MGH mission

Guided by the needs of our patients and their families, we aim to deliver the very best health care in a safe, compassionate environment; to advance that care through innovative research and education; and to improve the health and well-being of the diverse communities we serve.

An early look at the work of the MGH/MGPO Diversity Committee

(See Jeanette Ives Erickson’s column on page 2)
just like snowflakes, no two people are exactly alike. Each person has his or her own unique talents, strengths, and backgrounds. And while every snowflake is beautiful unto itself, we New Englanders know that when they come together in great numbers, they can transform an ordinary landscape into something magnificent and awe-inspiring. So too, can people. When individuals of different cultures and backgrounds come together, we have the potential to transform our landscape into something exponentially better, stronger, and more effective than any one of us could do on our own. That thinking was the impetus behind the creation of the MGH/MGPO Diversity Committee, an inter-disciplinary group that reports to the MGH General Executive Committee and is co-chaired by Jim Brink, MD, chief of Radiology, and myself.

In 2014, to support the MGH strategic plan and priorities, the newly formed Diversity Committee was charged with:

- setting over-arching diversity goals and priorities for the organization and assessing progress toward achieving those goals
- providing strategic guidance and oversight for diversity programming
- ensuring that relevant aspects related to the diversity of patients, our workforce, and the community are incorporated into implementation plans for the organization’s strategic initiatives
- advising on the allocation of resources for diversity efforts and initiatives

The committee has met regularly, we’ve held our first in a series of strategic retreats, and we co-sponsored several events, including last year’s MGH Community Dialogue on Race (along with the MGH Center for Diversity & Inclusion and the PCS Diversity Program).

We’ve met with Martin Davidson, a diversity consultant and author of the book, *The End of Diversity as we Know it*. Martin is professor of Leadership and Organizational Behavior at the University of Virginia’s Darden School of Business; he teaches and consults with leaders around the world on how to leverage diversity to generate superior business performance. We’ll continue to work with Martin as we clarify and advance our own diversity and inclusion strategy.
The task force has created a preliminary draft of a diversity and inclusion statement. The intent is to provide language that describes what we mean by diversity and inclusion and why it’s so important to our success and identity as an organization. As I said, what we have is a preliminary draft; we’ve shared it in a number of forums to solicit feedback. It will be reviewed by the PCS Executive Committee, patient and family advisory councils, and other key groups before going to the General Executive Committee and Board of Trustees for final approval. In the meantime, if anyone would like to have input or contribute to this work, please reach out to your manager or supervisor, or contact me directly. We’re anxious to hear from as many people as possible as we continue to refine our diversity and inclusion statement.

The work of the MGH/MGPO Diversity Committee is on-going, and there is still much to do. In support of the committee’s goals and the hospital’s strategic plan, we’re confident this work will:

- enable us to more effectively serve our diverse patient populations and ensure equitable care for all our patients and families
- improve our ability to attract, retain, and develop a diverse workforce
- help us forge and maintain strong relationships with individuals and organizations in the diverse communities we serve

I’ll continue to keep you informed as the work of this committee unfolds.
Inaugural Volunteer Pin Night

—by Jackie Nolan, director, Volunteer and Information Ambassador Services

On Monday, December 7, 2015, at the Paul S. Russell Museum, the Volunteer Department hosted its inaugural Pin Night Ceremony to recognize volunteers who’ve contributed significant hours of service to patients, families, and staff throughout the hospital (see list at left).

In addition to the pinning ceremony, Mandi Coakley, RN, staff specialist and principal investigator for the Pet Therapy Research Study, presented an overview of the Pet Therapy Program and shared the findings of her study. Volunteers had a chance to ask questions and meet some of the therapy dogs. Four therapy dogs and their handlers gave attendees a chance to experience the power of pet therapy first-hand.

Says Jackie Nolan, director of Volunteer and Information Ambassador Services, “We owe a great debt of gratitude to all the volunteers for their dedication and service to the hospital. They are a true example of the power of generosity and kindness.”

For more information about the inaugural Pin Night Ceremony, or any of the services offered by volunteers, call Nolan at 617-724-1753.

Volunteers recognized

<table>
<thead>
<tr>
<th>Hours</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,000</td>
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</tr>
<tr>
<td>3,000</td>
<td>Mary Martin</td>
</tr>
<tr>
<td>4,000</td>
<td>Kevin McElroy</td>
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<td>4,000</td>
<td>Betsy Ryder</td>
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<td>Joel Lesser</td>
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<td>Mimi McDougal</td>
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<td>7,000</td>
<td>Peggy Scott</td>
</tr>
<tr>
<td>More than 10,000</td>
<td>Patricia Austen</td>
</tr>
<tr>
<td>More than 10,000</td>
<td>Bill Lauch</td>
</tr>
</tbody>
</table>

Above right: volunteer handlers with their pet-therapy dogs at Pin Night.

Above: 2015 recipients of service pins (those who’ve volunteered 1,000 hours or more) with staff of the Volunteer Department.
Expanding spiritual care options for Muslim patients

Recently, senior vice president for Patient Care, Jeanette Ives Erickson, RN, sat down with emergency medicine chaplain, Reverend Dean Shapley, to talk about Chaplaincy’s new Muslim Visitation Program.

Jeanette: Can you tell our readers a little about the services offered by the Chaplaincy.

Dean: Chaplains assess and respond to the spiritual needs of patients, families, and staff, regardless of their religious affiliation or lack thereof. Spiritual needs can include comfort, companionship, emotional support, meaningful rituals and reflection, or conversations about life, care, relationships, and end-of-life decisions. MGH chaplains are clinically and theologically trained to meet the religious needs of those who belong to established faith traditions, and if specific religious needs can’t be met by our chaplains, we have access to many outside resources.

Jeanette: Stories in the news have contributed to a number of misunderstandings about Islam and Muslims. These misunderstandings can impact our efforts to care for Muslim patients. How is the Chaplaincy responding?

Dean: For years, an Imam, a leader in the Muslim community, has been part of the MGH Chaplaincy team. The Imam is available to visit Muslim patients and respond to matters that require an Imam’s expertise. The Imam is a resource for patients, families, and staff when there are questions regarding Islamic rules and guidelines as they relate to medical treatments and decisions. The Masjid (the Muslim prayer room), located on Founders 1, is available for patients and staff, and Friday prayers are held in the Thier Conference Room from 1:00-2:00pm. Copies of the Qur’an are available for Muslim patients free of charge; a CD version of the Qur’an is also available for borrowing.

Jeanette: Tell me about the new Muslim Visitation Program.

Dean: The Muslim Visitation Program is a new collaboration between the MGH Chaplaincy and the Islamic Society of Boston Cultural Center (ISBCC). We’ve been working with the ISBCC to recruit and develop a group of trained volunteers to visit and support Muslim patients through conversation, prayer, and reading from the Qur’an. These volunteers are specially trained to visit in a hospital setting in accordance with Clinical Pastoral Education guidelines. They’re qualified to respond to the spiritual needs of Muslim patients and families, both spoken and unspoken. The goal of the Muslim Visitation Program is to provide another way to meet the spiritual and religious needs of Muslim patients, especially when the legal or ethical expertise of an Imam may not be needed and to expand and strengthen our ties with the local Muslim community.

Jeanette: How can someone request a Muslim visitor?

Dean: Every Muslim patient and family receives an information card about the Muslim Visitation Program from the chaplain on their unit. Any patient, family, or staff member can request a Muslim visitor by calling 617-726-2220.

For more information about any of the programs or services offered by the MGH Chaplaincy, call 617-726-2220.
Positive outcomes through good communication, teamwork, and confidence-building

My name is Kristin Morris, and I’ve been a physical therapist at MGH for five years, the past two as part of the inpatient surgical physical therapy team. ‘John’ was a 50-year-old, otherwise-healthy man who’d been transferred from another hospital after falling from a 12-foot ladder. He suffered a spinal fracture at the first lumbar vertebrae and right-sided sacral and pelvic fractures.

John had been seen by Neurosurgery for his spinal fracture, and by Orthopedic Surgery for his pelvic and sacral fractures. Both services had deemed his injuries non-operative. John was to wear a thoracolumbosacral orthosis (a brace) at all times, as imaging of his spine had shown some instability and possible damage to the spinal cord at that level. John was allowed to bear full weight on his right leg despite the pelvic and sacral fractures. He had been seen by a physical therapist over the weekend; during that initial PT examination he’d been unable to tolerate rolling over in bed due to severe pain in his right leg.

On Monday, I became John’s primary therapist. I was greeted by his nurse who informed me she’d asked Neurosurgery to take a look at John, as he was too weak to stand, and she was concerned it might be because of his spinal fracture. Ideally, she would have liked to get him out of bed and into a chair as Orthopedics wanted to re-image his fractures after standing mobility. Since I was there to examine him, I offered to assess his impairments and help come up with a plan to assist him to stand safely. John had just received his pain medication, so it was a good time to proceed.

John was sitting on the edge of the bed after a failed attempt to stand with his nurse. He said, “I can’t stand. My calf cramps up.”

John appeared distraught, expressing surprise and frustration at his limited mobility. He was concerned that he wouldn’t be able to return to his job, which required physical labor, which would affect his ability to support his family. I listened to John. I knew I had to validate his concerns and the gravity of the situation from his perspective. I acknowledged that, yes, the injury was serious, and his recovery would be painful and require several weeks of physical therapy. But I assured him that with hard work, he could return to an independent, productive life. I suggested we try to focus on what we could control in that moment.

Once John knew I was listening to him, I was able to ask more probing questions about his symptoms to help me determine what might be causing his pain. John was apprehensive about engaging in physical therapy given his nurse’s concern about his leg weakness. I knew I’d have to perform a thorough examination to instill confidence in John about my ability to assess his pain and perceived weakness. I explain—

continued on next page
I think John’s improvement was maximized by my collaboration with his providers and my ability to communicate with John and the team at a level everyone could understand. I think my work with John helped instill confidence in him enabling him to achieve maximum benefit from physical therapy.

ed my plan, which was to re-evaluate his strength and sensation at the edge of the bed and try to improve his mobility and tolerance. After assessing his strength, I found he was primarily limited by pain, as expected, which was weakest at his right hip. I performed a modified test (due to John’s brace) to look for nerve-root involvement, which reproduced the pain in his calf. My sensory exam showed diminished sensation to light touch in his sacral dermatome, levels 1-2. I was able to discern what I believed the cause of John’s symptoms to be.

John’s nurse and the neurosurgery resident listened as I explained my findings to John. I explained that it appeared John’s strength was most impaired due to pain at the pelvic and sacral fractures, that his strength in many muscle groups was intact, and that his sensation was limited in dermatomes affected by his sacral fracture, which was confirmed by his MRI. I explained that the nerve-root levels responsible for referring pain to his calf upon standing were the same as those used when extending his knee and flexing his foot. Placing neural tension on those nerves re-produced the pain. Given the loading of his sacrum while standing, this could further irritate the nerve roots near the fracture site.

I asked the resident if he agreed with my assessment, and he concurred that there was no concern about compromise of the spinal cord due to the spinal fracture; so there were no safety concerns associated with progressing mobility.

I knew it would go a long way toward gaining John’s trust and facilitating progress if he had a successful physical-therapy experience. I decided to take advantage of having three providers in the room giving John an increased sense of safety with added assistance. I asked John to try to stand while the nurse and resident assisted with chair placement, and I facilitated his mobility. This gave John confidence. As I assisted him, I noted that he put the toes of his right foot on the floor but was unable to place his whole foot flat on the floor due to pain in his calf, which he described as shooting and stabbing. I facilitated a pivot transfer to the chair, keeping his weight primarily on his left leg to minimize pain.

After successfully completing the transfer, John seemed less anxious and pleased with his progress. I spoke with John and his nurse about a plan for how to get him back in bed. I took the opportunity to discuss our plan for physical therapy while John was at MGH and my recommendation for inpatient rehabilitation upon discharge. I shared the results of my examination with the team, emphasizing the primary limiting factor of pain in his right calf, which I felt was due to the compression of the nerve root. I asked the team if they thought adding gabapentin to target the nerve-related pain would be appropriate.

The next day, I performed strength and sensation testing with John, and his exam was consistent with the day before. I had coordinated with his nurse to pre-medicate John prior to our session. I assisted him in ambulating about 20 feet, but he was still unable to place his foot flat on the floor due to pain in his right calf. I reviewed his medications and noted that he hadn’t been started on gabapentin. I wondered if the team had decided it wasn’t appropriate for him. I caught up with John’s nurse practitioner in the hall and asked why he hadn’t been started on the gabapentin. Did the team think his pain was due to something else? The nurse practitioner agreed that gabapentin was a valid suggestion and said she’d confirm it with the team.

John was later started on gabapentin. After starting on the gabapentin, John’s pain improved. He was able to mobilize more and progress with gait training. I think John’s improvement was maximized by my collaboration with his providers and my ability to communicate with John and the team at a level everyone could understand. I think my work with John helped instill confidence in him enabling him to achieve maximum benefit from physical therapy.

When John was discharged, I sent a discharge summary detailing my exam findings. This set him up to be able to pick up where we left off when he transitioned to inpatient rehab. John expressed great appreciation for my time, thoroughness, patience, and encouragement throughout his stay.

Comments by Jeanette Ives Erickson, RN, senior vice president for Patient Care and chief nurse

This narrative is a great reminder that life can change in an instant. John’s fall thrust him into a situation where he worried whether he’d be able to support his family. Kristin knew she had to treat his emotional as well as physical health. Her knowledge, confidence, and skill gave John confidence that he could recover, which eased his fears so he could focus on the tasks at hand. Kristin worked seamlessly with the team to ensure John was safe, adequately medicated, and able to participate in his recovery.

Thank-you, Kristin.
Professional Achievements

Daigle Millotte certified
Staff nurse, Nicole Daigle Millotte, RN, became certified in Pediatric Nursing in November, 2015.

Haneffant certified
MGH-West staff nurse, Lori Haneffant, RN, became certified as an ambulatory perianesthesia nurse in November, 2015.

Firm speaks
Emily Firn, OTR/L, occupational therapist, was a lecturer at Boston University through December, 2015.

Harrington certified
Staff nurse, Nichole Harrington, RN, became certified as a critical care nurse in December, 2015.

Rushfirth appointed
Katherine Rushfirth, CNM, nurse midwife, was appointed president of the Massachusetts affiliate of the American College of Nurse Midwives, December 8, 2015.

Fostering Research-Intensive Organization recognized
The book, Fostering a Research-Intensive Organization: an Inter-disciplinary Approach for Nurses from Massachusetts General Hospital, by Jeanette Ives Erickson, RN, senior vice president for Patient Care; Marianne Ditomassi, RN, executive director; PCS Operations; and Dorothy Jones, RN, senior nurse scientist and director emeritus of The Yvonne L. Munn Center for Nursing Research, took second place in the Nursing Research category of the American Journal of Nursing Book Awards, December 29, 2015.

Hovsepian certified
Staff nurse, Jennifer Hovsepian, RN, became certified as an ambulatory perianesthesia nurse in November, 2015.

Limone certified
Staff nurse, Anna Limone, RN, became certified as a pediatric critical care nurse, in December, 2015.

Amirhosseini a panelist
Zary Amirhosseini, disability program manager, was a panelist for the National Diversity Leadership Exchange at the National Disability Institute in Washington, DC, on December 2, 2015.

McGah certified
MGH-West staff nurse, Cheryl McGah, RN, became certified as an ambulatory perianesthesia nurse in November, 2015.

Firm presents
Emily Firn, OTR/L, occupational therapist, presented, “Innovative Approaches to Intervention for Chronic Disease,” at the Lead the Way Symposium at Boston University, October 3, 2015.

Armstein appointed
Paul Armstein, RN, clinical nurse specialist, Pain Relief, was appointed a member of the Pain Management Expert Panel of the National Committee for Quality Assurance, in November, 2015.

Armstein presents

Amirhosseini a panelist
Zary Amirhosseini, disability program manager, was a panelist for the National Diversity Leadership Exchange at the National Disability Institute in Washington, DC, on December 2, 2015.

O’Gara certified
Staff nurse, Kathy O’Gara, RN, became certified as a pediatric critical care nurse, in December, 2015.

Porter-Joseph certified
Staff nurse, Katie Porter-Joseph, RN, became certified in Medical Surgical Nursing in December, 2015.

Wealth certified

SLPs present

Inter-disciplinary team publishes
Lucas Januszewicz, MD; Eszter Vegh, MD; Rasmus Borgquist, MD; Abhishek Bose, MD; Ajay Sharma, MD; Mary Orencole, RN; Theofanie Meia, MD; Jagmeet Singh, MD; and Kimberly Parks, MD, authored the article, “Prognostic Implication of Baseline PR Interval in Cardiac Resynchronization Therapy Recipients,” in the November, 2015, Heart Rhythm.

SLPs team presents
Dee Adams Nikjeh, CCC-SLP; Denise Dougherty, CCC-SLP; Kathleen Holterman, CCC-SLP; Renee Kinder, CCC-SLP; Carmen Vega-Barachowitz, CCC-SLP; Timothy Weise, CCC-SLP; and Neela Swanson, presented, “Coders, Documentation and Reimbursements for SLPs: Learn the Basics from the Experts,” at the annual convention of the American Speech-Language and Hearing Association, in Denver, November 12, 2015.

Beaton certified
Staff nurse, Robyn Beaton, RN, became certified in Pediatric Nursing in November, 2015.

Armstein presents

Walth certified

SLPs present

Inter-disciplinary team publishes
Dee Adams Nikjeh, CCC-SLP; Denise Dougherty, CCC-SLP; Kathleen Holterman, CCC-SLP; Renee Kinder, CCC-SLP; Carmen Vega-Barachowitz, CCC-SLP; and Timothy Weise, CCC-SLP, presented, “ICD–10 and Reimbursement Hot Topics for Speech-Language Pathologists,” at the annual convention of the American Speech-Language and Hearing Association, in Denver, November 13, 2015.

Caring Headlines — February 18, 2016

Page 8
Conway certified
Staff nurse, Abigail Conway, RN, became certified in Pediatric Nursing in November, 2015.

MacLean presents
Julie MacLean, OTR/L, occupational therapist, presented, “PT’s and OT’s Roles with Huntington Disease,” at a meeting of the Huntington Disease Association in Charlestown, November 14, 2015.

SLPs present
Speech-language pathologists, Cheryl Hersh, CCC-SLP; Sarah Sally, CCC-SLP; and Marie de Stadler, CCC-SLP, presented, “Radiation Exposure from Videofluorescopic Swallow Studies in Children with a Type 1 Laryngeal Cleft and Pharyngeal Dysphasia: a Retrospective Review,” at the annual convention of the American Speech-Language and Hearing Association in Denver, November 13, 2015.

Pizzi certified
Staff nurse, Julie Pizzi, RN, became certified in Emergency Nursing in December, 2015.

SLPs present

Maietta presents

Inter-disciplinary team presents

Goldsmith presents

Patient advocates present

Therapists publish

Arnstein publishes

Inter-disciplinary team publishes
Padma Gulur, MD; Katharine Koury; Paul Arnstein, RN; Hang Lee; Patricia McCarthy; Christopher Coley, MD; and Elizabeth Mort, MD, authored the article, “Morphine Versus Hydromorphone: does Choice of Opioid Influence Outcomes?” in Pain Research and Treatment, 2015.

Sullivan presents

Looby named Clafin Distinguished Scholar
Sara Dolan Looby, RN, nurse scientist, has been named a 2016 Clafin Distinguished Scholar for her project, “Cardiovascular Risk in HIV-Infected Women: Sex-Specific Mechanisms of Risk and Risk Reduction among REPRIEVE Trial Participants.” She is the first nurse at MGH to receive this prestigious honor.

Clinical Recognition Program
Clinicians recognized from October, 2015, to February, 2016

Advanced Clinicians:
- Abigail Fleisig, RN, Emergency Department
- Elizabeth Hanly, RN, Cardiology
- Jacqueline Havey, RN, Cardiology
- Erin Laing, RN, Main OR
- Elissa LeFleur, RN, Psychiatry
- Kristin Moms, PT, Physical Therapy
- Danielle Salguero, RN, Neurosciences

Clinical Scholars:
- Elizabeth Campbell, RN, IV Therapy
- Catherine Cusack, RN, Blake 12 ICU
- Ellen Fern, RN, Endoscopy
- Shanna Mavilio, RN, Obstetrics/Newborn Care Unit
- Tracy Waterhouse, RN, Charlestown HealthCare Center
**Office Ergonomic Champion Program**

Learning how to make yourself and your co-workers more comfortable while working at the computer:

Monday, February 22, 2016
9:00 am – 12:00 pm
Yawkey 4-940
presented by Terry Snyder, ergonomics specialist, PHS Occupational Health Ergonomics Program
Register on HealthStream
Look for Office Ergonomics
For more information, call 617-724-3995.

**ACLS Class**

Certification:
(Two-day program
Day one: lecture and review
Day two: stations and testing)

Day one:
February 19, 2016
8:00 am – 3:00 pm

Day two:
February 29th
8:00 am – 1:00 pm
Re-certification (one-day class):
April 6th
5:30 – 10:30 pm

Location to be announced.
For information, send e-mail to:
acls@partners.org, or call
617-726-3905

**Pharmacology Update IX: Innovation and Evidence**

Saturday, March 26, 2016
O’Keeffe Auditorium
7:50 am – 3:00 pm

The Pharmacology Update is a semi-annual program that focuses on current evidence-based information about medications. The March program will include medications used to treat thyroid disorders, an update on anticoagulation and antibiotic drugs that enhance and impede wound healing, and the new AHA Guidelines for Emergency Cardiac Care.

Target audience: nurses, pharmacists, and physicians

Pre-registration required
MGH employees: no fee
Partners employees: $100 per day
Non-Partner’s employees: $150 per day

Pharmacology contact hours will be awarded
Contact Hours will be awarded
For more information, call 617-726-1651.

**Black History Month Event**

Save the Date
February 24, 2016
2:00 pm
O’Keeffe Auditorium

For more information, call Deb Washington, RN, at 4-7469.

**Looking for excitement?**

Consider joining the MGH HAZMAT Team

The multi-disciplinary HAZMAT team is trained to respond to large-scale disasters involving hazardous materials.

Volunteers who qualify for the HAZMAT Response Team receive 16 hours of initial training, participate in regular practice exercises, and maintain annual competencies to ensure safety and preparedness.

To learn more, attend an informational session:

Thursday, February 18, 2016
2:00 – 3:00 pm
Haber Conference Room

Monday, March 21st
12:00 – 1:00 pm
Haber Conference Room

For more information, go to:
http://sharepoint.partners.org/phs/hazmat/default.aspx,
or contact Jacky Nally, RN, at 617-726-5353.
Raising Awareness

Physical and Occupational Therapy go RED for women’s health

MGH Physical and Occupational Therapy Services, including ten board-certified cardiovascular and pulmonary physical therapists, support the American Heart Association’s Go Red for Women campaign.
MGH continues to perform well on patient experience measures for calendar year 2015 to date, compared to the prior year. For our three areas of focus, Quiet at Night, Staff Responsiveness, and Pain Management, we’re positioned to achieve our goals.

Inpatient HCAHPS
2015 calendar year

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<th>CY 2015 Year To Date (as of 1/11/16)</th>
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Data complete through October, 2015; data partial for November, and December 2015. All results reflect Top-Box (or ‘Always’ response) percentages.