future usage by the St. John Providence Park Hospitals. For example, the survey tool would be able to be used a pre-evaluation and post-evaluation. After the HCAHPS 101 orientation has been implemented, the HCAHPS Awareness Survey could be used to re-assess the associate's knowledge of HCAHPS. The success of the
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orientation would be measured by seeing an improvement in the national HCAHPS survey scores.

Public Health Competencies Demonstrated

Select quantitative and qualitative data collection methods appropriate for a given public health context

Quantitative and qualitative data collection involved in the development a non-validated survey, which was conducted at St. Johns Providence Hospital, at both Novi and Southfield locations. The survey was implemented using face-to-face interviews, as this method often generates the highest response rate. Additionally, this allowed the researchers to clarify information or confusion experienced by the participants. Participants for this project were recruited through verbal solicitation. The survey tool was delivered using the web-based questionnaire, Google Forms. This allowed us to record and store the collected data in a safe location. We did not want to risk losing any data collected on paper questionnaires, even though the survey did not contain any participant identifiers. This survey consisted of closed-ended questions that would allow us to identify patterns of behaviors or opinions of hospital associates. The survey was used to help determine a baseline understanding of HCAHPS awareness in hospital associates, identify existing patient disparities, and identify areas of patient care that require improvements.

Analyze quantitative and qualitative data using biostatistics informative, computer-based programming and software, as appropriate

Our survey data were collected using Google Forms which is an online source used to collect survey information, without collecting IP addresses. Pie graphs and bar graphs reflected the counts of each question were collected from Google Forms, as they are automatically
generated with the data collection. Once all the surveys had been conducted, the information and data were then transferred into an Excel Spreadsheet. This is where, Toni and I cleaned, before inputting the information in IBM SPSS, version 24. Once we have ensured the data is free of error, data were transferred from Excel into SPSS. The qualitative data were recoding, and the variables were given a quantifiable value. Two of the survey questions allowed for multiple responses. The variables were individually tallied for a yes or no response. These questions were then given defined into multiple variable sets. SPSS was mainly used to calculate frequencies and compare means. Additionally, cross-tabulations were used to analyze relationships between multiple variables. While comparing results, the cross-tabulations were layered to look at the Novi and Southfield groups. After determining relationships and correlations, we were able to make recommendations to the hospitals, regarding educational content for the orientations. Toni analyzed the results of the Southfield data, while I analyzed the data collected from the hospital in Novi. We compared the results between the two locations to determine if differing disparities or population needs existed. Any identified differences would be used to determine if the HCAHPS Awareness orientation should require different education content when delivered to a particular location.

**Perform effectively on interprofessional teams**

This project involved organization between an interprofessional team. Collaboration occurred between Toni, associates from Novi and Southfield, and myself. Additionally, Toni and I arranged schedules that would allow for us to conduct our surveys within the hospitals. We worked closely together to determine differing needs of each hospital. In order to achieve our end goals, Toni and I need to work together and abide by our timeline and deadlines efficiently. This means we needed to schedule routine meetings with our community partners, to ensure their
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needs are being met. Toni and I needed to communicate frequently, via phone, email, and in-person meetings. We needed to respect each other's schedules to ensure work is being completed on both ends.

**Apply theoretical constructs in the development of intervention strategies specific to health issues**

While developing the survey tool, conducting the literature review, and making recommendations for the orientation, the Social Cognitive Theory was applied. The Social Cognitive Theory is exceptionally relevant to health communication, as health motivators and behaviors are influenced by the ongoing relationship between personal beliefs, behaviors, and environments, or reciprocal determinism. The HCAHPS survey examines patient experiences as a method to measure the quality of care provided in a hospital setting. This practice gives patients a sense of control over their environment and behavior. Completing the HCHAPS survey has the potential to improve a patient’s self-efficacy, as patients are provided with an opportunity to voice their concerns about their experiences in the hospital environment. This behavior allows for behavior modification in health care providers; in addition, can aid in improving the hospital environments. If hospital providers understand how cultural awareness, health literacy, and medical errors can affect patient experiences and health outcomes, quality improvements methods can be implemented.

CMS rewards hospitals with monetary incentives, or positive reinforcements, when behavior changes or quality improvements are implementing in the health care system. Higher HCHAPS scores generate higher reimbursements from CMS. The reimbursements can increase funding for resources need to make necessary hospital improvements and implement HCHAPS Awareness associate training. Through increased HCHAPS Awareness the hospital may see
improvements in patient-provider communication, reduced spending due to hospital error, and improve health outcomes. Developing and improving the health care system is wholly dependent on the balancing relationships between patient beliefs, provider practices, and the hospital environment.

**Describe the importance of cultural competence in communicating public health content**

The literature review was framed around factors contributing to low HCAHPS scores and low levels of patient satisfaction. Literature suggests low health literacy and improper communication affect the quality of provided patient care in hospitals. A provider's lack of awareness of cultural beliefs or values can lead to poor patient experiences and act as barriers to care. The importance of cultural competence was addressed in the development of the HCAHPS Awareness survey. Identifying existing health disparities in patients could help determine how strongly the orientation should focus on cultural competence. Recommendations for the HCAHPS Awareness orientation sought out methods to promote proper communication between patients and providers, including tools to identify language barriers, low health literacy, cultural values in patients. These recommendations will help associates understand that health care quality and health outcomes can be significantly compromised when cultural preferences are not considered. When cultural preferences or cultural needs are not being considered or respected, health care quality can be significantly compromised.
Chapter 2. Literature Review

Introduction

The literature review for this project focuses on the history, clinical measures, and goals of the HCAHPS survey. The first literature review examines the development and the implementation of the HCAHPS survey. This literature was reviewed to understand the importance of the HCAHPS survey and the role Centers for Medicare and Medicaid Services programs play in patient care improvement methods. Secondly, a review of the literature was conducted to define patient experience and to understand its importance in health care quality. This also involved reviewing if family involvement affected perceptions of patient experience and levels of hospital satisfaction. Additionally, a review of the literature was conducted to identify potential reasons for low HCAHPS scores. This involved looking at the implications of health literacy and health communication. Lastly, the literature seeks to examine how medical errors affect patients, providers, and hospital systems. Understanding the HCAHPS history, patient experience, health literacy, and medical errors are important because they all play a role in improving the quality of care provided to patients. Strengthening positive patient experiences can potentially lead to better health outcomes.
HCAHPS History and Measures

Reducing health care costs and improving the safety and efficiency of health care provided has long been a health care delivery goal. Many national initiatives have been made in attempts to examine the quality of care based on the perceptions of patient experiences during a hospital stay. Prior to the Hospital Consumer Assessment of Healthcare Providers and Systems survey, there was not a standardized method to measure levels of patient satisfaction. Patients are asked about six main areas including communication with doctors, communication with nurses, the responsiveness of hospital staff, pain management, communication about medicines, and information relating to hospital discharge (Richter & Muhlestein, 2017). Additionally, patients are asked about the hospital’s environment in relation to cleanliness and levels of noise. Based on their overall experience, patient’s are asked to provide a rating of the hospital and their likeliness to recommend the hospital to their friends or family members.

The HCAHPS survey was first implemented into hospitals in 2006, on a voluntary basis (CMS, 2017). Nearly 3,900 general acute care hospitals are involved in the HCAHPS program. This number can be credited to the payments received from reporting the collected data (Giordano, Elliott, Goldstein, Lehrman, & Spencer, 2010). Survey results are publicly reported quarterly, allowing for hospital comparisons on a local, regional, and national level (CMS, 2017). The HCAHPS survey is used as a method to improve the quality of care delivered by providing hospitals with monetary incentives. The survey seeks to hold health care providers accountable and increase levels of transparency during the occurrence of medical errors. Publicly reporting HCAHPS data allows consumers to compare hospitals and make informed decisions when choosing providers and selecting hospitals (Elliott, Cohea, Lehrman, Goldstein, Cleary,
Giordano, Beckett, & Zaslavsky, 2015). Publicly reporting performance data allows hospitals and providers with the opportunity to identify health care practices that need improvement.

The HCAHPS survey was the first of its kind to focus on patient-centered care, providing consumers with the opportunity to address concerns, perceptions, and experiences relating to the care received during their hospital stay. Research suggests there is a strong correlation between quality of care and patient experience. Previously, patient-reported data were thought to be less reliable and less valid than the information collected from reviewing medical records and claims made from administrative staff (Giordano et al., 2010). Evidence supports that higher quality health care can be credited to positive consumer reports (Giordano et al., 2010; Richter & Muhlestein, 2017). Positive patient experiences are likely to be associated with improved health outcomes. Not only is this important from a financial aspect, but positive experiences can help develop patient loyalty and improved employee retention.

Elliott et al. (2015) conducted a study to determine if HCAHPS improvements have been made in hospitals after the first five years of being implemented. Reimbursements from CMS have been a driving force for the growing interest in improving patient experiences. Hospitals have made many efforts to improve patient-centered care and health care practices. The researchers hypothesized that large, for-profit hospitals might be more likely to engage in quality improvement methods, likely due to the fact that these hospitals have greater access to resources (Elliott et al., 2015; Richter & Muhlestein, 2017). Public, non-profit hospitals may feel pressure to improve patient experiences through cultural competency methods. This may be due to the fact that non-profit hospitals often have higher rates of minority patients than private, for-profit hospitals. Researchers found after five years of publicly reporting HCAHPS scores hospitals did see improvements in patient care experiences (Elliott et al., 2015; Giordano et al., 2010; Richter
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Muhlestein, 2017. Significant improvements were made in low-scoring hospitals, potentially reducing gaps in rankings between hospitals.

**Relationship between patient experience and quality of care**

As a method of making improvements in patient-centered care, many researchers have examined the relationship between patient experience and health care quality received from medical providers. Patient experience plays a substantial role in HCAHPS, as its scores can be influenced in a positive or negative manner. The following review of the literature suggests patient experience data can be used to identify strengths and weaknesses in healthcare systems, motivate quality improvement methods, and promote patient choice and patient involvement.

Patient experience involves a range of interactions that take place between patients and their health care system, which involves health plans, doctors, nurses, hospital staff, and physician practice (Hekkert, Cihangir, Kleefstra, van den Berg, & Kool, 2009; Doyle, Lennox, & Bell, 2013). Literature defines patient experience as the quality and value of interactions, which are shaped by an organization’s culture, that influence patient perceptions and levels of satisfaction, throughout the duration of care (Doyle et al., 2013). These interactions can be direct and indirect and can involve interactions between clinical and non-clinical staff. Recent research suggests there is evidence to believe that patient experience is strongly linked to positive health care quality and health outcomes. Patients with positive experiences are more likely to comply with medical treatment, whereas those with negative experiences are often noncompliant with treatments plans and are inattentive to their disease symptoms (Doyle et al., 2013, 2015; Hekkert et al., 2009).

In a meta-analysis, researchers have found the inclusion of patient experience in healthcare practices has shown to improve patient safety and clinical effectiveness (Doyle et al.,
Communication plays a large role in patient experience inclusion. Health care providers who clearly communicate information to patients and respect a patient’s beliefs or concerns can help patients become more informed, which may improve levels of patient involvement when it comes to making decisions about medical treatments. Creating an environment where patients feel comfortable and included can improve patient’s willingness to disclose information, potentially improving the time it takes providers to diagnose and generate a treatment plan for the patient. This may also eliminate the need for excessive diagnostic testing (Doyle et al., 2013).

The researchers found improved patient experience not only increase patient’s adherence, but patients are more motivated to report complications to their provider. Additional existing studies have found conflicting results.

Interestingly, some studies found focusing on patient experience to be dangerous. Chambers, Benz, & Boat (2016) suggested negative health outcomes were associated with an increased focus on patient care. Additionally, the researchers found patient perceptions of improved may have been confounded by the increase in health care resources made available to the patient. The researchers found higher patient experiences were associated with higher utilization of diagnostic tests, higher overall health care expenditures, and higher rates of prescribed medications (Chambers et al., 2016). Sicker patients may have thought the additional tests and medications were representative of receiving a higher quality of care from their providers. While many studies suggest patient experience is an essential factor in measuring quality care and clinical outcomes, others suggest health outcomes can be compromised due to increased testing and overtreatment (Chambers et al., 2016).

A limited number of studies examined the role of family member’s perception of patient care; their involvement in improving patient care is not fully understood. Studies have found
family members and friends can play a significant role in patient care when it comes to accurately communicating information about a patient and ensuring discharge preparedness (Hekkert et al., 2009; Doyle et al., 2013; Tobiano, Chaboyer, & McMurray, 2012). Encouraging family involvement can potentially improve patient care. However, the role of family members in patient experience often overlooked. Researchers suggest family input may help enhance the accuracy of information communicated to health care providers, raise awareness of patient safety issues, and identify methods to improve continuity of care (Hekkert et al., 2009; Tabiao et al., 2012). The researchers conducted a qualitative study in Queensland, Australia to further their understanding of the issue. They found family inclusion was highly valued by patients and family members. Additionally, family members did play a decisive role in clarifying information for the provider, assisting in care, and interpreting information for the patient. Developing methods to improve family inclusion may be beneficial to improve standards of care in healthcare systems.

**Health literacy**

The Institute of Medicine refers to health literacy as an individual’s capacity to obtain, process, and understand basic health information and services, which are necessary to make decisions regarding their health care (IOM, 2014). Literature was reviewed to understand the relationship between health literacy and health outcomes. The additional research examined how health disparities relating to ethnicity and culture are affected by health literacy.

Research suggests when effective communication is present in patients and healthcare teams, health care outcomes can see improvements. Patients are more likely to play an active, participating role in their care and may be more likely to adhere to medical treatment (Cawthon, Mion, Willens, Roumie, & Kripalao, 2014). Those with low health literacy may incorrectly use
medications, misinterpret instructions, failure to keep health care appointments, seek unnecessary medical treatment, or experience hospital readmission (Berkman, Sherida, Donahue, Halpern & Crotty, 2011; Martensson & Hensing, 2012).

Communication failures are a leading cause of patient harm and can potentially lead to catastrophic events. Lack of proper communication due to low health literacy can lead to improper treatments, treatment complications, injuries, and death (Berkman et al., 2011; Cawthon et al., 2014; Martensson & Hensing, 2012). Research estimates nearly 90 million adults in the United States have low health literacy (Cawthon et al., 2014; Berkman et al., 2011). With increased mortality risk and health care costs, health literacy has become a national health care priority. Health care providers have a duty to understand the implications of health literacy and work to improve their communication skills with patients. Research suggests, properly communicating with patients is beneficial to health promotion and preventative health interventions (Berkman et al., 2011; Cawthon et al., 2014; Martensson & Hensing, 2012). Raising awareness of health literacy in patients can lead to quality improvement improvements and improve communication between patients and providers.

(Cawthon et al., 2014) conducted a study at Vanderbilt University Medical Center in Nashville Tennessee, using a multicomponent implementation strategy to incorporate the Brief Health Literacy Screen (BHLS) as a method to improve health literacy awareness and improve health care practices at both individual and systematic levels. Upon, implementation the nursing staff was encouraged to interview patients, using the BHLS tool. The tool was used to identify patient’s confidence in filling out medical forms, the frequency of patient’s needing help with reading materials and identifying patients with difficulties understanding information about their medical condition. This study consisted of 500 hospital patients and 300 clinic patients.
Researchers were looking to assess the feasibility of implementing health literacy screening in clinical practice and determine if screening can predict health outcomes (Cawthon et al., 2014).

The study found that implementing a health literacy awareness tool was a quick and easy process for nurses to adapt to in both hospital and clinical settings, as BHLS complete rates were higher than 90% (Cawthon et al., 2014). The selected tool allowed hospital providers to identify health literacy in patients and address barriers to health care, although the study did not incorporate strategies to change health care practices and behaviors. Additionally, the study had a positive effect on patient’s perception of care. About 94% of patients reported they felt their provided care would benefit if physicians and nurses knew about their struggles relating to low health literacy.

Encounters between physicians and patients from the varying cultural background are quite common in the healthcare systems today. However, research suggests a lack of cultural awareness can lead to medical miscommunication and act as a barrier to care for patients. Cultural competence refers to the ability of health providers and organizations to effectively deliver health care that is respectful of cultural beliefs, attitudes, traditions, language preferences and health practices (Saha, Beach & Cooper, 2008). That knowledge is applied by health care providers to produce a positive health outcome and reduce barriers in patient care. Research indicates cultural competence training improves knowledge, attitudes, and skills in health professionals (Betancourt et al., 2003; Beach, Price, Gary, Robinson, Gozu, Palacio et al., 2005).

Poor cultural competence is associated with decreased adherence to preventative services, poorer health status, higher utilization of health care services (Saha, Beach & Cooper, 2008; Betancourt, Green, Carrillo & Ananeh-Firempong, 2003). Higher morbidity and mortality from
chronic disease are often seen in racial and ethnic minorities (Betancourt et al., 2003; Beach et al., 2005).

Medical Errors

Frequent reports of patient dissatisfaction are due to hospital errors. Preventable medical errors are an ongoing and growing problem throughout health care systems in the United States. Patients seeking medical treatment in hospitals expect they will receive quality care in a safe environment, from competent providers. However, that is not always the case, as patients are impacted by medical errors, preventable injuries, infections, or death. Andel (2012) found nearly 98,000 deaths occur in the United States as a result of medical errors. The following review of the literature defines medical errors, provides insights into why they occur and examines how it affects patients and health care providers, as it can help identify methods to improve safety.

Medical errors can be defined as the failure to complete an intended, planned action or the use of a wrong plan to achieve a health goal (Costantino, Casazza, Cernuschi, Solbiati, Birocchi, Ceriani, Piergiorgio, Montano, 2013). According to the literature, medical errors can have an impact on patient health, hospitals systems, and healthcare providers. Common preventable medical errors may involve being prescribed the wrong medication, diagnostic error, receiving the wrong medical treatment, poor judgment, inadequate training, or simple human mistake (Kumar & Steinebach, 2008; Makary & Daniel, 2016). These errors have been shown to contribute to increased hospital-acquired infections, hospitals readmission rates, adverse health outcomes and patient mortality rates (Kumar & Steinebach, 2008; Makary & Daniel, 2016).

Providers are considered to be secondary victims of medical errors, as the incidents can cause emotional distress in providers (Elwahab & Doherty 2014; Lewis, Baernholdt, & Hamric,
EVALUATING HCAHPS AWARENESS IN HOSPITAL ASSOCIATES IN NOVI, MI

2013). Understanding how health care providers are affected when medical errors occur is an integral part of maintaining safety and quality patient care. Additionally, hospital errors can lead to moral consequences, such as stress and burnout in hospital employees. The added stress and fear of making a mistake can contribute to future hospital errors made by providers (Elwahab & Doherty, 2014; Lewis et al., 2013).

The cost of medical errors is a waste of medical resources. Financial and mortality costs of medical errors are well documented in research. Medical errors contribute to the rapidly rising healthcare costs (Kumar & Steinebach, 2008; Andel, Davidow, Hollander, & Moreno, 2012; Makary & Daniel, 2016). This literature is was examined because a major goal of HCAHPS is to reduce health care spending by improving the quality of care provided to patients. Providing adequate care and implementing safety standards in hospitals is essential to preventing medical errors and reducing unnecessary health care costs. Medical errors have a tremendous impact on society. While many studies are focusing on improving patient care standard and patient satisfaction, there is limited research addressing focusing on how medical errors affect providers. Addressing burnout, providing stress management and coping strategies, and providing counseling services for health care providers should be adopted into healthcare practices.

Chapter 3. Methodology

Research design

This project used a cross-sectional approach to observe and analyze data of a population during a short period of time. A survey was developed to understand employee’s current knowledge about the HCAHPS Survey, what methods they currently practice, and observations employees see when it comes to patient care and patient experiences. The observed data were used to identify associations between quality of care provided and levels of patient satisfaction.
The survey tool developed and used in the project is not a validated survey. Ethical approval had been obtained by the IRB for this project.

The development of the survey began by discussing with our community partners at St. John Providence Park Hospitals. The community partners wanted an assessment done to address HCAHPS knowledge in current associates. We assessed the five following questions 1) Are employees aware of HCAHPS? 2) What do employees believe is most important to patient experiences? 3) What disparities are commonly seen in patients? 4) How do employees interact with patients, regarding cultural awareness? and 5) Are there any noticeable differences between Novi and Southfield campuses? These research questions helped shape the questions of the survey.

The survey used to assess baseline knowledge of HCAHPS awareness in hospital associates was conducted using face-to-face interviews. The survey was provided to participants in a Google Forms document, using an electronic tablet and a mobile phone to record the data. Google Forms was selected since the database does not collect any IP addresses (Google, 2017). Therefore the information is secure and anonymous. Additionally, Google Forms allowed for branching of the survey questions. By using skip patterns, Google Forms lead participants to the corresponding section based on a yes or no response when asked if they were aware of the HCAHPS survey. Based on chosen responses in Section Two, Google Forms lead participants to the corresponding sections. Participant’s identity was protected as no form of identifiers are collected. Protecting individual’s identities ensured managers and coworkers would not see their survey answers.

Survey Development
The HCAHPS Awareness Survey was broken up into five sections and included a total of twenty questions. Participants were required to provide an answer to every question presented to them, but not all participants were presented questions from all five sections. The first section consisted of four demographic questions, including the hospital location where employees worked, job department, education level, and length of employment. These questions would be used to determine if specific job departments were more aware of HCAHPs than others. Additionally, we were looking to see if higher levels of HCAHPs Awareness were associated with higher education levels or longer employment durations.

Section Two consisted of one question, asking if employees were aware of the HCAHPS survey. Based on their answer, they would be directed to either Section three or Section four of the survey. Only those who were aware of HCAHPs were directed to Section three; all others were led to section four. Section three asked five questions regarding associates current HCAHPS knowledge. The purpose of this section was to if department managers have ever discussed HCAHPS with their employees, if employees could name HCAHPS domains, and which domains they practiced throughout their workday. Additionally, this section asked about influences that might affect a patient’s experience or health outcome and what measures employees take to ensure positive patient care.

All survey participants answered the questions in section four, which was used to measure what employees felt had an impact on patient experience. Questions involved asking employees how comfortable they were engaging with patients about their care. Additionally, this section examined how often associates talked to patients about their medical treatment plans and how often providers acknowledged cultural preferences. Survey participants were asked to identify patient experiences and social conditions that may affect the health outcome of the
patients. Lastly, the questions in section five about communication skills, associate cultural awareness, and responsiveness. Associates were asked if a patient’s socioeconomic status affected the quality of care they received. Additionally, associates were asked to report on social conditions and health disparities seen in patients. 

In order to measure responsiveness in staff, participants were asked if they acknowledged patients and family members in the hall and how often they answered patient call lights. These sections would allow us to see if health literacy and cultural awareness needed to be addressed in the orientation. A copy of the HCAHPS Awareness Survey can be found in Appendix A.

**Sample Population**

Survey collections took place at both St. John Providence Park Hospital campuses, located in Novi and Southfield, Michigan. This site was chosen based on the researchers’ affiliation with the hospital system, obtained through internship placements. Providence-Providence Park Hospitals employees consist of nearly 1,400 physicians, 4,600 nurses, 900 volunteers, and 180 medical residents and fellows. Approximately, a total of 127 HCAHPS Awareness Surveys were collected. Surveys conducted at the Novi campus accounted for 67 individuals, and 60 individuals were surveyed at the Southfield campus. Data collection took place at both locations in order to compare survey variables. Looking separately at the hospital campuses could potentially determine if there were existing differences in hospital needs or disparities seen between locations. Identifying hospital differences allowed us to determine if the hospitals require different recommendations for education content, based on the site of the orientation.

The sample population consisted staff members of various departments including nurses, physicians, kitchen staff, EVS, technicians, transporters, and volunteers. Participants were
selected on a voluntary basis. Additionally, they were not required to meet any type of inclusion criteria, other than being employed by the St. John Providence Park hospitals. The data collected did not require participants to provide personal data such as names, phone numbers, addresses, or birthdates. Additionally, follow up with the survey participants were not conducted.

Data Collection

To ensure a well-rounded population, varying in job departments, surveys were conducted on multiple occasions, during February and March of 2018. Data collection took place during the weekdays in the mornings, afternoons, and evenings. The participants were selected using the method of verbal solicitation. Partaking in the survey was solely on a volunteer basis. We did not target any specific individuals or specific job departments. Prior to conducting the surveys, researchers had no knowledge of participants job departments or demographic descriptors. Once we received a verbal affirmation, participants were provided with a tablet or phone which was used to answer the survey questions.

Statistical Analysis and Data Management

Once all of the data were collected, the information was transferred from Google Forms into an Excel spreadsheet for proper cleaning. Reports of job departments were regrouped into 17 different categories including administrators, anesthesia, emergency room staff, Environmental Services, Food services, Lab technicians, nurses, nutritionists, oncology/radiation, pharmacy, security/maintenance, social services, students/volunteers, surgical services, therapists, and transporters. Those who cooked, provided food to patients, or worked in the cafeteria were defined in the Food Services group. This included food preps, line preps, and cashiers. Anyone from the nursing staff was group into one category. This contains Registered Nurse, Certified Nursing Assistants, Emergency Room Nurses, Labor and Delivery
EVALUATING HCAHPS AWARENESS IN HOSPITAL ASSOCIATES IN NOVI, MI

Nurses, NICU nurses, Licensed Practical Nurses, Nurse Anesthetists, OB Nurses, Oncology nurses, Pediatric Nurses, and ICU Nurses. Those who assist patients with rehabilitation services were grouped as therapists. This included Occupational Therapists, Physical Therapists, Respiratory Therapists, and Respiratory Therapy Assistants. Student interns and volunteers, those who did not collect payment for services provided to the hospital, were grouped as Students/Volunteers. Employees who helped maintain safety standards and safety procedures were groups into the category of Security/Maintenance. These departments consisted of Maintenance, Security, Public Safety, and Electricians. All administrative staff, receptionists, and department coordinators were grouped together. This included staff from human resources, admins, Healing Arts coordinator, guest services, Internal Medicine Hospitalist, information desk receptionist, Assarian Cancer front desk receptionist, neurology receptionist, NICU receptionist, and RN staff coordinator. Oncology and radiation staff members including oncologists, oncology sonographer, radiation oncologist, radiology, and oncology sonographer were grouped together. By combining staff members were we able to generate departments with larger group size.

Once cleaned, the data were transferred into IBM SPSS Statistics 24, which was used to analyze and report out data, looking separately at the Novi and Southfield hospitals. Data analysis mainly involved comparing frequencies and means of variables. Cross-tabulations were run to examine the frequency of each variable and to compare the results between hospital. Using cross-tabulations allowed us to put the Novi and Southfield results side by side, bar graphs. We could easily compare the frequencies and identify differences. Additional tables and graphs were collected from Google Forms, as they were automatically generated by the database.

I examined the results from Novi, while Toni analyzed the results from Southfield, each looking at differing reports of HCAHPS knowledge, health disparities, and provider practices.
The results were used to make recommendations and to help shape the content of the HCAHPS 101 course. Additionally, we came together to compare our findings of each hospital and determine if there are different population needs. HCAHPS 101 information may need to be adjusted based on the hospital location and its specific needs. Once we gathered our recommendations, our findings were presented to our community partners at both Novi and Southfield locations, using a PowerPoint presentation.

**Ethical Considerations**

Before collecting any data, a protocol for the project was submitted to the Institutional Review Board at the University of Michigan-Flint. Approval for this project was granted by the IRB on February 7, 2018. The IRB Flint determined the project was categorized as a federal exemption, as minimal to no harm would be experienced by human subjects. Additionally, this project did not collect any type of personal information. Human subjects could not be identified through any of the gathered data.

**Chapter 4. Results**

**Introduction**

The associates of St. John Providence Park Hospital in Novi, Michigan, had a basic level of awareness of the HCAHPS survey. This cross-sectional univariate project examined associates of various departments, both clinical and non-clinical. The project assessed employees current work behaviors and practices regarding patient experience. Questions in this project included 1) Do employees know about the HCAHPS survey and which departments had the highest level of awareness? 2) Does HCAHPS awareness increase with employment durations or education levels? 3) Do employees partake in cultural awareness practices? 4) Do employees recognize existing health disparities in hospital patients? 5) How do the results of Novi compare to or differ
EVALUATING HCAHPS AWARENESS IN HOSPITAL ASSOCIATES IN NOVI, MI

from the results of Southfield? The purpose of these research questions was to identify areas in need of improvement, in order to properly develop an HCAHPS Awareness orientation for employees. Utilizing the results of the project, we made recommendations for quality improvement methods necessary to improve the overall patient experience.

Description of Sample

We identified a sample size of 127 hospital associates that voluntarily participated in the HCAHPS Awareness Survey. Of those, data were collected from 67 participants at St. John Providence Park Hospital in Novi, Michigan and 60 participants was from the Southfield hospital. This paper examines the data collected from Novi. Implementation of the survey took place between February and March of 2018; no follow up data collection was required for this project. A univariate analysis was used to assess the frequency of responses for each question. Additional crosstabs were used to compare frequencies of responses in those who reported being aware of the HCAHPS survey.

Statement of Results

Sixty-seven responses were collected from Novi. Approximately, half of the associates were aware of the HCAHPS survey. 34 (51%) of associated reported they were aware of HCAHPS, whereas 33 (49%) were not aware of HCAHPS. Data were collected from 17 different departments, with nurses 15 (22%) and admins 9 (13%) being in largest surveyed groups. The sample sizes of job departments are listed in Table 1. Majority of associates surveyed were employed with the hospital for one to five years 18 (27%), five to ten years 16 (24%), and fifteen to twenty years 12 (18%). Those with bachelor’s degrees and master’s degrees were most frequently surveyed. Those with bachelor’s degrees accounted for 33% (N 22), and those with
master's degrees accounted for 28% (N = 19) of the sampled population. The frequencies for the demographics of the HCAHPS Awareness Survey can be found below in Table 2.

<table>
<thead>
<tr>
<th>Table 1. Job departments</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital campus</td>
<td>67 (52.8%)</td>
<td>60 (47.2%)</td>
<td>127</td>
</tr>
<tr>
<td>Admin</td>
<td>9 (13%)</td>
<td>6 (10%)</td>
<td>15</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>1</td>
</tr>
<tr>
<td>ER</td>
<td>1 (1%)</td>
<td>1 (2%)</td>
<td>2</td>
</tr>
<tr>
<td>EVS</td>
<td>4 (6%)</td>
<td>3 (5%)</td>
<td>7</td>
</tr>
<tr>
<td>Food Services</td>
<td>5 (7%)</td>
<td>1 (2%)</td>
<td>6</td>
</tr>
<tr>
<td>Lab</td>
<td>0 (0%)</td>
<td>3 (5%)</td>
<td>3</td>
</tr>
<tr>
<td>Nurse</td>
<td>15 (22%)</td>
<td>15 (25%)</td>
<td>30</td>
</tr>
<tr>
<td>Nutrition</td>
<td>0 (0%)</td>
<td>2 (3%)</td>
<td>2</td>
</tr>
<tr>
<td>Oncology/radiation</td>
<td>4 (6%)</td>
<td>3 (5%)</td>
<td>7</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1 (1%)</td>
<td>2 (3%)</td>
<td>3</td>
</tr>
<tr>
<td>Security/maintenance</td>
<td>6 (9%)</td>
<td>5 (8%)</td>
<td>11</td>
</tr>
<tr>
<td>Social services</td>
<td>3 (4%)</td>
<td>1 (2%)</td>
<td>4</td>
</tr>
<tr>
<td>Student/volunteer</td>
<td>6 (9%)</td>
<td>1 (2%)</td>
<td>7</td>
</tr>
<tr>
<td>Surgical services</td>
<td>5 (7%)</td>
<td>5 (8%)</td>
<td>10</td>
</tr>
<tr>
<td>Therapist</td>
<td>4 (6%)</td>
<td>6 (10%)</td>
<td>10</td>
</tr>
<tr>
<td>Transporter</td>
<td>1 (1%)</td>
<td>3 (5%)</td>
<td>4</td>
</tr>
<tr>
<td>Grand Total</td>
<td>67</td>
<td>60</td>
<td>127</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2. Demographics</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years Employed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 to 1</td>
<td>7 (10%)</td>
<td>9 (15%)</td>
<td>16</td>
</tr>
<tr>
<td>1 to 5</td>
<td>18 (27%)</td>
<td>18 (30%)</td>
<td>36</td>
</tr>
<tr>
<td>10 to 15</td>
<td>7 (10%)</td>
<td>6 (10%)</td>
<td>13</td>
</tr>
<tr>
<td>15 to 20</td>
<td>12 (18%)</td>
<td>9 (15%)</td>
<td>21</td>
</tr>
<tr>
<td>20 or more</td>
<td>7 (10%)</td>
<td>5 (8%)</td>
<td>12</td>
</tr>
<tr>
<td>5 to 10</td>
<td>16 (24%)</td>
<td>13 (22%)</td>
<td>29</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associate degree</td>
<td>7 (10%)</td>
<td>16 (27%)</td>
<td>23</td>
</tr>
<tr>
<td>Bachelor's degree</td>
<td>22 (33%)</td>
<td>18 (30%)</td>
<td>40</td>
</tr>
<tr>
<td>Doctorate degree</td>
<td>2 (3%)</td>
<td>2 (3%)</td>
<td>4</td>
</tr>
<tr>
<td>High school diploma/GED</td>
<td>9 (13%)</td>
<td>5 (8%)</td>
<td>14</td>
</tr>
<tr>
<td>Master's degree</td>
<td>19 (28%)</td>
<td>11 (18%)</td>
<td>30</td>
</tr>
<tr>
<td>Trade/technical/vocational training</td>
<td>1 (2%)</td>
<td>2 (3%)</td>
<td>3</td>
</tr>
<tr>
<td>HCAHPS Awareness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>33 (49%)</td>
<td>30 (50%)</td>
<td>63</td>
</tr>
<tr>
<td>Yes</td>
<td>34 (51%)</td>
<td>30 (50%)</td>
<td>64</td>
</tr>
<tr>
<td>Grand Total</td>
<td>67</td>
<td>60</td>
<td>127</td>
</tr>
</tbody>
</table>
This section identifies the frequencies of responses in those who reported having HCAHPS Awareness; these results can be seen in Table 3. Of the 67 participants in this project, 34 reported having awareness for the HCHAPS Survey. Approximately 44% (N 15) were able to list the HCAHPS domains, whereas 56% (N 19) knew about HCAHPS but were unable to list the domains. Associates reported high frequencies of used Cleanliness N 21 (14%) and Responsiveness of Staff N 22 (15%). Only eight (5%) associates acknowledged practicing Quiet at Night. The counts of domains used can be seen in Figure 1. Twenty-three (68%) of participants reported the HCAHPS domains had been discussed with their manager. Improperly relaying and communicating information to the patient N 13 (38%) and staff burnout and stress N 9 (26%) were reported to have the strongest influences over a patient’s health outcome. Teach backs, a method used to ask patients to repeat information back to the provider to ensure patient adherence, were most often used in associates with HCAHPS Awareness. Forty-four percent (N 15) of survey participants reported using this method.

Figure 1. Domains most frequently used.
EVALUATING HCAHPS AWARENESS IN HOSPITAL ASSOCIATES IN NOVI, MI

Table 3. HCAHPS Awareness

<table>
<thead>
<tr>
<th>Can you list the HCAHPS domains?</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>No, I am not able to list the HCAHPS domains.</td>
<td>19 (56%)</td>
<td>19 (63%)</td>
<td>38</td>
</tr>
<tr>
<td>Yes, I am able to list the HCAHPS domains.</td>
<td>15 (44%)</td>
<td>11 (37%)</td>
<td>26</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have domains been discussed by manager?</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maybe</td>
<td>3 (9%)</td>
<td>8 (27%)</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>8 (24%)</td>
<td>5 (17%)</td>
<td>13</td>
</tr>
<tr>
<td>Yes</td>
<td>23 (68%)</td>
<td>17 (57%)</td>
<td>40</td>
</tr>
</tbody>
</table>

Which has a strong influence over patient outcome?

<table>
<thead>
<tr>
<th>Frequency of shift changes/patient handoffs</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6 (18%)</td>
<td>6 (20%)</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>4 (12%)</td>
<td>0 (0%)</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improperly relaying &amp; communicating information to patients</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13 (38%)</td>
<td>12 (40%)</td>
<td>25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient behavior</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2 (6%)</td>
<td>3 (10%)</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff burnout and stress</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9 (26%)</td>
<td>9 (30%)</td>
<td>18</td>
</tr>
</tbody>
</table>

What method do you rely on to ensure patient adherence?

<table>
<thead>
<tr>
<th>Goal setting</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>7 (21%)</td>
<td>6 (20%)</td>
<td>13</td>
</tr>
<tr>
<td>No</td>
<td>5 (15%)</td>
<td>5 (17%)</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I explain to the patient that I am unable to assist &amp; will direct them to an associate that is able to.</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5 (15%)</td>
<td>6 (20%)</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Show backs</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2 (6%)</td>
<td>4 (13%)</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Teach backs</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15 (44%)</td>
<td>9 (30%)</td>
<td>24</td>
</tr>
</tbody>
</table>

Grand Total | 34 | 30 | 64

Section four of the HCAHPS Awareness Survey assessed patient experience. Thirty-five (52%) of associates reported feeling comfortable engaging with patients about their care. Associates reported time spent with hospital associates N 21 (31%) and the ability to easily communicate with hospital associates N 18 (27%) were most likely to influence patient health outcomes. Additionally, twenty-two (33%) of associates reported that patient experiences are most likely to be compromised when a patient feels like providers do not listen to their patient’s needs or concerns. Thirty-four percent (N 23) of associates reported they often observed their coworkers acknowledging patient’s cultural values. Frequency reports for this section can be found in Table 4.
Section five of the HCAHPS Awareness Survey acknowledges communication and cultural competence. Reports of frequencies for this section are shown in Table 5. When asked if a patient’s education level, income level, or type of health insurance ever affect the quality of care provided, 30% (N 20) reported never, and 37% (N 25) reported sometimes. However, 35% (N 50) identified access to health care and health insurance as being a health disparity that is often seen in patients. The counts of health disparities seen in patients is shown in Figure 2.

Forty percent (N 27) of survey respondents stated they always communicate effectively with co-workers, when it comes to providing care for their patients. When asked how often associates
acknowledge patients and their family members in the hall, 20 (30%) said always, 24 (36%) said often, and 18 (27%) said sometimes. About 28% (N 19) of associates stated they always respond to call light, whereas 40% (N 27) reported that answering call lights was not a part of their job description.

Table 5. Communication & Cultural Competence

<table>
<thead>
<tr>
<th></th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How often does a patient's SES affect quality of care?</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>3 (4%)</td>
<td>0 (0%)</td>
<td>3</td>
</tr>
<tr>
<td>Never</td>
<td>20 (30%)</td>
<td>27 (45%)</td>
<td>47</td>
</tr>
<tr>
<td>Often</td>
<td>4 (6%)</td>
<td>8 (13%)</td>
<td>12</td>
</tr>
<tr>
<td>Rarely</td>
<td>15 (22%)</td>
<td>7 (12%)</td>
<td>22</td>
</tr>
<tr>
<td>Sometimes</td>
<td>25 (37%)</td>
<td>18 (30%)</td>
<td>43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Do you communicate effectively with coworkers when providing care for the patients?</strong></th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>27 (40%)</td>
<td>23 (38%)</td>
<td>50</td>
</tr>
<tr>
<td>Never</td>
<td>1 (1%)</td>
<td>6 (10%)</td>
<td>7</td>
</tr>
<tr>
<td>Often</td>
<td>29 (43%)</td>
<td>24 (40%)</td>
<td>53</td>
</tr>
<tr>
<td>Rarely</td>
<td>2 (3%)</td>
<td>1 (2%)</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>8 (12%)</td>
<td>6 (10%)</td>
<td>14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How often do you acknowledge patients/family members in halls?</strong></th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>20 (30%)</td>
<td>22 (37%)</td>
<td>42</td>
</tr>
<tr>
<td>Never</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>1</td>
</tr>
<tr>
<td>Often</td>
<td>24 (36%)</td>
<td>20 (33%)</td>
<td>44</td>
</tr>
<tr>
<td>Rarely</td>
<td>5 (7%)</td>
<td>6 (10%)</td>
<td>11</td>
</tr>
<tr>
<td>Sometimes</td>
<td>18 (27%)</td>
<td>11 (18%)</td>
<td>29</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How often do you respond to call lights?</strong></th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always</td>
<td>19 (28%)</td>
<td>11 (18%)</td>
<td>30</td>
</tr>
<tr>
<td>Never, this is not a part of my job.</td>
<td>27 (40%)</td>
<td>27 (45%)</td>
<td>54</td>
</tr>
<tr>
<td>Often</td>
<td>6 (9%)</td>
<td>7 (12%)</td>
<td>13</td>
</tr>
<tr>
<td>Rarely</td>
<td>7 (10%)</td>
<td>8 (13%)</td>
<td>15</td>
</tr>
<tr>
<td>Sometimes</td>
<td>8 (12%)</td>
<td>7 (12%)</td>
<td>15</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>67</td>
<td>60</td>
<td>127</td>
</tr>
</tbody>
</table>
Details of Data Analysis

The data analysis examined the frequencies in which employees reported HCAHPS awareness, communication skills, cultural awareness practices, and patient experience engagement. Results from the data analysis showed awareness for the HCAHPS survey increased with those who had higher levels of education and longer duration of employment with the hospital. Those with a bachelor’s degree or higher accounted for 28 out of 34 participants who reported HCAHPS awareness. These reports can be found in Figure 3 and Figure 4 in Appendix B. Additionally, clinical staff including nurses, therapists, Physician Assistants and surgical services associates, had higher reports of HCAHPS Awareness than the non-clinical staff departments including EVS, food services, security/maintenance, and students. These frequencies are reported in Figure 5 of Appendix B. Nurses were most frequently polled in this study, and the department had the higher reports of HCAHPS Awareness. Eleven (73%) out of the fifteen nurses reported they were aware of the HCAHPS Survey.
HCAHPS Awareness appeared to play a role in behaviors and health care practices in hospital associates. Twenty-six (76%) of those with HCAHPS Awareness reported feeling comfortable talking to patients about their care. However, 15 (45%) of those without HCAHPS Awareness did not feel comfortable engaging with patients. Additionally, 44% (N 15) survey participants reported they always talked to patients and medical teams about a treatment plan, but 33% (N 11) without HCAHPS Awareness reported they never talked to patients or medical teams.

When asked which patient experience influence health outcomes, the majority of those with HCAHPS Awareness reporting time spend with hospital associates (N 14, 41%), ability to easily communicate with staff (N 8, 24%), and personalized care to be the more influential (N 8, 24%). Those without HCAHPS Awareness felt the appearance and cleanliness of the hospital environment (N 10, 30%) and ability to easily communicate with staff (N 11, 33%) played an influential role in health outcomes. Those with HCAHPS Awareness were more likely to respond to call lights; results can be viewed in Figure 3. Sixteen (47%) of HCAHPS Aware associates always answered call lights. However, those without HCAHPS Awareness, 22 (59%) felt answering call light was not a part of their job descriptions. These variances are likely due to differences in responsibilities in the clinical and non-clinical departments.
Discussion of Results

Results from this project determined clinical departments had more awareness for HCAHPS than non-clinical departments. Additionally, HCAHPS Awareness increased in with the length of time employed at St. John Providence Park and in those with bachelor’s degrees or higher. This indicates HCAHPS knowledge and its promotion is present in the existing hospital practices. Additionally, reported frequencies of HCAHPS practices in hospital associates were comparable to the National HCAHPS Survey score.

In the HCAHPS Awareness Survey, hospital associates reported high levels of effective communication between coworkers and between patients. Nurse Communication and Doctor
COMMUNICATION were two of the higher scores on the national rankings; both domains received a score of 79%. CMS provided Providence Park Hospital with a low score in Quiet at Night, with a ranking of 62%. According to the HCAHPS Awareness survey, only 9 associates reporting practicing this domain during their workday, and only 22% (N 15) reported the ability to rest when the patient wanted to as a condition which can compromise patient experience. The HCAHPS Awareness orientation should include educational materials to improve the responsiveness of staff, the inclusion of family members, and cultural awareness.

Chapter 5. Recommendations and Limitations

Recommendations

It is recommended that a segment of the HCAHPS Awareness orientation should focus on non-clinical staff members. While they may not have direct care for patients, they do play a role in generating a pleasant atmosphere throughout the hospital. Majority of non-clinical position reported that answering call lights was not a part of their job description. However, requiring all associates to acknowledge call lights improves the responsiveness of care. The hospital may benefit from implementing a No Pass Zone initiative; this has been an effective method used at the Mercy Gilbert Medical Center in Gilbert, Arizona. This method would require any associate, regardless of their position, passing by a patient’s room to stop and respond to their call light.

A No Pass Zone can reduce response times and increase levels of patient experience. This is important because delayed response times can potentially lead to injuries in patients. Due to lack of assistance, patients needing to go to the bathroom may risk falling because they could not wait any longer for a hospital associate. Often, patients need help with simple tasks that anybody staff member is capable of helping with, such as ordering food or finding the TV remote. Many
patients would feel grateful that somebody would be willing to help, rather than letting them sit and wait. A No Pass Zone would act as a reminder to staff that answering call lights is a shared responsibility among clinical staff, non-clinical staff, and volunteers.

The HCAHPS Awareness Survey identified low reports of patient behavior and low reports of cultural awareness as a factor that compromises health outcomes. According to the research, failing to acknowledge cultural values and beliefs can result in miscommunications between providers and their patients. When patients do not understand information about their medical treatment, they are less likely to adhere to their treatment plan and less likely to follow-up with their provider. Provider’s lack of cultural awareness could explain the reasons why Providence Park Hospitals had low scores for medication explanation and for patients who “strongly agree” they understand care when they let the hospital. The National HCAHPS Survey scores reported only 60% of patients were satisfied with their medication explanation and 49% fully understood their care after leaving the hospital. The HCAHPS orientation should provide tools to help associates understand what it means to be culturally competent and to methods develop awareness of cross-cultural issues. Additional interventions could include recruitment of minority health professionals and development of language appropriate educational materials to provider to patients (Betancourt et al., 2018). It could be beneficial for the orientation to administer a cultural competence self-assessment. Associates who take this assessment may be able to identify concepts and practices that need improving.

Other methods to improve communication between providers and patients should include providing tools to identify low health literacy in patients, as this can act as a barrier to receiving medical treatment. Understanding a patient’s capacity to understand basic health information can help providers identify patients who may require additional attention or communication aids.
EVALUATING HCAHPS AWARENESS IN HOSPITAL ASSOCIATES IN NOVI, MI

According to the research health literacy assessments are easy to implement in a healthcare setting and only requires a few minutes of the patient’s time (Berkman et al., 2011; Cawthon et al., 2014; Martensson & Hensing, 2012). Identifying health literacy and improving communication are effective in reducing medical errors due to improperly relaying information between patients and their providers.

In addition to the low reports of provider’s cultural misperceptions about a patient, the HCAHPS Awareness Survey identified lower reports of family perception towards patient care. It is recommended that hospital provides training to include family members in medical treatment plans. Detailed information regarding symptoms and concerns of the patients is beneficial to the provider as it can potentially reduce the number of diagnostic tests and time it takes to make a diagnosis. Furthermore, patients often report hospital discharges and care transitions are abrupt and feel they receive little information about care after leaving the hospital. They often have concerns about side effects, complications to watch for, or whom to contact with questions regarding their recovery (Smith, Saunders, & Stuckhardt, 2013; Hekkert et al., 2009; Tabiao et al., 2012). This information is often too much for them to handle on their own and nearly one-fifth of patients are readmitted to the hospital within 30 days (Smith et al., 2013). Well-informed family members can clarify information and assist the patient in their care after leaving the hospital. The inclusion of family members is often valued in patients and ease the anxiety and fears associated with discharge preparedness. Methods to include family in discharge preparedness may involve providing families with general information about the patient’s health concerns, help caregivers understand when they should call for help. Additionally, health care providers can assist the family and caregivers in developing a care plan and setting goals for the
patient. Family inclusion has the potential to improve communication with providers, patient’s willingness to disclose information, and adherence with their treatment plan.

**Limitations**

**Small Sample Size:**

A significant limitation of involved the quantity of the surveys collected. Various factors contributed to a reduced sample size of survey participants. The first limitation involved a delay in approval from the Institutional Review Board. Upon initially submitting the protocol for the project in November, not all the project investigators were PEERS certified. As a result, data collection could not and did not start until February 7, 2018, affecting the amount of time available to collect survey responses. Furthermore, the selected method of face-to-face interviews, used to collect data may have limited the number of responses received. The face-to-face interviews served to be time consuming and inconvenient to the participants. Most participants were surveyed in the hospital cafeterias, during their lunch breaks. Many individuals refused to participate, as they did not want their short work break to be interrupted.

**Implementation of data collection methods:**

Participants for this project were selected through verbal solicitation in the hospital cafeteria. In doing so, we were unaware of participant’s job departments. We had a vast range of hospital departments that participated in the survey. An overwhelming amount of responses were from nurses. The nursing departments accounted nearly half of the participants selected were from the nursing department. While many of the remaining departments had only one or two participants, requiring us to group together some job departments during the data analysis. Manipulating this data may have inaccurately represented the level of HCAHPS Awareness in specific departments. Well-Rounded group size for each department was not acquired in this
EVALUATING HCAHPS AWARENESS IN HOSPITAL ASSOCIATES IN NOVI, MI

project. Future use of the survey tool may benefit from using an online questionnaire. This may increase the response numbers, allowing for larger department group sizes.

**Lack of previous studies in the research area**

There appeared to be a lack of available research pertaining to the HCAHPS survey. The HCAHPS survey has only been conducted within the last decade. Within this time frame, a limited number of HCAHPS studies have been performed in hospital systems. The literature review was based on the goals and measures of the HCAHPS survey, common reasons for patient dissatisfaction, methods to improve the quality of patient care, and strategies to strengthen reports of patient satisfaction.

**Conclusions**
References


Makary, M. A., & Daniel, M. (2016). Medical error—the third leading cause of death in the US. *Bmj*, 353, i2139. 10.1136/bmj.i2139


EVALUATING HCAHPS AWARENESS IN HOSPITAL ASSOCIATES IN NOVI, MI


Appendix A

Survey Conducted

HCAHPS Awareness Survey

Section 1: Demographic of Hospital Associates

1. Which hospital campus do you work at?
   - Novi
   - Southfield

2. Job Department ____________________________

3. Education Level
   - Some high school, no diploma
   - High school graduate, diploma or the equivalent (for example GED)
   - Some college credit, no degree
   - Trade, technical, or vocational training
   - Associate degree
   - Bachelor’s degree
   - Master’s degree
   - Professional degree
   - Doctorate degree

4. Number of years with the organization
   - 0 to 1
   - 1 to 5
   - 5 to 10
   - 10 to 15
   - 15 to 20
   - 20 or more

Continue to section 2

Section 2: HCAHPS Awareness

5. Are you aware of what the HCAHPS survey is?
   - Yes (Continue to section 3)
   - No (Continue to section 4)

Continue to appropriate section

If yes- Continue to section 3 (HCAHPS knowledge)
If no- continue to section 4 (Patient experience
Section 3: HCAHPS Knowledge

What does the associate currently know about the HCAHPS survey?

6. Can you list the HCAHPS domains?
   - Yes, I am able to list the HCAHPS domains
   - No, I am not able to list the HCAHPS domains

7. Have the HCAHPS domains been discussed with you by your department manager?
   - Yes
   - No
   - Maybe

8. Which domains do you most often put into action during your workday? Choose all that apply.
   - Quiet at night
   - Cleanliness
   - Medication explanation
   - Nurse communication
   - Pain management
   - Responsiveness of staff
   - Discharge preparedness
   - Transition of care
   - Overall patient experience
   - Willingness to recommend

9. Which of these has a strong influence over the patient’s health outcome?
   - Frequency of shift changes/patient handoffs
   - Hospital noise levels
   - Staff burnout and stress
   - Patient behavior
   - Improperly relaying and communicating information to the patient

10. What method do you most often rely on to ensure a patient is adhering to their medical plan?
    - Teach backs- Example: asking the patient to explain what they understand about their medical treatment plan.
    - Show backs- Example: asking the patient to show how to change a wound dressing or how to take a medication.
    - Goal setting- Example: setting small, achievable goals to avoid discouraging patient’s ability to follow through with medical treatment.
    - I explain to the patient that I am unable to assist them and will direct them to an associate that is able to.
    - I do not have interactions with patients.
Section 4: Patient experience

11. Are you comfortable engaging with patients about their care and experiences in the hospital?
   o Yes
   o No
   o Maybe

12. Which patient experience most influences the patient’s health outcome?
   o Time spent with hospital associates, including nurses, doctors, housekeeping, and all others
   o Ability to easily communicate with hospital associates and patients
   o Appearance and cleanliness of the hospital environment
   o Personalizing care or interactions with staff members

13. How often do you talk to patients and medical teams about a patient’s medical treatment plan?
   o Always
   o Often
   o Sometimes
   o Rarely
   o Never

14. How often do you observe your coworkers acknowledge patient’s preferences and cultural values?
   o Always
   o Often
   o Sometimes
   o Never
   o I do not interact with patients

15. What social conditions compromise patient experience the most?
   o Provider's cultural misperceptions about a patient
   o Inability to rest or relax when the patient wanted to
   o Feeling like providers do not listen to the patient's needs or concerns
   o Unpleasant and unclean environment within the hospital
   o Family’s perception towards patient's care

Continue to section 5
Section 5: Communication and cultural competence

16. How often does a patient’s income level, education level, or type of health insurance affect the quality of care provided by your coworkers?
   - Always
   - Often
   - Sometimes
   - Rarely
   - Never

17. What social conditions and health disparities are often seen in patients? You may select more than one.
   - Income inequality
   - Racial and ethnic prejudice
   - Access to health care and health insurance
   - Food insecurity
   - Behavioral norms held by social groups, cultures, or religions

18. Do you communicate effectively with your coworkers when it comes to providing care for the patients?
   - Always
   - Often
   - Sometimes
   - Rarely
   - Never

19. How often do you acknowledge patients or family members, even when you are not currently clocked in? Example: smiling or waving at a hospital guest in the hall.
   - Always
   - Often
   - Sometimes
   - Rarely
   - Never

How often do you respond to call lights, even if you do not have direct responsibility for the patient?
   - Always
   - Often
   - Sometimes
   - Rarely
   - Never, this is not a part of my job.

The survey is complete. Thank you for your time!
### Appendix B

#### Figures and Tables

**Table 6. Domains**

<table>
<thead>
<tr>
<th>Domains most often used</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Grand Total N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quiet at Night</td>
<td>8 (5.5%)</td>
<td>6 (5.6%)</td>
<td>14</td>
</tr>
<tr>
<td>Cleanliness</td>
<td>21 (14.4%)</td>
<td>12 (11.2%)</td>
<td>33</td>
</tr>
<tr>
<td>Medication explanation</td>
<td>17 (11.6%)</td>
<td>11 (10.3%)</td>
<td>28</td>
</tr>
<tr>
<td>Nurse Communication</td>
<td>13 (8.9%)</td>
<td>13 (12.1%)</td>
<td>26</td>
</tr>
<tr>
<td>Pain Management</td>
<td>15 (10.3%)</td>
<td>11 (10.3%)</td>
<td>26</td>
</tr>
<tr>
<td>Responsiveness of Staff</td>
<td>21 (15.1%)</td>
<td>11 (10.3%)</td>
<td>32</td>
</tr>
<tr>
<td>Discharge Preparedness</td>
<td>14 (9.6%)</td>
<td>9 (8.4%)</td>
<td>23</td>
</tr>
<tr>
<td>Transition of Care</td>
<td>11 (7.5%)</td>
<td>9 (8.4%)</td>
<td>20</td>
</tr>
<tr>
<td>Overall Patient Experience</td>
<td>13 (8.9%)</td>
<td>16 (15%)</td>
<td>29</td>
</tr>
<tr>
<td>Willingness to Recommend</td>
<td>12 (8.2%)</td>
<td>9 (8.4%)</td>
<td>21</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>145</td>
<td>107</td>
<td>252</td>
</tr>
</tbody>
</table>

**Table 7. Social conditions and health disparities**

<table>
<thead>
<tr>
<th>Social conditions and health disparities</th>
<th>Novi N (%)</th>
<th>Southfield N (%)</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income inequality</td>
<td>28 (19.7%)</td>
<td>37 (25.3%)</td>
<td>65</td>
</tr>
<tr>
<td>Racial and ethnic prejudice</td>
<td>27 (19%)</td>
<td>28 (19.2%)</td>
<td>55</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>15 (10.6%)</td>
<td>14 (9.6%)</td>
<td>29</td>
</tr>
<tr>
<td>Behavior norms held by social group</td>
<td>22 (15.5%)</td>
<td>24 (16.4%)</td>
<td>46</td>
</tr>
<tr>
<td>Access to health care and health insurance</td>
<td>50 (35.2%)</td>
<td>43 (29.5%)</td>
<td>93</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>142</td>
<td>146</td>
<td>288</td>
</tr>
</tbody>
</table>
Figure 3. Frequency of HCAHPS Awareness in Education Level

Figure 4. Frequency of HCAHPS Awareness in Number of Years with the Organization
Figure 5. Frequency of HCAHPS Awareness in Job Departments
EVALUATING HCAHPS AWARENESS IN HOSPITAL ASSOCIATES IN NOVI, MI

Appendix C

IRB Approval

SUBMISSION INFORMATION:
Title: Assessing hospital associates knowledge of HCAHPS
Full Study Title (if applicable): Evaluating baseline knowledge of HCAHPS awareness in hospital associates in Novi and Southfield St. John Providence Park Hospitals
Study eResearch ID: HUM00138890
Date of this Notification from IRB: 2/7/2018
Date of IRB Exempt Determination: 2/7/2018
UM Federwide Assurance: FWA00004969 (For the current FWA expiration date, please visit the UM IRB Website)
OHRP IRB Registration Numbers: IRB00000248

IRB EXEMPTION STATUS:
The IRB Flint has reviewed the study referenced above and determined that, as currently described, it is exempt from ongoing IRB review per the following federal exemption category:

EXEMPTION #2 of the 45 CFR 46.101(b):
Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Note that the study is considered exempt as long as any changes to the use of human subjects (including their data) remain within the scope of the exemption category above. Any proposed changes that may exceed the scope of this category, or the approval conditions of any other non-IRB reviewing committees, must be submitted as an amendment through eResearch.

Although an exemption determination eliminates the need for ongoing IRB review and approval, you still have an obligation to understand and abide by generally accepted principles of responsible and ethical conduct of research. Examples of these principles can be found in the Belmont Report as well as in guidance from professional societies and scientific organizations.

SUBMITTING AMENDMENTS VIA eRESEARCH:
You can access the online forms for amendments in the eResearch workspace for this exempt study, referenced above.

ACCESSING EXEMPT STUDIES IN eRESEARCH:
Click the "Exempt and Not Regulated" tab in your eResearch home workspace to access this exempt study.

Kazuko Hiramatsu
Chair, IRB Floc

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