PCHs and HCAHPS Update: Cancer Hospital Workgroup

Moderators:
Deb Price, PhD, MEd,
Educational Coordinator, Inpatient Quality Reporting Program SC

Henrietta Hight, RN, BA, BSN, CPHQ
Project Coordinator, PPS-Exempt Cancer Hospitals
Inpatient Quality Reporting Program SC

Speaker:
William G. Lehrman, PhD
Centers for Medicare and Medicaid Services (CMS)

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PRESENTATION

Henrietta Hight: Hello. Welcome to the August 28th Cancer Hospital Workgroup call and webinar. My name is Henrietta Hight. I'm a Quality Specialist with the Hospital Inpatient Support Contractor. Along with Barbara Choo from CMS, I look forward to the pleasure of working with all of you on the PPS-Exempt Cancer Hospital Quality Reporting Program.

Before we get started, we've had a couple of people send in questions regarding where they can get a copy of the slides. The slides for today's presentation can be found at www.qualitynet.org under the “Cancer Hospitals” tab, then select “Webinars” from the drop-down menu.

On your computer, you will see today a tool that we're – a WebEx tool that we are using, the WebEx Q&A tool. This will give you the ability to submit questions to us during the presentation; and then at the end, time allowing, we will cover as many questions as we can.

Any questions – those questions that we have answered and any other questions that we have not had time to answer – will be answered, and then the questions and answers will be posted on the QualityNet website. So, feel free to submit your questions during the presentation.

The slide on your computer right now displays the steps that you need to follow to submit a question using the Q&A feature. What you will need to do is go up – move your mouse up to the WebEx navigation bar at the top of your screen, and you will see a menu – a drop-down menu.

Move your cursor over to the right, to the drop-down – the down arrow, and the top item in the list is a Q&A icon tool. Click on it, and the Q&A panel will display on your screen. Click the drop-down arrow next to "Ask" and select "All Panelists." Type your question, and then click the "Send" button. Your question will be viewed and addressed by subject matter experts. We look forward to your questions.

So, again, let's begin our webinar and call for the Cancer Hospital Workgroup. A couple of things just to remember. All lines from attendees are being muted automatically. The presentation is being recorded and will be posted to QualityNet. Today's slides, as we indicated, are also already posted to QualityNet. They're posted in two formats: one slide per page, and three slides per page, for your convenience and preference. And again, today we are using the WebEx Q&A tool.

Also, after today's call and webinar we will be sending a SurveyMonkey tool to each of the recipients who provided their e-mail addresses when they registered. This will give us the opportunity to get your feedback on the presentation, and there is also a text box where you can provide us the suggestions on other topics that you would like to learn about.

And now I would like to introduce our speaker. We're going to have a silent roll call using the list of the people who registered for the webinar. We'll be able to compare that to the members of the Cancer Hospital Workgroup, and that will complete what I'm calling a silent roll call. Because, since you all are all on mute, you can't say "present."

Just to give you a couple of PCHQR updates, the HCAHPS update is going to be presented today to give you – to prepare you for the Quarter 2 2014 data submission of the HCAHPS survey results that are due on October 1st. Also, another update – we are working very hard with Barbara Choo and our team here to look at the Cancer Hospital tab on QualityNet, identifying some opportunities for improvement to make the tab more navigable for you to find all the information that you need.

And now I would like to introduce our speaker for today, William G. Lehrman. William G. Lehrman is the Government Task Leader for the HCAHPS Survey, which is the Hospital Consumer Assessment of Healthcare Providers and Systems at CMS, the Centers for Medicare and Medicaid Services.

Since joining CMS in 2003, he has participated in the development, management, public reporting, and oversight of HCAHPS, and the analysis and publication of its results.

So, Dr. Lehrman, we look forward to hearing from you as the expert on the HCAHPS Survey.

William Lehrman: Thank you, Henrietta, and thanks to everybody for spending some of their busy time with us today to learn about the HCAHPS Survey.

As Henrietta mentioned, I'm the Government Task Leader for the HCAHPS Survey. I've been working on HCAHPS since 2003, so, from the very beginning. So, I'm pretty familiar with it.

Today I'd like to cover some basics about the HCAHPS Survey, and also leave time for some questions and answers. I will be talking for maybe 40 to 45 minutes about the HCAHPS Survey, and try to reserve some 10 to 15 minutes at the end to address the questions. And I think Henrietta explained how to submit questions for us to queue up and then to answer toward the end.

So, today we're going to go over the HCAHPS Program and background, and talk a little bit about the purpose of the survey. We're going to look at a little bit – in a little bit more depth at sampling and administration of the survey. We already mentioned the PCH data submission timeline. We'll be saying a bit more about that. And I will give you a slide that has a lot of important details on it as to where you can find more information about joining HCAHPS, asking questions about it, and submitting data.

And let me put a plug in for our hcahpsonline website. That's the website address at the bottom of this page. That is really the main source of information about HCAHPS. That's where we put up current information.

We make a lot of in-depth analyses of HCAHPS data available; we notify HCAHPS users of important events that are upcoming; we have the survey there; we have the quality assurance guideline manual there. We have just a wealth of resources. So, if you're doing HCAHPS you should become very familiar and frequent the hcahpsonline website.

Here's the data submission schedule for the PCH hospitals. And this is the regular data submission schedule for HCAHPS data. So, for instance, Q2 2014: those are patients discharged between April and June of this year. The data submission deadline for those surveys is October 1st. So, if you began or have been doing HCAHPS Surveys, that data is due October 1st.

Similarly, every quarter has a data submission deadline, as you can see on this slide. I'm assuming a few of the hospitals – PCH are doing HCAHPS currently. Maybe a few are getting ready to do it, and maybe a few are thinking about getting ready to do it.

Just let me mention that we have regular HCAHPS training in March of every year. We have a sign-up period that begins, I think, in maybe January. We can sign up for training. So, if you're – even if you're going to use a survey vendor for HCAHPS, we recommend that you attend the training just to get a better idea of how we do HCAHPS, and the important things involved.

A little bit of HCAHPS background. HCAHPS was developed jointly by the Agency for Healthcare Research and Quality and CMS. We implemented the survey back in 2006. Back in 2006, about 2,500 hospitals started participating. It was voluntary at that point.

We began publicly reporting HCAHPS scores in 2008, and about that time – actually 2007 – all IPPS hospitals had to participate in HCAHPS and publicly report their scores in order to get their full annual payment update.

Then, beginning in – well, actually October 2012, IPPS hospitals had to participate in a value-based purchasing program at CMS, and HCAHPS has, from the beginning, been one element in the scoring formula for VBP.

The goal of the HCAHPS Survey is to provide standardized – a standardized survey instrument and data collection methodology for measuring patient perspectives on hospital care. .

We can break that down a bit into three objectives of HCAHPS. Standardization of the surveys permits meaningful comparisons across hospitals for public reporting purposes. So, from the very beginning – in fact, the initial motivation for HCAHPS was to provide public reporting of patient experience of care, to allow comparisons and selections across hospitals.

It also increases the hospital's accountability, and increasingly has also provided incentives to hospitals for them to improve their quality of care, especially their patients' experience of care. And we also think that HCAHPS helps to enhance public accountability for the investment that is made by society into hospitals by shedding more light on patient experience.

A bit more detail. HCAHPS standardized – standardizes how hospitals gather and interpret data on topics that are important to consumers.

I should mention that we just didn't pull the HCAHPS items out of the air. There's a long process of reviewing the literature, of creating questions that are important to patients, of testing them on focus groups and other groups, of trialing the early versions of the survey, seeing what worked – what didn't work. We spent a lot of effort actually reducing the number of items. HCAHPS is a fairly short survey, as these things go.

We created a very detailed process and scientifically tested process to standardize the survey, and then standardize data – sorry, how the survey's administered, how the data is submitted, how the data is analyzed and reported.

HCAHPS has created a common metric for patient experience of care data. Before HCAHPS, a lot of hospitals do – and maybe still do – had a way of – had a survey. But HCAHPS was the first publicly reported standardized national survey of patient experience of care. It's become a common metric. Some people call it the industry standard or the gold standard for

measuring and reporting patient experience of care. It facilitates comparison across hospitals through public reporting reports. It's utilized in value-based purchasing. It motivates hospital quality improvement. And it also addresses National Quality Strategy priorities.

The method of HCAHPS. This is making it pretty basic. The survey asks patients about important aspects of their experience in a hospital. We collect the data in a standardized and a consistent manner across all participating hospitals. We analyze and adjust the data. I'll tell – say a bit more about how we do that. And then we publicly report the results.

The hospitals receive the results several months before they're publicly reported. They get those results in preview reports from CMS or one of its contractors. Hospitals that employ survey vendors, or maybe even do the survey themselves, get the data much more quickly than what we can provide. So, we encourage hospitals to look at those early unadjusted results to get some idea about patient experience of care – address problems sooner – as soon as possible.

It's important to note that the survey asks only what only the patient knows. It's been established that patient experience of care is a fundamental aspect of the healthcare experience and a distinct dimension of quality.

We have done a lot of research on HCAHPS results, as well as a lot of other people. The results are publicly reported. And there's a growing body of literature that better patient experience of care is linked to better technical quality of care, better clinical outcomes, better 30-day readmissions, lower mortality, and a host of other clinical and outcome measures.

A lot of research, and a growing body of research, is establishing that, indeed, good patient experience of care is associated with clinical and other outcomes, and that by improving patient experience of care, hospitals typically improve those other outcomes.

Looking at the survey itself, the 32 items – the first 25 items, we call the core of HCAHPS. It's important to note that when you do – when you participate in the HCAHPS Survey, you cannot mess with the survey. It has

to be given the same way every time: that is, the same sequence of questions, the same wording, the same response categories, et cetera.

The first 25 items are the core of the survey. When you participate in HCAHPS, these are the first 25 items on the survey. There are 21 substantive items about patient experience, and there are four screener items that tell patients whether or not – or, ask patients whether or not something happened, and thus whether they should answer the subsequent questions.

The second part of the survey we call the "about you" items. There are seven questions about information about the patient. Those can be separated from the core items. If a hospital wants to add some supplemental items, they have the option of adding those after the core items and before the "about you" items. Or, they can ask – add them after the "about you" items. They cannot ask them before the core items. The core items have to be the first items on the survey.

Here are some actual questions from the survey. And I'm showing you these just to make a few points about how HCAHPS asks patients about their experience.

You might notice that the questions begin, "During this hospital stay." We try to ground the patient in the hospital stay. The cover letter the patient receives, or the beginning of the interview if on the telephone, will ask the patient: “Were you in the hospital and discharged at a particular date, or about that date?” And they'll say, “Yes.” And they say, “Okay, everything refers – all these questions refer to that hospital stay.”

The second thing to notice is, we ask how often important things happened – how often important things happened. We don't ask how satisfied you were with something. We ask how often things happened. Such as, how often did nurses treat you with courtesy and respect? So, the HCAHPS – in fact, the whole family of CAHPS surveys asks how often certain key experiences happen during a – in this case, an inpatient hospital stay.

The response categories run from most negative to most positive. That is, never, sometimes, usually, and always. And that's true for almost all the

HCAHPS items, with a couple of exceptions. There are also – there are good methodological reasons why we present them in this order. In fact, there's good methodological reasons why the survey has to be presented just like this. This is the mail version of the survey. A lot of testing has gone on about the best way to display the response categories, et cetera. We decided this was the best way to do it, and we have standardized that.

So, what comes out of the HCAHPS Survey? There are 20 – what did I say? – 25 substantive questions. And from those 25 substantive items, we publicly report 11 pieces of information on Hospital Compare, beginning with the seven composites.

The seven composites are, as you can see here: communication with doctors – with nurses; with doctors; how responsive were the staff; questions about pain management; communication about medicines; discharge information; and something that's brand new in this December's public reporting – transition to post-hospital care.

Each of the composites are made of two or three items in the survey. We just saw the three items that went into the communication with nurses composite. And the reason we roll certain items up into these composites is, we think it's easier for consumers and patients to understand the information when we arrange it this way.

There are also a few individual items. We ask an individual or single question about cleanliness of the hospital, and one about the quietness of the hospital. These are not composites. We just ask the question and report the results to each of these single questions.

And then there are two – we call them global items, asking about the hospital stay in general. The overall rating of a hospital on a scale from 0 to 10; and would you recommend this hospital to friends and families – friends and family, on a 4-point scale.

Just a few comments about these items. These are fairly typical items on patient experience surveys that preceded HCAHPS. A lot of hospitals wanted to have something like this on the HCAHPS survey for continuity with what they've been asking in the past. If you read the literature on

HCAHPS, either popular or scientific, you will note that a lot of people use these as the main indicators from the HCAHPS survey.

We don't see them that way. These are just two items in the survey. And overall rating the hospital, 0 to 10, taking everything into account, what did you think about your hospital stay? Recommend this hospital – would you recommend it to friends and family?

These two items don't ask specifically about part of the patient experience. They don't ask about discharge information, or communication with nurses, or how clean was the room, et cetera. They ask about overall impressions, and we think that they're valid for that reason.

But we don't think they should be used as a summary of the patient's hospital experience. We don't think they should be looked – the only thing looked at when hospitals review the data, or when – for that matter – when researchers analyze the data. They're just two items on the survey.

In addition to the substantive items, there are seven demographic items. We call these the "about you" section of the survey. We ask the patient about their level of education, their self-reported health status, their ethnicity, their race, their language spoken at home.

We ask these questions, in part, to do patient-mix adjustments on the survey data, for analytical purposes, and also for congressional reports. So, the two items in the survey that are the – create the most friction, are the ethnicity and race items. We have to keep those items in the survey. They're mandated by Congress, and they're used in disparities reports that have to be produced for Congress. We don't use them to adjust the data; we just use them to report the data to Congress.

In addition to these seven demographic "about you" items, there are – we get some administrative data from the hospitals, such as the patient's age and the patient's service line – medical, surgical, or maternity care. We also use that information to patient – to adjust the data.

And when I say adjust the data, I mean things like – we know, for instance, that patients seen for maternity care typically have a much better patient

hospital experience than other patients. If a hospital has a lot of maternity patients – maybe only maternity patients – they tend to do better in the HCAHPS Survey, but it's mainly because of the types of patients they see.

Because we know that patients within service lines tend to have different experiences and report things differently, and the same with age and education, we adjust for those factors such that we can fairly compare all hospitals to each other as if they had the same mix of patients.

A couple of points to remember for the PPS-Exempt Cancer Hospitals. The national/state benchmarks do not apply. What we mean here is, when we publicly report HCAHPS results in Hospital Compare – and I'd strongly encourage you to look at how we do it on Hospital Compare; you can go to that website – you'll see that we'll give a hospital's results for, say, communication with nurses. We'll give the state average for that composite as well as the national average for that composite.

That's just for comparative purposes. We don't use that – we, CMS, don't use that for anything except to show the public for comparative purposes. Those state and national benchmarks aren't applied to the – any hospitals. They're just there to show how the hospital does compared with state and national – other hospitals.

Currently, I believe there are three, or maybe more, PPS-Exempt Cancer Hospitals that participate in HCAHPS, and I understand that even though they participate fully and they report the data to us, and they get preview reports, that CMS does not currently publicly report the results for that category of hospitals, that is, PCH hospitals.

A couple of important roles and responsibilities for your – for you; for your hospital. Comply with all HCAHPS Survey protocols. If you're using a survey vendor – and I hope most of you will, if not all – provide your patient discharge list and admin data in a timely manner to the survey vendor so the survey vendor can select a sample and do the survey.

We strongly recommend that hospitals use the survey in the language that the patients speak. We provide official translations of the mail survey in English, Spanish, Chinese, Vietnamese, Russian, and, just recently,

Portuguese. And now, vendors and hospitals don't have to use anything but English. But we strongly recommend that if you want to know about the experience of all your patients, not just the English-speaking ones, that you do the survey in those official translations.

There are a number of feedback reports that come from the data warehouse to the hospital or survey vendor. We recommend you look at those. And also, do not influence patients about the survey. And I'll be saying a bit more about that later.

But essentially, we don't want hospitals trying to game the system by doing things like wearing buttons or badges, or having posters saying, you know, say that we're an "always" hospital, or give us a 10 and we'll get a free pizza party, or something like that.

We strictly forbid any kind of attempts to influence how patients will answer the survey. We want the patient to answer the survey free of any influence from the hospital, the survey vendor, or anybody else.

I'm assuming, if not hoping, that PCHs and other hospitals will use survey vendors. In fact, about 98% of hospitals use a survey vendor for the HCAHPS survey. And those survey vendors, by the way, have to be approved by CMS. We oversee the survey vendors. We visit them. We check their data very carefully, quite frequently, from our database, to make sure that things are being done correctly.

We communicate very often with survey vendors to make sure they understand how to do things. If they're having problems, they communicate with us. So, the survey vendors who are approved to do the HCAHPS Survey – by the way, they're listed on our hcahpsonline website – are carefully trained and constantly monitored to make sure they're doing the survey correctly.

But if a hospital is using a survey vendor, then we want to just note here that they must – the hospital must submit its entire discharge list to the vendor in a timely manner. We ask that they monitor the feedback reports, comply with any oversight that we want to perform, and, of course, go to hcahpsonline regularly to see what's new.

Just one note about using a survey vendor. They are approved, and we do monitor and oversee them. However, if there's a problem with the survey, and we find out that there was mistakes – so, for instance, maybe a hospital forgot to submit a couple of months of data, or the vendor did, or the vendor only surveyed maternity patients and omitted medical and surgical patients; or lots of other circumstances.

When we become aware of those situations, we sometimes will apply a sanction – usually a footnote to the data in – on Hospital Compare saying there was a discrepancy in the way the data was – survey was administered. And we work with the vendor and the hospital to make sure that discrepancy is corrected and not repeated.

But if something goes wrong, and that's a mild thing that goes wrong, the hospital gets a footnote on Hospital Compare. If it's something major, like they failed – well, it wouldn't apply to – I don't think it applied to PCH hospitals, because they're PPS-exempt. But there are other requirements of IPPS hospitals that, if they fail to meet the requirement, and even though it's the vendor's fault, the penalty – or footnote or withholding of payment or whatever – applies to the hospital, not to the vendor.

So, choose your vendor carefully. Monitor your vendor. Make sure that they're doing things the right way and on time because if something goes wrong, the penalty will accrue to the hospital.

I'm hoping we're not having any self-administering hospitals out there. If they do want to self-administer, they will have to attend training the next time it's offered, which will probably be March of 2015.

A couple of key points about data collection. Hospitals should strongly strive to achieve at least 300 completed surveys in a 12-month reporting period. The HCAHPS Survey is continuous and ongoing. It goes through every month of the year – hopefully covers patients discharged every day of the year.

Unlike a lot of other surveys, we require multiple attempts to contact patients. If you're doing a mail survey, they have to get the initial survey, and if no response, a second survey. If you're doing the telephone mode,

there are up to five attempts to reach the patient to do the survey. And also, let me note that no proxy respondents are allowed. That means only the patient himself or herself can answer the survey. We want to hear from the patient directly about the experience.

Even if the spouse or the child or the – anybody else would like to answer the survey, they're not allowed to; only the patient can report – can answer the survey, because it's about the patient's experience and perceptions of the hospital stay.

This – data collection. As I mentioned, or maybe I didn't mention, there are four different survey modes, and we'll talk about those a bit later. And the data is submitted to our QualityNet warehouse through a secure portal, and the – we recommend that the data be submitted in the XML file format.

There is a lot of technical information about how to administer and – the survey and submit the data. We cover that in training in March. It's also covered in some detail in the Quality Assurance Guidelines, and I should have mentioned that earlier. That is a very large manual that goes over every aspect of the survey and survey administration.

Quality Assurance Guidelines are now up to volume 9.0. We've been doing it for nine years now. And you can get the QAG, or Quality Assurance Guidelines, on the hcahpsonline website.

A couple of key points about survey administration. And things that make HCAHPS special or different, and we think more effective than the average patient satisfaction survey.

The survey is administered after discharge. The patient has to be discharged from the hospital 48 hours afterwards at the earliest, up to six weeks after discharge. So, the survey is post-discharge. We want the patient to be at home or wherever the patient goes to after discharge, before the patient answers the survey. We don't want the hospital to have any direct ability to influence how the patient answers the survey.

It's – HCAHPS is administered to a random sample of eligible discharges. There are four modes of survey administration: mail, telephone, mixed mode – and by that we mean a mail survey is followed by telephone follow-ups if the mail survey is not returned – and then IVR, or Interactive Voice Response. Okay. That's right. That's another option for administering the survey.

Regardless of which survey mode is used, there are standardized data collection, data submission, analysis we do, and reporting. And I should have mentioned earlier when I talked about patient mode adjustment – another thing we adjust for is survey mode. We know, and it's well-established, that when people answer a survey by telephone, they tend to be more positive in responding, and in the way they respond, than if they get a mail survey.

Survey results should not reflect simply the mode of survey administration. So, we also do an adjustment for mode of survey. So, essentially, telephone surveys are adjusted downward relative to mail surveys, because of that effect of people giving more positive responses to a telephone survey than they would, had they had the same survey by mail.

Communication with patients – or not communicating with patients might be a better way to put it – no communication with patients intended to influence survey results is permitted.

We've seen hospitals get very creative, putting up signs and posters in the hospital, nurses or other people wearing buttons or badges. We've even come across a hospital that had placemats, and on the placemats was printed the survey questions and encouragement that the patient answers "always" or "ten" or "definitely recommend" – whatever the highest response category is.

We strongly discourage that. If you know hospitals are doing that, let us know; we'll remind them that they're not allowed to do things like that to influence how the patient answers the survey, or even if the patient gets a survey, or at all.

No incentives are allowed. You can't have one ward getting a prize because they had better results than another ward on the HCAHPS survey. The – we don't allow incentives to the patients or – and we discourage incentives to – or, at least, the hospitals saying, oh, you know – or the nurse saying, or the doctor saying, I will get a bonus if you rate me a ten. That is not allowed.

You shouldn't show the survey to the patient while the patient's in the hospital. And there's no pre-notification letter or postcards about the survey. You can tell all patients in the hospital that they may receive a survey after their discharge. That's okay if all patients are told, but we don't want specific information about the survey being given to patients while they're in hospitals.

I'm going to cover sampling very briefly, because I'm assuming most of the hospitals are using a vendor, and the vendor is the person or entity that's in charge – that's charged with doing the sampling. But essentially, these are the steps in the sampling process: identify the population that's eligible to survey; identify the patients who are eligible for HCAHPS – and we'll talk about the major eligibility criteria in a moment; remove patients who should be excluded from the survey; perform de-duplication.

So, for instance, if a patient is in the hospital twice in the same month, only one of those visits is eligible for the survey, and the other visit will be de-duplicated. Develop the HCAHPS sample frame – that is, the patients who are eligible and not excluded – and then draw the sample. And, as I mentioned, you can find in-depth information about doing sampling on our website and in the Quality Assurance Guidelines.

So, who is eligible for the survey? These are the most important parameters. The survey is meant for adults – that is, 18 and older – patients who were seen. Or if the primary service line was medical, surgical, or maternity care, they had to be in the hospital overnight or longer; that is, they had to be an inpatient and spend at least one night in the hospital, and they had to be alive at discharge.

That may seem very obvious, of course – how else are they going to do the survey; why would they get the survey? But it also underscores the point that only the patient himself or herself is allowed to answer the survey. We

want to hear from the patient himself or herself. If the hospital knows that the patient died after discharge, they can remove that patient from the sample frame. But otherwise, they would be in the sample frame.

And in general, about 80 to 85 percent of hospital patients are eligible for the HCAHPS Survey. The primary categories of patients who are not eligible are pediatric – that is, under 18 – and those with a psychiatric primary diagnosis.

Who do we exclude? In addition to the ones I just mentioned, there are a couple of other exclusion categories. Patients who are discharged to hospice; patients who are discharged to court or law enforcement – that is, to prison or jail; patients with a foreign home address; patients who at admission request that there be no publicity about them being in the hospital. If they request that, then they would not be eligible to receive the survey either.

Some states have further regulations about who is eligible for surveys. You'd have to consult the states you operate in about those regulations.

And more recently, we excluded patients who are discharged to nursing homes, skilled nursing facility swing beds within hospitals, and skilled nursing facilities. Now, the primary reason for these exclusions is that these types of patients are very hard to contact within that two-day to six-week post-discharge window for submission of the survey, or they're very difficult to contact in certain institutions like nursing homes. So, we decided over the years to categorically exclude these types of patients.

I mentioned earlier that hospitals should acquire at least 300 completed surveys in a rolling four-quarter period; that is, a four-quarter period. That is because we need 300 completed surveys to meet the kind of statistical reliability that we feel is necessary for public reporting and other purposes.

In order to get 300 completed surveys, as you might guess, you've got to survey more than 300 patients. We give some guidelines; in fact, the – a formula in the Quality Assurance Guidelines about how many patients you ought to target in order to get 300 completes over four quarters. And in fact,

we ask hospitals to try to get 335 completes, because that improves the chances of them getting at least 300 completes.

I mentioned some of these points earlier, but they're worth reiterating. Sampling is ongoing and surveys are ongoing. Patients throughout each month and throughout each day of the month should be eligible for the HCAHPS survey. The sampling may be done on a daily, weekly, bi-weekly basis, or at the end of the month. But the sample frame must include eligible discharges from the entire month; that is, every day of the month. So, all eligible discharges must have an equal chance of being sampled for the survey.

That's another important feature of the survey that separates it from other satisfaction or other types of surveys that hospitals or other healthcare providers may use, or may have used. We want everybody in the hospital who is eligible to have a chance to receive the survey.

What happens if you get more than 300 completed surveys? Well, we're happy about that. But do not stop surveying when a total of 300 is reached. Continue to survey every patient in the sample in every month. That is, the surveying must continue even if your – even if a hospital sets a predetermined quota or target. Even if it meets that quota, it must continue to survey throughout the month, throughout the year.

We have a problem sometimes clarifying this point with vendors who may be more familiar with doing, say, marketing surveys, where a certain quota of surveys is all they need, and once they get that quota they can stop. HCAHPS is not like that. It's continuous. It's ongoing. It's meant to get at least 300 completes. We're more than happy if hospitals get more than 300 completes. We use all those surveys to calculate the scores for public reporting.

If, on the other hand, you have – you're a small hospital or you have big problems getting patients to respond to the survey, or perhaps you're not using a Spanish-language survey even though a lot of your patients only speak and prefer to speak Spanish – if there are fewer than 300 completed surveys, attempt to obtain as many completes as possible.

And some hospitals, we say, do census sampling; that is, survey every eligible patient. Don't pick a sample, but every patient who's eligible ought to be surveyed in order to achieve that 300 complete threshold.

A couple of key points about sampling. Some of these I may have mentioned already, and some of them really do apply more to the vendors who administer the survey. The same sampling type must be maintained throughout the survey – throughout the quarter. We have rules about random sampling and a couple of other variants of random sampling that we approve. But it must be maintained throughout the quarter.

As I mentioned, the sample must include discharges from each month. If a hospital's doing multiple surveys of the same patients, then the HCAHPS sample must be drawn first and the patients must be given the HCAHPS sample – Survey before they receive some other survey the hospital may be administering.

Sometimes hospitals do studies of their own, and they may want to sample patients to administer the survey. That's okay, but we require that the HCAHPS sample be drawn first and the HCAHPS survey administered before that other survey or study is given to the patient. And as I mentioned, don't stop sampling or surveying even if there are already – you have already achieved 300 completes.

I mentioned earlier the modes of administration. I can tell you that about 60 percent of hospitals use mail mode, about 40 percent use telephone, and very small numbers use either mixed mode or IVR – Active Interactive Voice Response. I said it wrong a little bit earlier.

I mean, personally, our favorite is mixed mode. That tends to achieve the highest response rates because it used two different methods to reach the patient, but unfortunately, it's not real popular. Most hospitals opt for either mail only or telephone only.

A few things I said before I'll reiterate again. No changes are permitted to the content or order of the HCAHPS questions or answer categories for either the core or the "about you" questions. I mean, none of the questions

can be altered. They have to be used in a standardized, same manner, even the way the response category's presented.

As you noted earlier, we show them, like, in a column stepped from "never" to "always." We don't let vendors or hospitals put them in a row, as we found out through testing that when you put answers in a row rather than a column, skipping and other things tend to happen, which we want to avoid.

I mentioned earlier that the "about you" demographic items must remain together as a block – one block of questions – seven questions. They can be separated from the core questions. The hospital has the option of inserting its own customized questions between the core and the "about you." But the "about you" items, just like the core items, cannot be altered in any way, and they have to remain together as a block.

Finally, data files are submitted to CMS via the QualityNet Secure Portal and by the data submission deadline, and there are lots of rules and regulations about (inaudible) that I'm not going to get into, but if your hospital is registered or is going to register, they will be tutored by QualityNet about how to gain access, get an account, submit data, et cetera.

And the last point – copyright language must be added to the HCAHPS Survey. Well, if you look at the survey in our Quality Assurance Guidelines, it's printed out there. Or if you look at it on hcahpsonline – I'll read the language that has to be put onto the survey at the end – or we recommend it to be at the end. "Questions 1-22 and 26-32 are part of the HCAHPS Survey and are works of the U.S Government. These questions are in the public domain and therefore are not subject to U.S. copyright laws. The three Care Transition Measure questions (Questions 23 to 25) are copyright of The Care Transition Program." So, this language has to appear on the survey.

A few reminders for the hospital and the vendors. HIPAA guidelines are very important. You ought to be familiar with HIPAA guidelines – patient confidentiality – and follow those guidelines.

I'll just note here that when the data is submitted – the HCAHPS survey data is submitted to the QualityNet warehouse, it is de-identified. That is, there's no patient identifier. There's a patient ID number that's coded so the vendor knows what it is, but we don't know what it is, and nobody else knows what it is. So, the patient data is de-identified. We report HCAHPS data at the hospital level, not at the ward level, and not at the doctor level or any other sub-hospital level – just the hospital level.

Maintain patient confidentiality and data security, especially the survey vendor, but within the hospital, too. Hospitals have to be careful with whom they share their HCAHPS Survey results, whether they came from CMS or they came before that from – directly from the survey vendor.

There is a – there is recommended language in the cover letter to the HCAHPS Survey about patient confidentiality and privacy assurances. That language, I think, is required in your HCAHPS cover letters. And hospitals and especially vendors have to ensure that physical and electronic data security guidelines are being followed, again, to provide security for that patient information.

Steps to joining in 2014. Well, if you didn't join in 2014, you'll join in 2015. And the steps will be pretty much the same. You have to submit a Participation Form. You have to do training. We recommend that you do a dry run to get used to doing the survey and submitting data before it really counts.

And we'll cover all these points in great detail in training. They're also covered in the Quality Assurance Guidelines. And as I mentioned, the next training for HCAHPS will be probably in early March of 2015. And the announcements and sign-up for training will probably occur in January. .

At the outset I mentioned, well, where can I get – where can I go to get more information about HCAHPS? This is the plug for the hcahpsonline website, and it gives you an idea of what you can find there.

And the has some contact information for the HCAHPS technical assistance help desk. Either – you can contact them either by e-mail or telephone.

Please know what your CCN is and provide that when you provide your question to the help desk.

Finally, a reminder – as Henrietta mentioned at the outset – the data submission deadline for Quarter 2 discharges is coming up fast; it's October 1st. So, do plan ahead. If you're participating, plan ahead to get the data in by October 1st.

If you're really keen on finding out what we train on for HCAHPS, I believe the training slides from the last – that is, 2014 – training sessions are still on our website.

And with that, I'll conclude my portion of the presentation and open it to questions that I may be able to answer.

END

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