Hospital Value-Based Purchasing (VBP) Program

Support Contractor

HCAHPS: Overview, Updates, and Hospital Value-Based Purchasing

Presentation Transcript

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Bethany Wheeler-Bunch: Hello and welcome to the HCAHPS Overview, Updates, and Hospital Value-Based Purchasing webinar. My name is Bethany Wheeler-Bunch, and I am the Support Contract Lead for this program at the Hospital Inpatient Value, Incentives, and Quality Reporting Outreach and Education Support Contractor. I will be hosting today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the question-and-answers will be posted to the Inpatient website, www.qualityreportingcenter.com, again that's www.qualityreportingcenter.com, and to the *QualityNet* site in the future. If you registered for this event, a reminder email with a link to the slides were sent out to your email about two hours ago. If you did not receive that email, you can still download the slides at our Inpatient website. Again, that's www.qualityreportingcenter.com. If you have a question as we move through the webinar, please type your question into the chat window, and we will answer as many questions as we can, at the end of the webinar. We do request that, when you ask a question in the chat window, to please reference the slide number

within the question, so we can reference the slide in the response. As a reminder, any relevant questions that are not answered during our question-and-answer session at the end of the webinar, will be posted to qualityreportingcenter.com in the future. I would like to now introduce our presenter for today. Dr. William Lehrman is the Government Task Leader for the HCAHPS Survey at CMS. Since joining CMS in 2003, he has participated in the development, management, public reporting, and oversight of HCAHPS, and the analysis of the publicly reported results. He is also involved in the development, implementation, and evaluation of the Hospital Value-Based Purchasing Program and the coordination of patient-experience surveys for other types of healthcare providers. Prior to joining CMS, Dr. Lehrman taught and conducted research on organizations at universities in the United States, Australia, and Japan. As a reminder, please type the slide number when you are submitting your questions to Dr. Lehrman. Thank you for joining us today. And, Dr. Lehrman, the floor is now yours.

William Lehrman: Thank you, Bethany, and thanks – I thank all of you for spending some time with us today to learn about the HCAHPS Survey, and its connection with Hospital Value-Based Purchasing, and a few other topics. As Bethany mentioned, I've been working on HCAHPS since 2003, when it was still being developed. So I've been here for most of its development: its testing; national implementation, which occurred in 2006; public reporting, which began 2008; its use in Hospital Value-Based Purchasing, which began in 2012. And I'm also involved with the oversight of the survey; and, also doing research on the results. In addition to the HCAHPS work, I'm also involved in developing other surveys here at CMS, including one about emergency department patients. Okay, so next slide.

The purpose of this event is to provide an overview of the HCAHPS Survey, including: the background of the survey; trends of the HCAHPS measures over time; the role of HCAHPS and Hospital Value-Based Purchasing, or VBP; a new measure in HCAHPS Care Transition; the removal of the Pain Management dimension from the Value-Based Purchasing Program; and, a quick look at some correlations amongst the HCAHPS measures. Two things I mentioned at the outset. I think I might have forgotten to put this in the slide. We have a website for HCAHPS. It's called hcahpsonline.org. That's hcahpsonline.org. And that's our dedicated website for HCAHPS, where we put up all the information. We put

up some of the results. We put up information for hospitals and survey vendors, and lots of other interesting stuff. So, I'll refer to that, and I'll give it to you again later, but hcahpsonline.org is the place to go for official information about HCAHPS. Okay, next slide, Objectives.

At the conclusion of this presentation, participants will be able to recall the background of the survey, identify how hospitals will be evaluated using HCAHPS in Hospital Value-Based Purchasing, and recognize implications of the new Care Transition Measure and the removal of the pain dimensions in HVPB. And, I may toss in a few other nuggets along the way. Next slide.

The name of the survey. Well, the official name is the CAHPS® Hospital Survey. And please notice that CAHPS is a registered trademark of the Agency for Healthcare Research and Quality, another US government agency. So the official – while the official name is the CAHPS Hospital Survey, it's also known as Hospital CAHPS or more simply as HCAHPS, which is pronounced as you can see here, "H-caps." HCAHPS standardizes how hospitals gather and interpret data on topics that are important to consumers and patients. It creates a common metric for patient experience of care. It facilitates comparison across hospitals through public reporting of how well they do on the survey. As you know, it's been utilized for value-based purchasing since 2012. And, we hope and believe that it motivates hospitals to improve the quality of care that they provide for all of their patients. It also addresses one of the National Quality Strategy priorities. Next slide, is a quick overview of the method of HCAHPS.

This is very simply what the survey does. We ask patients about fundamental aspects of their hospital experience. That is, we survey patients. And we do that in a standardized, consistent manner, across all hospitals that participate in HCAHPS. We believe that patient experience of care is fundamental to healthcare quality. And that patient experience is a distinct dimension of quality. It's also related to other measures of quality. And since HCAHPS has been implemented, and the results have been published, lots of research have been, has been, done on hospitals and how well they do in HCAHPS. And, many researchers have found, that hospitals that do well on patient experience, as measured by HCAHPS, also do well on clinical quality measures, on outcome measures like mortality, on readmissions, on patient safety, and a host of other,

maybe more traditional, measures of hospital quality. So we truly – we always believed – and now there's a lot of evidence to support – that patient experience of care – patients have a unique window into hospital quality, and what you know. And how they experience quality there often reflects other aspects of hospital quality: clinical, and process, and outcome measure, or outcome dimension, as well. So we believe, we always believed, and we have more evidence now, that the patient experience of care is a very good indicator of overall quality of the hospital. So we analyze – we collect the data, we analyze it, and adjust it. We report the results on *Hospital Compare* website. And we hope hospitals, and we believe hospitals, use this information to improve the quality of care in their facilities. Okay, next slide.

I call HCAHPS 101, series of slides. Talking first about which hospitals participate in HCAHPS. So basically, it's short-term acute care hospitals. Sometimes called general hospitals. These include both inpatient prospective payment system hospitals, that's a CMS term most of you are probably familiar with, and also Critical Access Hospitals. These are different categorizations of hospitals CMS has created for paying hospitals. IPPS hospitals are penalized if they do not participate in HCAHPS; whereas, other hospitals, including Critical Access Hospitals, can participate in HCAHPS if they'd like to. And I notice, this slide should have been updated. It says, "PPS-exempt cancer hospitals can voluntarily participate." I believe their participation is now mandatory. So just recently, the cancer-exempt hospitals have been mandated to participate in HCAHPS, as well. But what's more important is, which hospitals do not officially participate; and, those are pediatric, psychiatric, and specialty hospitals. So currently, there are more than 4,000 hospitals officially participating in the HCAHPS Survey. And we'll talk more about them a bit later. In the next slide…

We talk about the types of patients who are eligible to receive the survey. So it broadly covers these categories of patients: those who are 18 or older upon admission; those who are admitted in the medical, surgical, or maternity service lines; those who have been in the hospital overnight or longer; and those who are alive at discharge, which may seem obvious. But it also speaks to one of the CAHPS principles that we see in HCAHPS. That is, HCAHPS is for the patient, himself or herself, to complete. We do not allow proxies. We do not allow other

people to answer for the patient. We ask the patient, himself or herself, to complete the survey about their own experience during their hospital stay. So we do exclude certain types of patients: hospice discharges; prisoners or law enforcement patients; patients with foreign home addresses; no-publicity patients, that is, patients who request not to let anybody know that they're in the hospital. And also, patients are excluded due to state regulations. Patients discharged to nursing homes, SNF swing beds within the hospital, or skilled nursing facilities are also excluded. And I should mention that, the reason these categories are excluded is, because it's very difficult to contact patients, these types of patients, in a timely manner, to do the survey. So it's a matter of how easily they can be contacted to do the survey, which determines what – if – they can't be easily contacted, then they have been excluded. But even given all that, even given exclusions, we estimate that HCAHPS encompasses about 80 – 85 percent of inpatients in the eligible hospitals. Next slide, we talk about how the survey is administered.

There are four survey modes that can be used in HCAHPS: mail; telephone; mixed mode, which is a mail survey followed by telephone calls; and, interactive voice response. As you can see from the slide, most hospitals choose mail, the remainder choose telephone mode, and only a very small number of hospitals choose mixed or IVR. We would really like to see hospitals choose mixed mode because it has much better response rates. But few hospitals have made that choice. I can tell you that, over time, that the trend has been for hospitals to switch from mail to telephone mode, or to join in telephone mode rather than mail mode. A couple of other important features of the survey. It's a post-discharge survey. That is, it cannot be administered in the hospital, and it should not be administered until the patient has been discharged for at least 48 hours. And, the patient can be contacted up to 42 days after discharge. So, we don't want patients to be surveyed in the hospital. We want them to get to their destination, their home or wherever, settled in, settled down, and then be contacted to reflect upon their experience. HCAHPS is administered to a random sample of the eligible patients. As I noted, there are four ways of administering the survey. And, of course, we have standardized data collection, data submission, analysis, and reporting of HCAHPS results. And, not all hospitals who have officially participated in HCAHPS actually do report the results on *Hospital Compare*.

We'll see that number a little bit later. But, for instance, Critical Access Hospitals, they are allowed to suppress the results from public reporting, if they choose to do so. Whereas, the IPPS hospitals must report the results on *Hospital Compare* or face penalties. Next slide. Who administers the survey?

There are, in a recent quarter, there were 36 approved survey vendors, and they administered almost all of the surveys, over 99 percent. We do permit hospitals to self-administer the survey, if they're trained by CMS and approved by CMS, to do so. And, currently, there are about 61 hospitals that self-administer. And, hospitals can even act as, kind of like, a survey vendor for other hospitals. We call that a multisite-hospital situation, but it's not very popular. The survey vendors who are approved for HCAHPS are listed on that HCAHPS online website that I mentioned earlier. Next slide. HCAHPS never rests.

It's a continuous survey. For instance, the HCAHPS results that are currently on the *Hospital Compare* website, are comprised of scores from more than 3.1 million completed surveys, from patients at over 4,000 hospitals. So the result you see in *Hospital Compare* are very broadly based; many patients, many hospitals. Looked at another way, everyday, on average, more than 8,500 patients complete the HCAHPS Survey. So it's ongoing, all the time, every day of the year. And, hospitals and patients are continuously having their patients surveyed, and we're continuously updating the result in *Hospital Compare*. Okay, next slide. This is a slide I added just recently.

Using HCAHPS Scores for Intra-Hospital Comparisons. HCAHPS was designed and intended for intra-hospital comparisons. That is, between hospitals; that is, hospital-to-hospital comparisons. So HCAHPS was designed to create metrics, or measures, that would allow consumers to compare hospital A to hospital B. And at CMS, by hospital, we mean the entity that has its own CMS Certification Number, or CCN. But we know hospitals with the survey, and with the results that they own, often do more than just report their hospital-level results. Some hospitals use the scores, and they break it down by the ward, floor, or even individual staff member, that they connect with survey somehow, using their own internal data. We caution that, those kind of comparisons are unreliable, unless a large sample size is collected at that intra-hospital level, at the ward level, floor level, or individual staff-member level. So, unless you have a huge amount of

data at one of those intra-hospital subdivisions, like a ward or floor, then the results are probably going to be unreliable. Just as importantly, the HCAHPS Survey does not specify the individual doctor, nurse, or hospital staff, who the patient encountered. They ask about nurses in general, doctors in general. So we know that some hospitals will connect results to individual practitioners, nurses, or doctors, but the survey does not specify them. And so, we question the validity of the use of the survey for those types of comparisons. And, last year, in the 2015 Inpatient Prospective Payment System rule, we made this – we formalized this – this statement that, we do not endorse the use of HCAHPS scores for comparisons within hospitals, such as comparison of HCAHPS scores associated with a particular ward, floor, provider, or nursing staff. So, we want to be clear about that. We wrote an article; it's in the *JAMA* (journal), earlier this year, about the dangers of using HCAHPS data for intra-hospital comparisons. Okay, next slide.

I just want to show you quick peek at the trends of the HCAHPS measures over time. These data are from March 2009 through April 2016. So, seven years of data, you can tell at a glance, that all the measures have been improving over time. These are the top-box scores, by the way. And the top box is the most positive survey response such as, "Doctors always treated me with courtesy and respect." So, you can see the top-box scores are increasing over time for all the measures. There's a pretty consistent pattern, or ranking, of the measures. Discharge Information to the top, that's a bit of a – discharge is just two yes-no items. So, in some way, it's not strictly comparable to the other items that have usually four response categories. But you can see Communication with Doctors has consistently been in the top. At the bottom is Quietness of the Hospital. I could add here, and when, after this slide, I will add the Care Transition Measure. That's actually a bit lower than the other measures right now. Okay, so, and also to note here, that the top score, looks like Communication – sorry – Discharge Information, is about 86 percent of patients saying yes to those items. That still leaves a lot of room to improve, even for the highest ranked measure. So there's room to improve all of this quality dimensions in hospitals. Okay, I'd like to turn next to Hospital Value-Based Purchasing. And just as a bit of background in the next slide.

HVBP links a portion of CMS payment to hospitals to their performance on a set of quality measures. The VBP Program applies only to those IPPS hospitals, and it was established by the Patient Protection and Affordable Care Act of 2010, the infamous, or at least, well-known, Affordable Care Act. And it began with discharges from October 1, 2012, forward. As you probably know, the Hospital VBP Program is funded now, by a 2 percent reduction of participating hospitals' base-operating MS-DRGs payments each year(s); and, requires CMS to redistribute a portion of the Medicare payments to hospitals for inpatient services, based upon performance on quality measures.

Next slide. The purpose of VBP is to encourage hospitals to improve the safety and quality of care inpatients receive during their acute-care stays. We encourage hospitals to reengineer hospital processes to improve patient experience of care, which is measured by the HCAHPS Survey. And that's the goal of HVBP, and a number of other similar programs now at CMS, is to pay hospitals for the quality of the care that they provide, not just the quantity of services that they provide. On the next slide…

We can see how the payment reduction has been ratcheting up over the past five years. So, the value-based incentive payment percentage, the withhold from hospitals, has increase from 1 percent, when VBP was introduced in the fiscal year 2013, to 2 percent in fiscal year 2017. And we foresee that the percent reduction will remain 2.0 percent in future years. So it's gone up steadily over the years. It's, kind of, reached a ceiling now in fiscal year 2017, which began a little over a month ago. Okay, next slide.

A couple particulars about VBP for this fiscal year, 2017. So, in 2017, there are four domains in VBP. These are broad areas of quality, which include Clinical Care; Safety; Efficiency and Cost Reduction; and what's been termed, Patient and Caregiver Centered Experience of Care/Care Coordination, or HCAHPS. And as you can see here, HCAHPS accounts for 25 percent of the Total Performance Score in VBP in 2017. A couple of things to note, the HCAHPS data that is used in the VBP Program is collected through the Hospital IQR or Inpatient Quality Reporting Program. So there's no additional information or data collection necessary for hospitals to participate in VBP. We take the data. We take – in this case the HCAHPS scores, or data, rather, that was collected for *Hospital Compare*

– and we use that for creating the HCAHPS domain in VBP. And, you can see here, in the last bullet, in the current fiscal year, well, fiscal year has been paid now. Over 3,000 IPPS hospitals had HCAHPS scores. And just to note, over time, when HCAHPS when – sorry – when VBP was launched in 2013 – or 2012 – HCAHPS accounted for 30 percent of the Total Performance Score. Over time, CMS has added new domains, like Safety, and Efficiency, and the weight of HCAHPS has dropped down to 25 percent. And I should also note that, we became a little bit overweighted in terms of the way we named the domain. So, from 2019 forward, the official name of the HCAHPS domain will be Person and Community Engagement. And I'll probably just call it, Patient Experience or HCAHPS domain, just to make it easy. Okay, next year, there's going to be a change. In FY 2018, couple of changes in VBP. The Clinical Care dimension is being reduced a bit and streamlined.

But the HCAHPS domain will remain 25 percent. Next slide. Looking inside the HCAHPS domain a little bit.

The Patient Experience, or HCAHPS, domain score is the sum of a Base Score and a Consistency Points Score. The Base Score is worth 80 points; the Consistency Score is worth 20 points. So, in total, the Patient Experience domain runs from zero to 100 points. And as I noted earlier, it comprises 25 percent of the Total Performance Score in VBP. Now, the way HCAHPS scored is a little bit complicated. We have a document on our HCAHPS online website that explains how the HCAHPS score is created. There is also a *QualityNet* web page specializing in VBP, which also has a very good information about how the VBP scores are calculated. But just to mention a few basics. Each hospital's HCAHPS dimensions, and there are eight of them, are scored in both performance period and then a baseline period. And the baseline period is two years before the performance period. And we measure both how the hospital does compared to all other hospitals to measure its achievement. And we also compare how a hospital did two years ago to its performance two years later. And that's called – sorry, Achievement – Improvement, rather. So there's Achievement dimension and an Improvement dimension. And that's – I think that's the same for all of the different domains in VBP. In addition to scoring hospitals on their achievement and improvement, we also have something called, Consistency points in

HCAHPS. And that is where we look at the hospital's lowest performing dimension. And we give extra points, based upon that one lowest scoring dimension to motivate hospitals, to improve, to focus their effort on where they're doing worst. So, if their lowest scoring dimension is actually at the national average, or median, or higher, then they get all 20 Consistency points. They're, kind of like, bonus points. If their lowest performing dimension, say nurse communication, is below the national median, they can earn from zero to almost 20 points, depending again how far below the national median that dimension is. So, Consistency points is our way to encourage hospitals to focus attention, especially on, where they're doing most poorly. Okay. Next slide.

Little comparison between – okay – well, this is the original. The first five years of VBP. There were eight HCAHPS dimensions I mentioned: communication with nurses, with doctors, staff responsiveness, pain management, communication about medicines, discharged information, how clean and quiet the hospital was, and the overall rating of the hospital. So, these are mostly, for the most part, measures that we report on *Hospital Compare*. As I mentioned, the score is based upon the percent of patients who choose the top-box or most positive response to those survey items. The differences between VBP and what's on *Hospital Compare* is, in value-based purchasing, we combine the cleanliness and quietness measures into one dimension, and we only use the overall rating of hospital. We do not use the Recommend the Hospital. We do that because recommend and overall rating are very highly correlated, and we didn't want to overrate that global dimension of patient's assessment of hospital care. I should also mention that each of the eight dimensions has equal weight. And overall rating of hospital was just as important to say, Pain Management or Communication with Nurses. There are a couple of changes in the coming year in FY 2018, which we can see on the next slide.

Two important things are going to happen next year. The Care Transition Measure is being added to Hospital Value-Based Purchasing, and the Pain Management dimension is being removed from VBP. So, we're basically swapping pain management for care transition. So there will continue to be eight dimensions of Patient Experience in Hospital Value-Based Purchasing. And each of those eight dimensions will have an equal weight, while each account about

one-eighth of the Patient Experience domain. So, let me go into that a little bit further on the next slide.

The Care Transition Measure was added to the survey back in 2013. We began reporting results for care transition on *Hospital Compare* beginning in October of 2014. We had four quarters or whole year of data to report.

And the next slide, discuss briefly the Pain Management dimension. This is being removed from Hospital Value-Based Purchasing in FY 2018. We just published weeks ago, two weeks ago, the Outpatient Prospective Payment System Final Rule in which we finalized our proposal to remove the Pain Management dimension from a Hospital VBP. We did this because, some of you may be aware, there's been a lot of outcry, or accusations, about the presence of questions about pain management, and the survey causing doctors to feel pressure from hospitals to do more to get patients to respond positively. And some people say that hospitals are pressuring physicians to prescribe more opioids, in hopes that that would cause patients to say their pain management was always great. We don't really think that's what happens, for a number of reasons, but, out of an abundance of caution, and in the midst of a national opioid epidemic, CMS has decided to remove that Pain Management dimension from value-based purchasing. However, the pain management items remain on the HCAHPS Survey, and we will continue to report the Pain Management measure on *Hospital Compare*. But it will not affect hospital payments. That is it. It will not be in the VBP Program. So that's a significant change in how we run the VBP Program here at CMS. So, on the next slide…

We can see in FY 2018 and going forward, there will still be eight HCAHPS dimensions. But pain management is gone and has, in effect, been replaced by care transition. Okay. The next slide…

Discusses the VBP time periods for 2018. As I mentioned earlier, value-based purchasing essentially measures hospitals at two points in time, or two years, actually: a baseline period and a performance period. The baseline period is two years prior to the performance period. So, we look at how well hospitals do in HCAHPS dimensions in 2014. We compare that to how well they did in 2016. And I may have neglected to mention earlier that IPPS hospitals must have at

least 100 completed surveys to be in the VBP Program. If hospitals don't have enough data in the baseline period, then we cannot compute performance scores – or achievement scores – actually. If they lack 100 surveys in the performance period, then we do not create a Patient Experience domain for the hospital. So, in the VBP Program, hospitals might miss one or maybe two domains and still be included. I forget what the rule is now, one or two. But it's possible to be in VBP without an HCAHPS domain. If you didn't have 100 completed surveys in the performance period, then we would not compute the HCAHPS score for value-based purchasing. Okay. The next slide…

Is a quick summary of the key differences between Inpatient Quality Reporting and value-based payment. In the Hospital IQR Program, that is, on *Hospital Compare*, we report current HCAHPS performance, and we do it a number of ways. We show the top box, which is 10 percent of patients who chose the most positive response category. The bottom box, those who chose the worst-performance categories, or worst-experience categories, such as something sometimes, or never, happened. And we also report the middle box. And, we also report, since last year, HCAHPS Star Ratings. Whereas, in VBP, HCAHPS has an Achievement, Improvement, and a Consistency points dimension. Achievement and Improvement go into the Base Score and Consistency points go into that consistency part of the formula. And on *Hospital Compare*, we report 11 HCAHPS measures, but there are only eight dimensions in VBP. And we get the eight by combining clean and quiet into one dimension and not using the recommend item. IQR includes both the Pain Management measure and the Care Transition Measure. But as I just mentioned, in 2018, pain management will be removed and care transition will be added to VBP. In Hospital IQR, both IPPS and not-IPPS hospitals participate. That's about 4,200 hospitals. Whereas, on VBP, only IPPS hospitals can participate. And something that's new beginning in December, if a hospital has fewer than 25 completed surveys, we will not publicly report the results on *Hospital Compare*. But the hospital will still see its results in its own, sort of, personal preview report. It will see its scores. But because we have reservations about the reliability of scores, based on such a small number of completed surveys, we will no longer report them on *Hospital Compare*. And as I mentioned earlier, IPPS hospitals must have 100 completed – 100 or more

completed – surveys in the performance period, to be included in the VBP Program. Okay, next slide.

Here's another late edition. We try to do a lot of quality-checking here at CMS. And when hospitals receive a preview report or payment summary report for VBP, they can, if they like, try to figure out how they got there. They can calculate their scores. We published the formulas for how we get the scores in a document on that HCAHPS online website. It's a 12-step program, or a 12-step paper, about how we actually create the scores for VBP. And we found out just recently, that somebody calculated the scores, and they came up with slightly different results than ours; and, they asked why. So, we looked into it. And we realized that, in the score report that the hospitals receive, we give the rates, or the performance of the dimensions, to two decimal places. As you can see here, xx.xx. So, we round them to two decimal places. However, when we actually do the score calculations in our computers here, we don't run the numbers. The numbers go to like 16 decimal places. So that can, in rare and random occasions, cause an Improvement or Achievement point for a dimension to be off by minus-one or plus-one point. And this is because the difference in rounding that we do here, as to what hospitals can do using the reports. We, kind of, anticipated this sort of thing happening. I think it happens to all the measures, all the demands. So, we note on that VBP Percentage Payment Summary Report that the calculated values are subject to rounding. So, you know, this hospital wondered why, in one case, it got one more point than it thought it deserved, in another case, it thought it got one fewer. And we looked into it and found out this is what was been happening. So, I will try to make this more clear on the reports that, if you recalculate the scores, they, in random and rare circumstances, may be off by one point. Okay. Next slide is a short summary.

VBP links hospital payments to Patient Experience of Care. The HCAHPS has been part of VBP since it began in 2012. No additional data collection is required for VBP. And only hospitals with 100 or more completes during the performance period receive an HCAHPS score in VBP. The next slide has a few additional sources, resources for you.

There's a *QualityNet* website there. It's a really good resource. There's a slide deck that we created back when VBP was launched that's still available. And

there is a CMS website dedicated to VBP. And once again, the website for our HCAHPS online, our own dedicated HCAHPS website is, hcahpsonline.org, that's one word, .org. Okay. A few additional comments about the Care Transition Measure, the next slide.

Or the one after.

As I mentioned, care transition was added to the HCAHPS Survey back in 2012, I believe. And we did it because, again, we still receive lot of comments from stakeholders, and others in the public, who are concerned about poor care transitions. That is, poor transitions from the hospital to the post-hospital setting. So, we adopted three new items for the survey to delve into this topic. We did it because poorly managed transitions can result in post-discharge complications and avoidable readmissions. And, that we believe there are several root causes of poorly managed transitions have been identified, including poor communication between the patient and hospital staff. And, really, the new items, which we'll see in a moment, are about how well the hospital staff communicated with patients about what was happening to them, during discharge, and after discharge. Eric Coleman, a physician in Colorado, who's been studying care transitions for many years, developed these measures, which we have adopted in the survey to measure the quality of care, the quality of communication about care transitions, during the hospital stay. And the Institute of Medicine has identified Care Transitions as the glue that bonds hospital quality. So, a lot of attention and, I think, increasing attention, in recent years, and going forward on the preparation of the patient for post-hospital – the post-hospital setting with the idea of improving quality care and reducing readmissions, infections, or any other problems that might occur after the hospital stay. Next slide.

The Care Transition Measure, as I mentioned, was adopted from the Care Transitions Program®. And this measure, like all the measures in HCAHPS Survey has been endorsed by the National Quality Form. And the next slide.

We can see the actual questions on the survey about care transitions. If you're familiar with HCAHPS, you'll notice they're slightly different. The, kind of, point-of-view of the questions is slightly different and the response options are different. So, for instance, the first one reads, and this is 23, so we added, kind of,

to the end of the survey, "During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my healthcare needs would be when I left." And the response options range from strongly disagree to strongly agree. You'll notice also the options always begin with the most negative then they go to the most positive. Strongly agree here is a top-box category. Disagree and strongly disagree are the bottom-box category. And, agree is the middle-box category for this item. And then we combine these three items, three individual items, into the Care Transition Measure that is reported on *Hospital Compare*. And, in FY '18, it will also be part of value-based purchasing. Okay, the next slide.

A couple of implications for policy. As mentioned, transitions in care is a critical aspect of hospital care. The data indicates there is room for quality improvement in this area. I mentioned earlier that care transition has not been around too long, but it is currently trending as the lowest-rated HCAHPS dimension. Currently, the national top-box average for care transition is only 52 percent. It has been improving. Since we started reporting it three years ago, it has improved, but is still lower than all the other HCAHPS measures. And we are hopeful that collection and reporting of care transitions will aid quality improvement efforts. Okay. The next slide.

A few slides on the Pain Management measure.

As noted earlier, VBP, the Pain Management dimension will be dropped from VBP in 2018. And, in addition to doing that action, we are also, that is, CMS is also looking in developing new questions about pain management. We think it's a very important dimension, or aspect, to hospital quality. We are keeping it on the survey. But, in response to concerns about the current items, we are developing replacement items for the pain management questions in the survey. So, over the past year or so, we've done field tests, empirical analysis, conducted focus groups, done a large-scale mode experiment, and done cognitive interviews with hospital staff, administrators, and patients about pain management in the hospital, and the types of items that might best be used to measure that. I can tell you that CMS, when we introduce new pain management items, we will do so through the rule-writing process, which we go through every year. So, there's – the regular process of CMS announcing what we would like to do, putting in the

public domain, asking for comments, reviewing those comments, making final decisions, and then finalizing that in another rule. So, currently, we are developing possible replacements for the current pain management items, in recognition that pain control is an important aspect of delivering quality care. So, there'll be more information about that in the future. But just to let you know that CMS is actively looking into developing replacements for the current pain management items on HCAHPS Survey. And just in case you wondered, here are the current pain management questions.

Like some other measures, it begins with the screener item, in this case, number 12, which reads, "During this hospital stay, did you need medicine for pain?" If you said, yes, you would answer the next question about whether your pain was well-controlled, and the next question, where the staff did everything they could to help you ease your pain.

And these are the questions which some people find possibly motivating over prescription of opioids. So, these are the ones – they're likely to be removed and replaced in the future.

Okay. One or two more things about the survey. I noted earlier…

That the beginning of December – sorry, the next slide. Sorry, 25 or more completed surveys will be required for HCAHPS scores to appear on *Hospital Compare*. And that begins in December public reporting, which is slated for, I think, sometime in mid-December. *Hospital Compare* will be updated with the most recent data. And beginning then, if a hospital had fewer than 25 completed surveys, we will not report these results on *Hospital Compare*. But that hospital will receive its preview report and will see that information; its scores right there on that report.

Okay. Next, I promise to show you some correlations among the HCAHPS measures.

This table can be found on HCAHPS online or website. We update this, I think, once a year, we update these numbers. So you can see, these are details. These are patient-level Pearson correlations of rescaled linear means of HCAHPS measures for patients discharged between June of 2014 and July of 2015, which is

based upon 3.2 million completed surveys. And all of these correlations are significant. So, I had mentioned earlier, for instance, that overall rating is highly correlated with recommend. You can see in the last column, second to the last row, that the correlation between rating and recommend is 0.76. And it's always been quite high, and that's why we don't want to have both of those measures in the Value-Based Purchasing Program. And, across the table, you can see how each measure correlates with each, every, other measure. If you're interested in the sort of thing, we have these correlation matrices going back to maybe 2009. And there's an archive of them on the HCAHPS online website. There's also data there about the state-level, top-box scores going back to the beginning of HCAHPS. The – we have a set of hospital-level indicators, a chartbook that shows how hospitals differ in terms of HCAHPS scores, based on things, such as bed size, location, region of the country, et cetera. That's there to look at. And also the means and median of the HCAHPS scores over time. And I guess I should mention that we began reporting HCAHPS Star Ratings about a year, a little over, a year ago.

And we now report – well, there's a report on *Hospital Compare* – but on HCAHPS online or on website, we present Star Ratings by each state for each measure. So, a little bit more detailed information about the Star Ratings. As you can see for each state, the number of, I think, five stars for each state. Okay. So, I'd encourage you to go to the HCAHPS online website to find more information about the HCAHPS Survey. And that, kind of, brings me to the end of the content about HCAHPS. So, I'll turn this back to Bethany. And I think we'll do some – we have some time for questions and answers. Thank you.

Bethany Wheeler-Bunch: Thank you, Bill. Like Bill said, we have just a little bit of time left for questions-and-answers. So, starting on slide 12. Bill and I will move to slide 12 for you.

The question is, what is IVR?

William Lehrman: Yes, sorry, I get a little bit lost to my acronyms. That means interactive voice response. So, that's like when you get telephone call from somebody and they say press one for this, press two for that, et cetera. So, it's, kind of, an automated way of doing for survey. It's an option hospitals have for implementing the survey. As I showed you earlier, it's not terribly popular.

Bethany Wheeler-Bunch: Thank you, Bill. The next couple of questions are also from slide 12. Will there be an option for an email survey in the future?

William Lehrman: You know, we get that question a lot, and we have been looking into it. About five years ago, we actually tested, kind of, a web-based version of the survey; didn't turn out too well. It wasn't too popular. But we continue to look into it. We know that there is a demand out there, even expectation that web – the surveys be offered in new modes: electronically, email. So we are looking into it. And, a couple different experiments we've done lately: we tried email versions or web versions of surveys, and we're analyzing that data. We will let you know how that turns out.

Bethany Wheeler-Bunch: Thanks, Bill. Next question is also on slide 12. Which method has the best response rate?

William Lehrman: Well, mixed mode. I can definitely say that. And that's why I wish more hospitals would use it. So, mixed mode means, you try to mail first. And people don't respond by mail; then you call them. So you tap into two different pools of people: people who like mail and people who don't like mail but like telephone. So this is the best response rate. I think mail and telephone, they're pretty similar now, in terms of response rate. I should note, you probably already, you may already know, that response rates for all kinds of surveys has been, kind of, falling year by year. And HCAHPS is not immune from the trend. But another reason we encourage mixed mode. And we also encourage hospitals who are, you know, not getting the kind of response rate they would like, to look into things like, do they have a lot of patients who don't speak English? And they can use a translation, official translation of the HCAHPS Survey, to tap into that population. We have Spanish, as well as, Russian, Portuguese, Chinese, Vietnamese versions of the survey that can be used to help improve response rates.

Bethany Wheeler-Bunch: Thank you, Bill. I think we have time for two more questions. The first one, how many days after discharge can the survey be completed?

William Lehrman: You know, it goes up to, actually, up to 84 days. It has to be, the patient must be, contacted within the first 42 days, but they have up to 84 days to actually complete the survey. And after that it's too late.

Bethany Wheeler-Bunch: Thank you, Bill. And I think – I'm going to combine a couple of the questions that came in. One, I think everyone just wants you to restate what the web – what your website is that explains the HCAHPS in further detail and how HCAHPS is viewed in VBP in terms of the scoring methodology. Also, we had a request for you to restate the title of the *JAMA* article that you referenced earlier.

William Lehrman: Okay, so the website is www.hcahpsonline.org. *JAMA* article was – it was in *JAMA*, I think in… Okay, the title is, "Measurement of the Patient Experience: Clarifying Facts, Myths, and Approaches." And it was published online on March 3, 2016 in the *JAMA* (journal).

Bethany Wheeler-Bunch: Great. Thank you. And I think that is all the time that we've had for today.

Just as a reminder, any of the questions that we did not get to, and I know there were quite a few, we will answer those, and post them to the qualityreportingcenter.com website in the future. So please keep checking back to that website to look for that Q&A transcript when it comes available. Now, I will turn it over to Ms. Debra Price to present on the Continuing Education Credits. Thank you.

Debra Price: Thank you, Bethany, and thank you, Bill. I'm going to go quickly through these slides, so follow along. And if you have problems, please just email me, and I'll help you through it. This first slide shows you the boards that we are licensed to provide credit for; mostly Florida boards. However, the last bullet is the Board of Registered Nursing. That one is across the nation. So, if you have a nursing degree in any states, you can use that provider license.

This one talks about the CE process. And, at the end of our slide, a survey will pop up. Take the survey, and then, when you hit Done at the end of the survey, you will be sent to register for your certificate. It's a separate registration. So, keep in mind if you registered for the webinar, it's not the same registration that you will have for our CEs. And if you do not immediately receive a response to your email, that means that there's a firewall somewhere, either set up on your computer or in your hospital, not allowing our link in. So, what we are asking is for you to register your personal email and a personal phone number. So our links will be able to go through to you.

This is what the survey will look like in about one minute. You notice the bottom right-hand corner, the little Done button. Press the Done button.

And then, this page will open up. It has two green links on it. The first link is the New User link. And, if you have not received CEs with us, or if you've been having problems having, getting, your CE certificate, please use the New User link.

And, this is what will pop up when you hit the New User link. You put your first name, last name, and give us your personal email and personal phone number, and then, click Register on the bottom. Then, you will go to that email, and you'll be given a link to finish your registration.

This is the page that pops up if you click on the green Existing User link. You would type in your username, which is your entire email address, including what's after the @ sign, and the password. If you forgot your password, click into that box, and you'll be allowed to redo a password.

And that will do it for me. I'd like, we would like, to thank everyone for spending the last hour with us. We hope you learned something. And, keep in mind that if your question did not get answered, it will be posted at a later date on our qualityreportingcenter.com website. Thank you and enjoy the rest of your day. Goodbye, everyone.