Introduction to HCAHPS Survey Training

March 2023

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Introduction to HCAHPS Survey Training

Welcome!

HCAHPS Training Objectives:

- Explain purpose and use of the HCAHPS Survey
- Provide instruction on managing the survey
- Discuss modes of survey administration
- Instruct on sampling, data preparation, data submission, and public reporting
- Review oversight and quality checks activities

Introduction to HCAHPS Survey Training

Quality Assurance Guidelines

- This presentation is based on the HCAHPS *Quality Assurance Guidelines (QAG) V18.0*
  - QAG V18.0 applies to all patient discharges July 1, 2023 and forward

- Survey vendors and hospitals are responsible for reviewing and familiarizing themselves with all of content in the QAG

Background of the HCAHPS Survey

Introduction to HCAHPS Survey Training

Overview

- Background and Development of HCAHPS

- Composition of the Survey

- Roles and Responsibilities

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The Name of the Survey

- Official name:

CAHPS® HOSPITAL SURVEY

- Also known as **Hospital CAHPS®** or

HCAHPS

⇨ Pronounced *"H-caps"*

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. Government agency.

The Method of HCAHPS

- Ask patients (survey)
- Collect in standardized, consistent manner
- Analyze and adjust data
- Publicly report hospital results
- Use to improve hospital quality of care

HCAHPS 101

Participating Hospitals:

- Short-term, acute care hospitals
  - *"General Hospitals"* (AHA)
    - IPPS hospitals penalized if don't participate
    - Critical Access Hospitals, PPS-Exempt Cancer, Veterans Affairs or Department of Defense Hospitals can voluntarily participate
    - Excludes pediatric, psychiatric and specialty hospitals

How the Survey is Administered

Participating hospitals, second quarter 2022 (4,568):

- Mail: 3,805 hospitals; ~ 83.3%
- Telephone: 718 hospitals; ~ 15.7%
- Mixed Mode: 45 hospitals; 1.0%

Who Administers the Survey

Second quarter 2022:

- 20 Approved survey vendors
  - 99.96% of surveys
- 23 Self-administering hospitals
  - 0.04% of surveys

HCAHPS Never Rests

- April 2023 publicly reported scores are based on approximately **2.27 million completed surveys** from patients at **4,494 hospitals**
- **Every day** almost 6,200 patients **complete** the HCAHPS Survey

Composition of HCAHPS Survey

- HCAHPS contains 29 questions:
  - 19 substantive questions
  - 3 "screener" questions
  - 7 "About You" questions

Introduction to HCAHPS Survey Training

Example of HCAHPS Survey Items: "*Your Care From Nurses*"

1. During this hospital stay, how often did nurses treat you with <u>courtesy and respect</u>?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

2. During this hospital stay, how often did nurses <u>listen carefully to you</u>?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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Roles and Responsibilities

Hospitals

- Comply with all HCAHPS Survey protocols (whether self-administering or contracting with an approved survey vendor)

- Produce patient discharge list with complete administrative data in a timely manner

- Use survey versions in the language of patients

- Review HCAHPS data submission reports

- Do not influence patients about HCAHPS Survey
  - Communication with patients
  - Concurrent surveys

Roles and Responsibilities *(cont'd)*

Hospitals Using a Survey Vendor

- The *Vendor's role* in data collection and submission:
  - Create sample frame of eligible discharges
  - Draw sample of eligible patients and administer survey
  - Submit HCAHPS data in standard format via the Hospital Quality Reporting (HQR) System (formerly QualityNet Secure Portal)
  - Review HCAHPS data submission reports
    - Including HCAHPS Submission Results Report (formerly the Review and Correction Report)
  - Comply with oversight process, including site visits
  - Conduct ongoing quality assurance activities
    - Including data quality checks
  - Monitor HCAHPS Web site for updates

Roles and Responsibilities *(cont'd)*

CMS: Support, Report & Oversight

- Provide training and technical assistance

- Accumulate, clean and adjust data

- Calculate and publicly report results, including Star Ratings

- Analyze results

- Provide scores to CMS programs, such as Hospital Value-Based Purchasing (VBP)

- Oversee all survey processes, survey vendors and self-administering hospitals

Using HCAHPS Scores for Intra-Hospital Comparisons

- HCAHPS was designed and intended for *inter-hospital* (hospital-to-hospital) comparisons
  - Identified by CMS Certification Number (CCN)
- CMS does **not** review or endorse the use of HCAHPS scores for *intra-hospital* comparisons
  - Such as comparing a ward, floor or individual staff members
  - Such comparisons are unreliable unless large sample sizes are collected at the ward, floor, or individual level
  - HCAHPS questions do not specify individual doctors/nurses

Unofficial use of HCAHPS Survey

- The HCAHPS Survey results are <u>not</u> intended to be used for marketing or promotional activities
    - **Only the HCAHPS scores published on Care Compare on [Medicare.gov](https://www.medicare.gov/care-compare/) (https://www.medicare.gov/care-compare/) are the "official" scores**
    - **Scores derived from any other source are "unofficial" and must be labeled as such**

Unofficial use of HCAHPS Survey
(cont'd)

- The HCAHPS Survey and the questions that comprise it are in the public domain and thus can be used outside of official HCAHPS purposes (e.g., for non-HCAHPS eligible patients, etc.)
  - **However, when used in an unofficial capacity**
    - **The HCAHPS OMB language must not be used**
    - **All references to "HCAHPS" must be removed**
    - **The copyright statement for the Care Transition Measure (CTM) items must be used**

Advertising Guidelines

- Care Compare on <u>Medicare.gov</u> is the <u>official source</u> of HCAHPS results
  - Reports created by survey vendors or others that mention anything other than the official HCAHPS scores, such as estimates or predictions, must note that such scores or results are "unofficial." This is done in two ways:
    - The introduction or executive summary of such reports must include the following statement:
      - "This report has been produced by [Survey Vendor] and does not represent official HCAHPS results, which are published on Care Compare on <u>Medicare.gov</u> (<u>https://www.medicare.gov/care-compare/</u>)."
    - Each page of the report where unofficial results are displayed (print or electronic) must contain the following statement:
      - "This report has been produced by [Survey Vendor] and does not represent official HCAHPS results."

Advertising Guidelines *(cont'd)*

- CMS does not endorse hospitals or survey vendors
  - *Or commercial Hospital VBP tools, etc.*
- Care Compare is designed to provide objective information to help consumers make informed decisions about hospitals

Participation and Program Requirements

Participation Overview

- HCAHPS Web site and Technical Support
- Rules of Participation
  - Step 1: Introduction to HCAHPS Survey Training
  - Step 2: Program Participation Form and Teleconference
  - Step 3: Hospital Quality Reporting (HQR) System Registration
  - Step 4: Data Collection
  - Step 5: Participate in Oversight Activities
  - Step 6: Public Reporting
  - Step 7: Future Update Training
- Minimum Business Requirements

Introduction to HCAHPS Survey Training

HCAHPS Web site and Technical Support

https://www.hcahpsonline.org

- Official web site for content, announcements, *HCAHPS Bulletins*, reminders and new developments

- Monitor weekly for updates under "What's New"

- Quick links to Current News, Background, Participation, etc.

HCAHPS
Hospital Consumer Assessment of
Healthcare Providers and Systems

CAHPS® Hospital Survey

Home Page

Search

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Introduction to HCAHPS Survey Training

HCAHPS Web site Home Page

HCAHPS Technical Support

- Email: hcahps@hsag.com
  - Hospital 6-digit CMS Certification Number (CCN)
  - Contact information
  - Hospital name
- Telephone: 1-888-884-4007
  - Hospital 6-digit CCN
  - Contact information
  - Hospital name

HCAHPS Technical Support *(cont'd)*

- QualityNet Help Desk
  - When opening a QualityNet Help Desk Incident Ticket for HCAHPS data-related issues, please forward the email correspondence with the Incident Ticket Number to the HCAHPS Technical Assistance email (hcahps@hsag.com) for tracking purposes

Step 1: Introduction to HCAHPS Survey Training

- Who is required to participate?
  - New organizations intending to apply for approval to administer the HCAHPS Survey
    - Hospitals applying to self-administer HCAHPS
    - Hospitals applying to conduct HCAHPS for multiple sites
    - Survey vendors applying to conduct HCAHPS for client hospitals
    - Subcontractors/partners and other organizations who would have responsibility for major survey administration functions
  - New project managers of currently approved organizations

- Who is recommended to participate?
  - New staff assigned to work on HCAHPS administration
  - Hospitals contracting with a survey vendor or another hospital for survey administration

Step 2: Program Participation Form and Teleconference

- Available online at https://www.hcahpsonline.org
  - March 3, 2023 through March 24, 2023

- Who needs to submit a Participation Form?
  - New organizations intending to apply for approval to administer the HCAHPS Survey
    - Hospitals applying to self-administer HCAHPS
    - Hospitals applying to conduct HCAHPS for multiple sites
    - Survey vendors applying to conduct HCAHPS for client hospitals
  - Currently approved organizations intending to apply for approval to administer the HCAHPS Survey in additional mode(s)
  - *Not required for hospitals contracting with survey vendor*

Step 2: Program Participation Form and Teleconference *(cont'd)*

- Participation Form must be completed in its entirety
  - Organizations approved to administer the HCAHPS Survey must conduct all business operations within the United States, applicable to all staff and subcontractors/partners or other organizations
  - An applicant's prior CAHPS Survey administration experience will be considered when reviewing Participation Forms
  - Additional explanations must be provided, if applicable
  - Staff assigned as key HCAHPS project staff must be identified
  - Subcontractors must meet the minimum requirements for the roles they are performing

Step 2: Program Participation Form and Teleconference *(cont'd)*

- Participation Form must be completed in its entirety
  - Approval status is based on the information provided at the time of application. If changes are made to the major HCAHPS Survey administration functions, including changes to HCAHPS subcontractors, the HCAHPS Project Team must be notified in a timely manner. These changes may be subject to review and evaluation by the HCAHPS Project Team.

Step 3: HQR System Registration

- Register with the Hospital Quality Reporting (HQR) System, specifically for HCAHPS and obtain necessary roles

    - Contact QualityNet Help Desk for questions regarding registration

        - Telephone: (1-866-288-8912)

        - Email: qnetsupport@cms.hhs.gov

- Keep the HCAHPS Project Team (HPT) informed of any HCAHPS-related QualityNet tickets by e-mailing HCAHPS Technical Assistance including the Help Desk ticket number(s)

        - Email: hcahps@hsag.com

Step 4: Data Collection

- Hospitals/Survey vendors will:
  - Adhere to the HCAHPS *QAG V18.0*

  - Submit an Exception Request Form for consideration of approval for requesting variations to HCAHPS protocols

  - Review the compliance and the accuracy of their data collection processes

  - Alert HCAHPS Project Team to any discrepancies occurring during survey administration and submit a Discrepancy Report online via the HCAHPS Web site

  - Submit data by the HCAHPS data submission deadline

Step 5: Participate in Oversight Activities

- Submit a HCAHPS Quality Assurance Plan (QAP)
- Submit additional information as requested
- Comply with on-site visit requests
- Comply with conference call requests
- Implement corrective action(s), as necessary

Step 6: Public Reporting

- HCAHPS results will be publicly reported on a quarterly basis on Care Compare on Medicare.gov (https://www.medicare.gov/care-compare/)

- The appropriate pledge forms (Notice of Participation) must be signed and on file

  - Contact the QualityNet Helpdesk for more details

Step 7: Future Update Trainings

- As scheduled by CMS

- Details to be posted on the HCAHPS Web site (https://www.hcahpsonline.org)

- Required for all approved survey vendors, hospitals conducting survey for multiple sites, self-administering hospitals, subcontractors/ partners, or other organizations performing major HCAHPS Survey administration functions

- Recommended for hospitals using a survey vendor

Minimum Business Requirements

1. Relevant survey experience (also applies to subcontractor)

   – Demonstrated **recent, continuous** (for the time period specified in the QAG) experience in fielding patient-specific surveys (as an organization) using requested mode(s) of administration

     • Number of years conducting patient-specific surveys

     • Number of years in business

     • Sampling experience

Minimum Business Requirements *(cont'd)*

2. Organizational survey capacity

– Capability and capacity to handle a required volume of surveys and conduct surveys in specified time frame

- Personnel *(no volunteers are permitted)*
- System resources
- Sample frame creation
- Survey administration
- Data submission
- Data security
- Data retention and storage
- Technical assistance/customer support
- Organizational confidentiality requirements

Minimum Business Requirements *(cont'd)*

2. Organizational survey capacity *(cont'd)*

  – The following activities must be performed by staff directly employed by the organization approved to administer the survey

    • Sampling process
    • Data submission

Minimum Business Requirements *(cont'd)*

3. Quality control procedures

- Established systems for conducting and documenting quality control activities
  - In-house training for staff and subcontractors involved in survey operations
  - Quality control activities
  - Documentation and discussion
  - Data quality checks
    - Traceable data trail
    - Review of data files
    - Review of electronic programming code
    - Accuracy of data processing activities
- QAP documentation requirements (update annually and as needed)

Minimum Business Requirements *(cont'd)*

- HCAHPS Minimum Business Requirements continually apply to all HCAHPS approved self-administering hospitals/survey vendors/multi-site hospitals for as long as the organization maintains HCAHPS approval status

- Includes maintaining adequate and sufficient resources (e.g., staffing, system resources, etc.) in order to fully comply with HCAHPS protocols, deadlines and HCAHPS Project Team requests

Steps to Join HCAHPS in 2023

1. **Complete HCAHPS Training requirements**
2. **Submit the HCAHPS Participation Form**
   - Hospitals applying to self-administer HCAHPS
   - Hospitals applying to conducting HCAHPS for multiple sites
   - Survey vendors applying to conduct HCAHPS for client hospitals
   - Form available online, **March 3, 2023**
3. **If approved, collect and submit HCAHPS Survey data on a continuous basis**

Sampling Protocol

Overview

- Steps of Sampling Process

- Methods of Sampling

- Population, Sample Frame and Sample

- Quality Control for Sampling

- Key Sampling Facts

Steps of Sampling Process

A. Population (Total Inpatient Discharges)

B. Identify *Initially* Eligible Patients

C. Remove Exclusions

D. Perform De-Duplication

E. HCAHPS Sample Frame

F. Draw Sample

See *QAG V18.0,* HCAHPS Sampling Protocol Illustration

Step A: Population
(Total Inpatient Discharges)
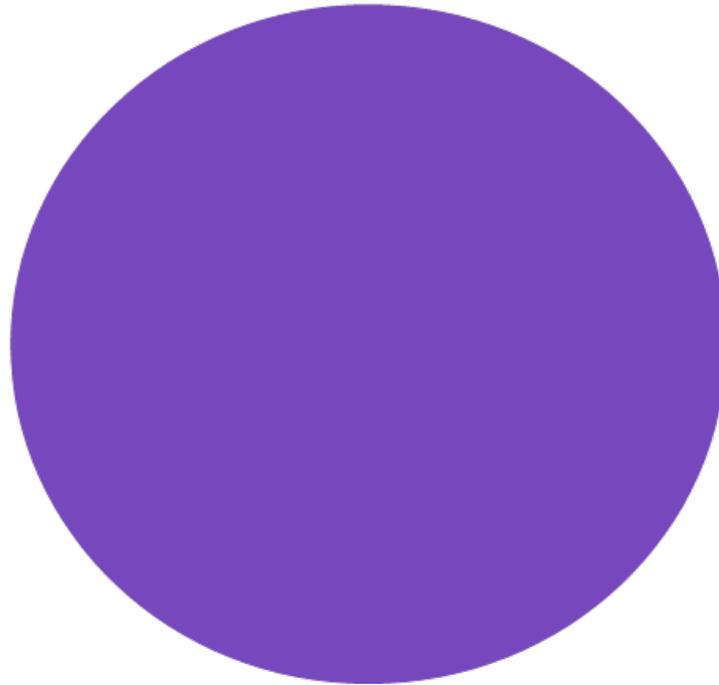
Step B: Identify *Initially* Eligible Patients

All *Initially* Eligible Patients
- **18 years or older at the time of admission**
- **Admission includes at least one overnight stay in hospital**
- **Non-psychiatric MS-DRG/principal diagnosis at discharge**
- **Alive at the time of discharge**
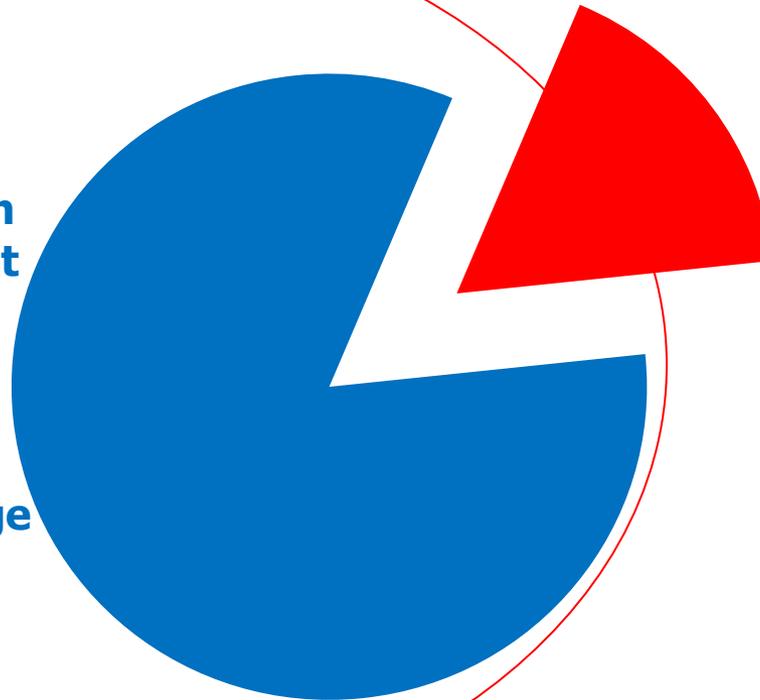
Ineligible Patients
- *Record count of ineligible patients*

Step C: Remove Exclusions

Ineligible Patients

Remaining Initially Eligible Patients

Exclusions
- "No-Publicity" patients
- Court/Law enforcement patients (i.e., prisoners)
- Patients with a foreign home address
- Patients discharged to hospice care
- Patients who are excluded because of state regulations
- Patients discharged to nursing homes and skilled nursing facilities

Step D: Perform De-Duplication

Ineligible Patients

Exclusions

De-Duplication
- **Household**
- **Multiple discharges**

Remaining Initially Eligible Patients
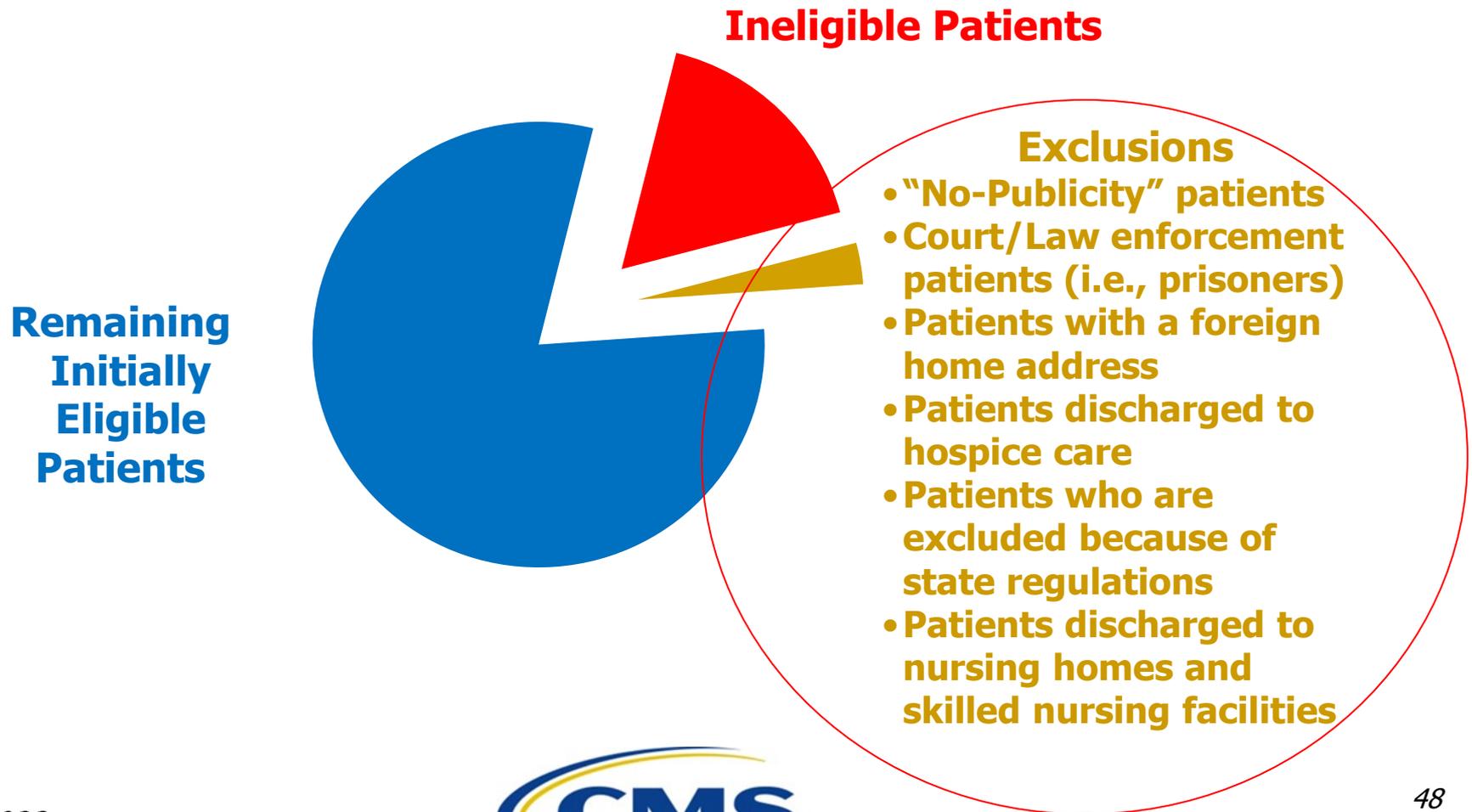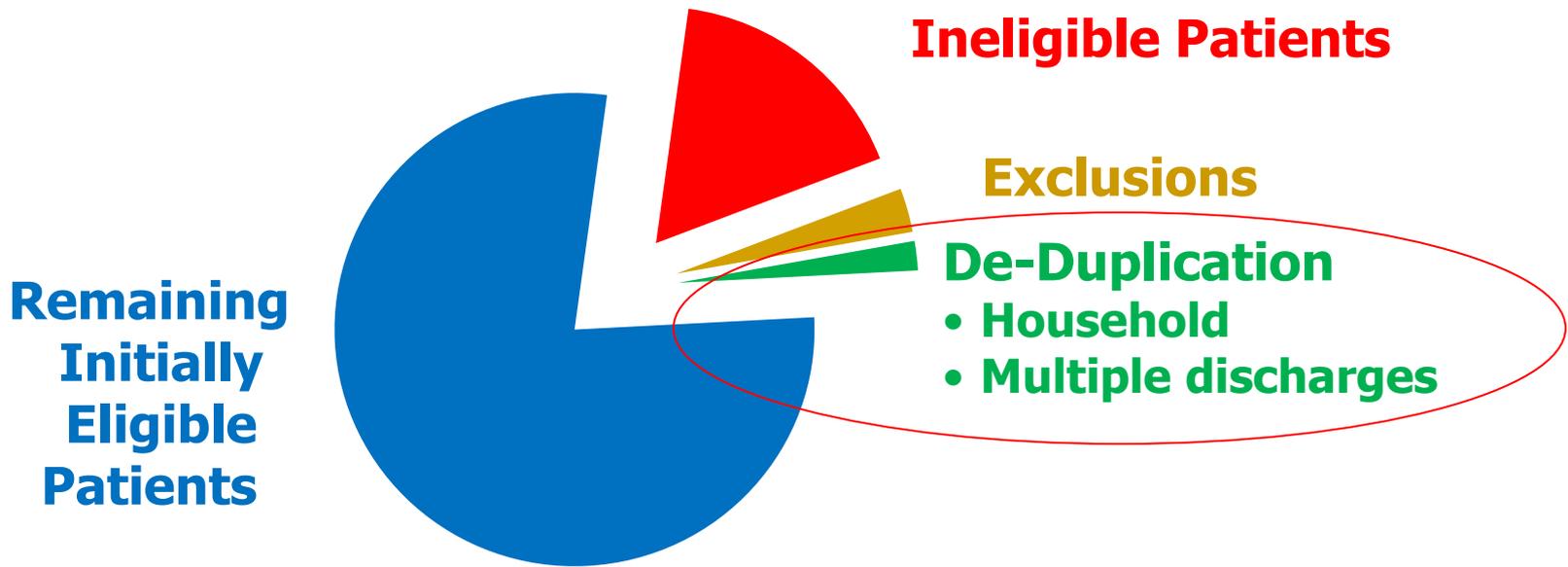
Note: De-duplication must be performed using the **sample frame, not the sample,** within each calendar month, utilizing address information (or telephone number for Telephone, Mixed and IVR modes) and the patient's medical record number (or other unique identifier)

Step D: Perform De-Duplication *(cont'd)*

- De-duplication process depends on whether sampling is conducted continuously throughout the month, or is conducted only at the end of the month

Sampling Time	Method Used for De-duplication
Continuous Daily	Include only the first discharge date identified in the sample frame
Weekly	Each weekly discharge list must be compared to the previous weekly discharge lists for the month
End-of-the-month	Include only the last discharge date of the month in the sample frame

Step E: HCAHPS Sample Frame

Ineligible Patients

Exclusions
De-Duplication

Remaining Initially Eligible Patients from which Sample is Drawn
(Sample Frame)
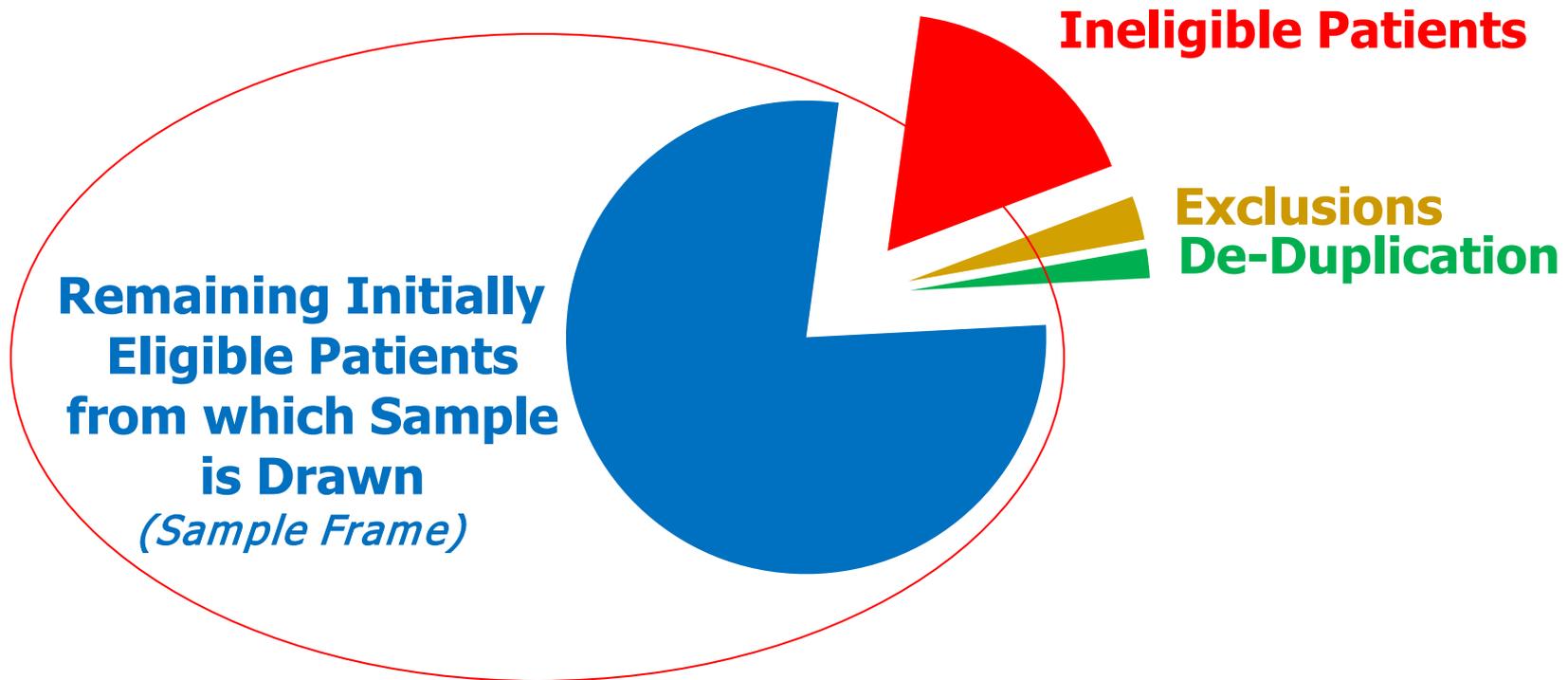
Step E: HCAHPS Sample Frame *(cont'd)*

- Example of sample frame layout (Appendix R)
  - Strongly recommend that hospitals/survey vendors collect <u>all of the elements</u> from this layout
  - Total number of ineligibles
  - Total number of exclusions and number in each exclusions category
  - Total number of inpatient discharges

- Must maintain sample frame for a minimum of three years

Step F: Draw Sample

Eligible Patients Not Selected in Sample

Ineligible Patients

Exclusions

De-Duplication

Sampled Patients
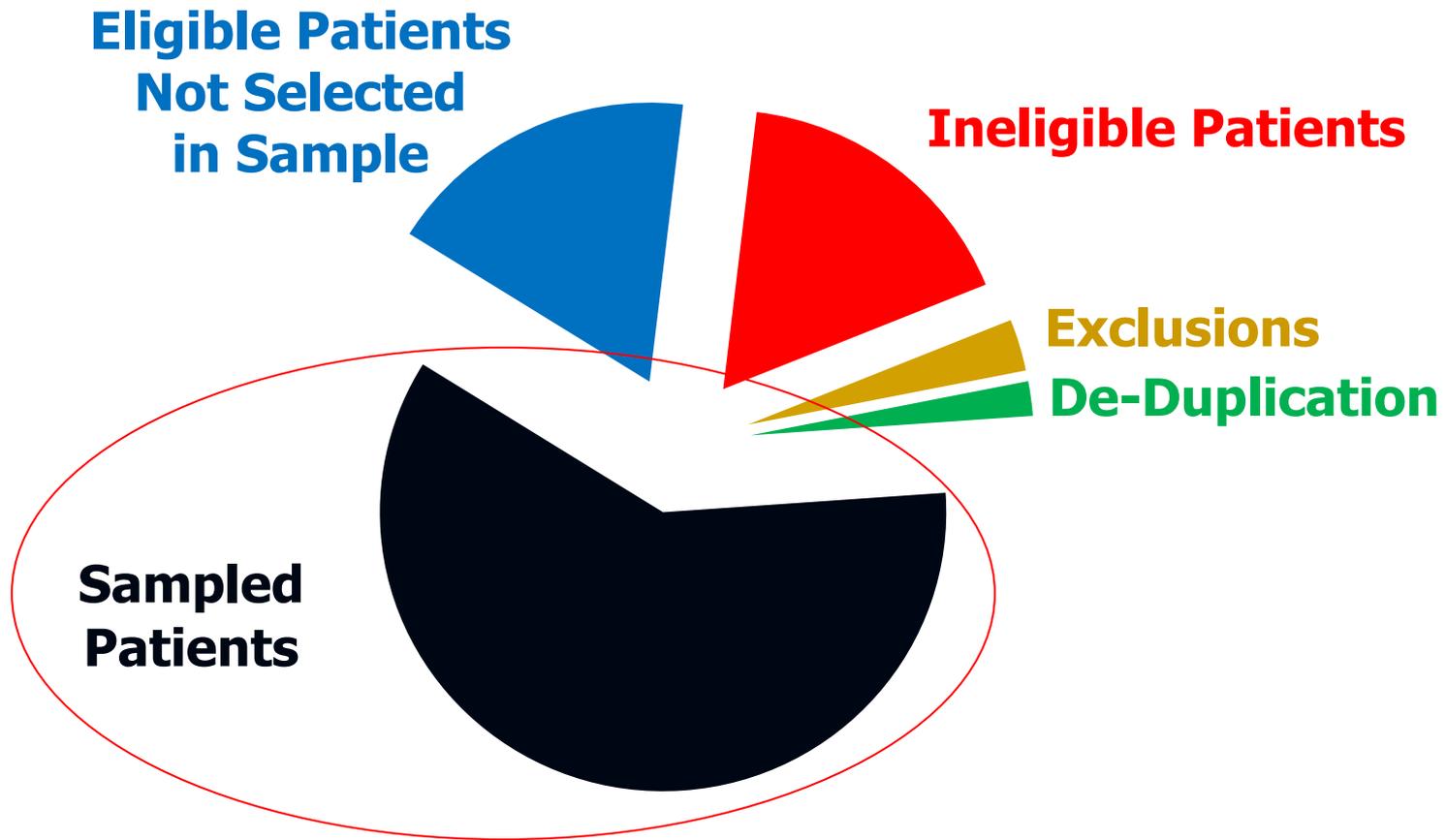
Step F: Draw Sample *(cont'd)*

- Requirement: Obtain at least 300 completed HCAHPS Surveys in a rolling four-quarter period
  - Small hospitals
    - If cannot obtain 300 completed surveys, sample all eligible discharges

Step F: Draw Sample *(cont'd)*

- Why 300?
  - For statistical precision of the ratings, which is based on a reliability criterion
  - At least 300 completes ensures that the reliability for the publicly reported measures will be 0.80 or higher
  - Calculate sample size based on target of **335** completes
    - To ensure attaining 300 completes most of the time

Step F: Draw Sample *(cont'd)*

- Draw a random sample of eligible discharges on a monthly basis
    - Sampling may be daily, weekly, bi-weekly, or at the end of the month
    - Sample frame must include eligible discharges from the entire month
    - All eligible discharges must have a chance of being sampled

Step F: Draw Sample *(cont'd)*

- Draw sample for each unique CCN
- Hospitals that share CCN
  - At least 300 completes for CCN
  - All hospitals sharing one CCN must participate
  - Use same survey vendor
  - Use same mode of administration
  - Use same sampling type and frequency

Step F: Draw Sample *(cont'd)*

Sample Size Calculation

- Estimate the proportion of patients expected to complete the survey:

  I = proportion of discharged patients who are ineligible

  R = expected response rate among eligible patients

  P = the proportion of discharged patients who actually respond to the survey

  P = (1 - I) x R

Step F: Draw Sample *(cont'd)*

- How many patients need to be sampled to <u>consistently</u> produce at least 300 completes?

  C = Number of completed surveys targeted (335)

  N_{12} = Number of discharges to be sampled over 12 month period

  N_1 = Number of discharges sampled each month

$$N_{12} = C/P$$
$$N_1 = N_{12}/12$$

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Step F: Draw Sample *(cont'd)*

Example: Sample Size Calculation

Assumptions:

- ~17% of discharged patients will be ineligible for the survey
  - Source: National Hospital Discharge Survey

- ~26% of eligible patients will respond to the survey
  - Source: Current national average for HCAHPS

- Ineligible rates and response rates should be adjusted based on each hospital's experience

Step F: Draw Sample *(cont'd)*

Example: Sample Size Calculation

1. Estimate the proportion of patients expected to complete the survey:

   P = (1 - I) x R

   $\quad$ = (1 - 0.170) x 0.260

   $\quad$ = 0.216

Step F: Draw Sample *(cont'd)*

Example: Sample Size Calculation

2. Determine how many discharges are needed to produce 335 completes:

Per 12-month

N_{12} = C/P

= 335/0.216

= 1,551

Per month

N_1 = N_{12}/12

= 1,551/12

= 129

Step F: Draw Sample *(cont'd)*

- Should estimate I and R from hospital's own data

- Should adjust the target in subsequent quarters if not regularly obtaining at least 300 completed surveys

  – Sampling rates should be consistent among the months in a given quarter

Step F: Draw Sample *(cont'd)*

- If More than 300 Completed Surveys:
  - Do not stop surveying when a total of 300 is reached
  - Continue to survey every patient in the sample
  - Surveying must continue even if hospital's predetermined target (quota) has been met
  - Full protocol for each mode of administration must be completed
  - Submit the entire sample

Step F: Draw Sample *(cont'd)*

- If Less Than 300 Completed Surveys:
  - Attempt to obtain as many as possible
  - Survey all eligible discharges
  - All hospital results will be publicly reported on Care Compare on <u>Medicare.gov</u>
  - The lower precision of scores based on less than 100 and less than 50 completed surveys will be noted in public reporting

Methods of Sampling

- ## Option 1: Simple Random Sample (SRS)
  - Group of patients randomly selected from a larger group
  - Census sample of all eligible patients is considered a simple random sample
  - *All patients have equal probability of selection (equiprobable)*

Methods of Sampling *(cont'd)*

- **SRS Example 1: Daily simple random sampling throughout the month**
  - Based on randomly sorting each day's eligible discharges and sampling 40% from each day

Day 1:

- 10 eligible discharges are randomly sorted, then numbered 1 through 10
- 4 patients (40%) would be selected for Day 1
- Since patients are randomly sorted, the first 4 patients are chosen

  [**1**, **2**, **3**, **4**, 5, 6, 7, 8, 9, 10]

Day 2:

- 8 eligible discharges are randomly sorted, then numbered 1 through 8
- 40% of 8 patients is 3.2, which rounds to 3 patients
- Again, since random sorting was performed, the first 3 patients are selected

  [**1, 2, 3**, 4, 5, 6, 7, 8]

Methods of Sampling *(cont'd)*

- **SRS Example 2: Census sampling**
  - Hospital chooses to sample <u>all eligible discharges</u>
    - Each patient has an equal chance (100%) of being included in the sample and the patients are not stratified in any manner
  - Hospital has 80 eligible discharges for a given month
    - Each of the 80 eligible patients is included in the hospital's HCAHPS sample

Methods of Sampling *(cont'd)*

- **Option 2: Proportionate Stratified Random Sample (PSRS)**
  - Patient discharge population divided into strata
    - Due to sampling (by day or by week)
    - Divided by hospital unit, or floor, etc.
    - Multiple hospitals share the same CCN and the random sample is drawn separately from each hospital before each hospital's data are combined
  - <u>Same sampling ratio</u> applied to each stratum
    - *All eligible discharges have equal probability of selection (equiprobable)*
  - Exception Request Form not required

Methods of Sampling *(cont'd)*

- **PSRS Example 1: Weeks—Strata are defined as weeks within a month**
  - Sample is pulled each week, creating 5 strata: Wk1, Wk2, Wk3, Wk4, Wk5
  - Even though the number of eligible discharges differs across the five weeks, the same proportion (or percentage) of "sampled" discharges is used each week
  - 20% of eligible discharges are randomly pulled from each stratum
  - Results in different number sampled from each week, but each eligible discharge had an equal chance of being chosen

Stratum	Week	Eligible Discharges	Sampling Rate	Sampled Patients
1	1	20	**0.20**	20 * 0.20 = **4**
2	2	25	**0.20**	25 * 0.20 = **5**
3	3	30	**0.20**	30 * 0.20 = **6**
4	4	15	**0.20**	15 * 0.20 = **3**
5	5	10	**0.20**	10 * 0.20 = **2**

Methods of Sampling *(cont'd)*

- **PSRS Example 2: Hospital Units—Strata are defined as units within a hospital**
  - Sample is pulled from three units, creating 3 strata: Unit 1, Unit 2, and Unit 3
  - Even though the number of eligible discharges is different in each of the three units, the same sampling ratio is used for each unit
  - 30% of eligible discharges are randomly pulled from each stratum
  - Results in different number sampled from each unit, but each eligible discharge had an equal chance of being chosen

Stratum	Unit	Eligible Discharges	Sampling Rate	Sampled Patients
1	1	150	**0.30**	150 * 0.30 = **45**
2	2	50	**0.30**	50 * 0.30 = **15**
3	3	400	**0.30**	400 * 0.30 = **120**

Methods of Sampling *(cont'd)*

- **Option 3: Disproportionate Stratified Random Sample (DSRS)**
  - Patient discharge population divided into strata
  - <u>Dissimilar sampling ratio</u> applied to each stratum
    - *Some patients have higher probability of selection (<u>not</u> equiprobable)*
  - Sample a minimum of 10 eligible discharges in every stratum in every month
  - Additional information collected to weight data
  - Exception Request Form must be submitted for CMS review and approval

Methods of Sampling *(cont'd)*

- **DSRS Example 1: Hospital Units—Strata are defined as units within a hospital**
  - A sample is pulled for three units in each month, creating three strata: Unit 1, Unit 2, and Unit 3
  - Even though the number of eligible discharges is different in each of the three units, the same number of eligible discharges from each unit is selected
  - Ten eligible discharges are randomly pulled from each unit
  - The number of eligible discharges selected for the sample does not result in the same proportion of discharges across the three units

Stratum	Unit	Eligible Discharges	Sampling Rate	Sampled Patients
1	1	20	**0.50**	20 * 0.50 = **10**
2	2	40	**0.25**	40 * 0.25 = **10**
3	3	100	**0.10**	100 * 0.10 = **10**

Methods of Sampling *(cont'd)*

- **DSRS Example 2: Weeks—Strata are defined as weekly time periods**
  - A sample is pulled in each week of the month
  - Sampling rates used are: 10%, 50%, 50%, 10%, and 50% for Week 1, Week 2, Week 3, Week 4, and Week 5, respectively

Stratum	Week	Eligible Discharges	Sampling Rate	Sampled Patients
1	1	100	**0.10**	100 * 0.10 = **10**
2	2	108	**0.50**	108 * 0.50 = **54**
3	3	102	**0.50**	102 * 0.50 = **51**
4	4	110	**0.10**	110 * 0.10 = **11**
5	5	30	**0.50**	30 * 0.50 = **15**

Population, Sample Frame and Sample

Population (Total Inpatient Discharges)

Hospital Population (Total Inpatient Discharges) = 1 + 2 + 3 + 4 + 5

HCAHPS Sample Frame = 1 + 2

Sampled Patients = 1

Sample Drawn

2 **Eligible Patients Not Selected in Sample**

3 **Ineligible Patients**

4 **Exclusions**

5 **De-Duplication**
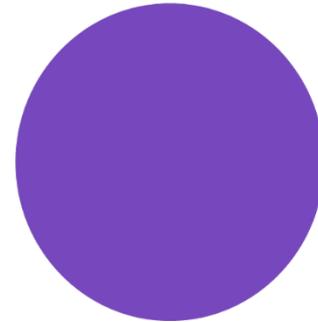
1 **Sampled Patients**
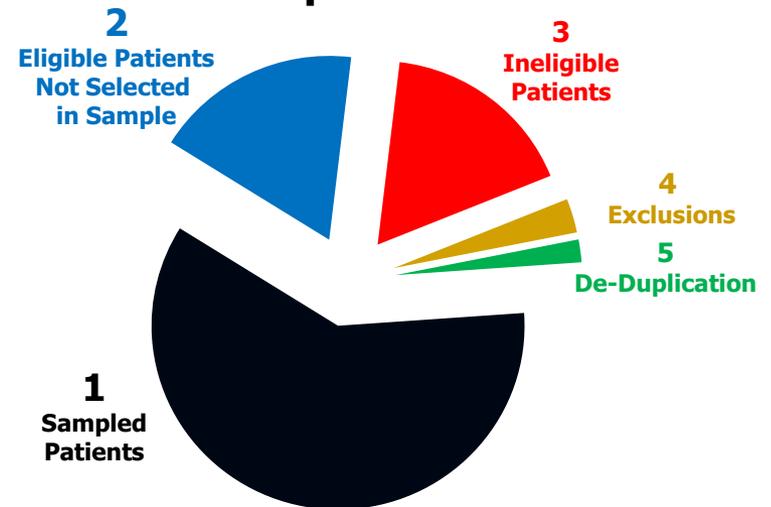
Quality Control for Sampling

- Receipt of patient discharge list
  - Within 42 calendar day initial contact period
  - Secure file transfer
- Application of eligibility and exclusion criteria
- Method used to determine HCAHPS Service Line
- Update patient discharge information
- All patients have opportunity to be selected

Key Sampling Facts

- Same sampling type must be maintained throughout the quarter

- Sample must include discharges from each month in the 12-month reporting period

- HCAHPS sample drawn first if multiple surveys administered

- Do not stop sampling/surveying if 300 completed surveys are attained

Survey Administration

Overview

- Survey Management

- Survey Instruments and Materials

- Communicating with Patients about the HCAHPS Survey

- Program Requirements

- Supplemental Questions

- Modes of Survey Administration
  - Mail Only
  - Telephone Only
  - Mixed Mode (Mail with Telephone Follow-up)
  - Active Interactive Voice Response (IVR)

Survey Management

- Establish survey management process to administer survey (Section V *QAG V18.0)*
  - System resources
  - Customer support lines
  - Personnel training
  - Monitoring and quality oversight
  - Safeguarding patient confidentiality and privacy
  - Data security
  - Data retention
  - Disaster recovery plan

Survey Management *(cont'd)*

- System resources
  - Adequate physical plant resources available to handle survey volume
  - Survey system to track sampled patients through the data collection protocol
    - Store the sample frame
    - Track key events
    - Assign random, unique, de-identified IDs and match to outcome for each sampled patient

Survey Management *(cont'd)*

- Location of survey operations
  - Mail survey administration activities must not be conducted from a residence or non-business location, unless an approved Exception Request in place
  - Telephone interviews/monitoring must not be conducted from a residence or non-business location, unless an approved Exception Request in place
    - Silent monitoring capability must include the ability to monitor calls live, both on-site at the hospital's/survey vendors' or their subcontractors' business locations and from remote locations. All staff conducting HCAHPS interviews must be included in the monitoring.

Survey Management *(cont'd)*

- Requirements for hospital/survey vendor customer support telephone lines
  - Survey vendor must maintain a toll-free customer support line
  - Telephone staffed live during business hours
  - Voice mail is acceptable "after hours," but must be regularly monitored and replied to within one business day
  - Voice mail recording must specify that the caller can leave a message about the HCAHPS Survey or hospital survey
  - Database or tracking log of calls maintained

Survey Management *(cont'd)*

- Customer support lines provided by hospitals that contract with survey vendors
  - The survey vendor is responsible for monitoring the hospital's customer support line, **at a minimum on a quarterly basis**
  - Blind calls are placed to each hospital client's customer support line to check the accuracy of responses to questions and to assess hospital compliance with HCAHPS customer support guidelines
  - Questions from Appendix Q of *QAG V18.0* should be used during the quarterly monitoring/assessment activity
  - Hospitals/Survey vendors must document questions and responses

Survey Management *(cont'd)*

- Personnel training
  - HCAHPS project staff (no volunteers permitted)
    - Customer support
    - Mailout and data entry
    - Telephone interviewers/IVR operators
    - Programmers
  - Monitoring and quality oversight of staff
    - Ongoing monitoring of staff and subcontractors
    - System to evaluate patterns of errors
    - Detection and correction of performance problems
    - Documentation of QA activities

Survey Management *(cont'd)*

- Safeguarding patient data
  - Follow HIPAA guidelines
  - Obtain confidentiality agreements, which contain language related to HIPAA regulations and the protection of patient information, from staff and subcontractors who have access to confidential information
    - Review and re-sign periodically at a minimum of every 3 years
  - Establish protocols for identifying security breaches and instituting corrective actions
    - Hospitals/Survey vendors must notify the HCAHPS Project Team within 24 hours upon discovery of a data breach that potentially affects HCAHPS Survey administration with their organization, including subcontractors or client hospitals

Survey Management *(cont'd)*

- Safeguarding patient confidentiality
  - Protocols must be established to limit the use or disclosure of protected health information to the minimum necessary to accomplish the intended purpose
    - Ensure that the identity of patients who respond to the HCAHPS Survey is not shared with hospital direct care staff
    - Direct care staff should not be able to identify the individual patients who provided survey responses
    - Social Security numbers <u>must not</u> be used to identify patients and <u>must not</u> be included in HCAHPS discharge lists that are sent to survey vendors

Survey Management *(cont'd)*

- Data security
  - Establish protocols for secure patient discharge file transfer from hospitals
    - Emailing of PHI via unsecure email is prohibited
  - Recommend that hospital's HIPAA privacy officer confirm that hospital's transmission method for patient discharge files are in compliance with HIPAA regulations
  - HCAHPS Survey question responses are confidential and private, and are de-identified in submission to CMS

Survey Management *(cont'd)*

- Physical and electronic data security guidelines
  - Returned mail surveys and electronically scanned questionnaires are stored in secure and environmentally controlled location
  - All HCAHPS-related files, including patient discharge files, must be retained for a minimum of three years
  - HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files, must be destroyed in a secure and environmentally safe location
    - Obtain a certificate of destruction
  - Firewalls and other mechanisms are employed for preventing unauthorized system access
  - Access levels and security passwords are used to safeguard sensitive data

Survey Management *(cont'd)*

- Physical and electronic data security guidelines
  - Physical and electronic data files must be easily retrievable regardless of whether they have been archived
  - Backup procedures are in place to safeguard system data
  - Frequent saves are made to media to minimize data losses
  - Electronic data backup files must be tested quarterly
  - Security safeguards for physical location
  - Disaster recovery plan in place

Survey Instruments and Materials

- 29 Item HCAHPS Survey
  - Mail questionnaire, translations and materials found in QAG Appendices A through I
  - Telephone and IVR scripts and translations found in QAG Appendices J through O

- All Modes – Survey Languages
  - CMS strongly encourages hospitals to administer the HCAHPS Survey in **both English and Spanish**
  - CMS also encourages offering the official HCAHPS Survey translations (Chinese, Russian, Vietnamese, Portuguese, German, Tagalog, and Arabic) for hospitals with significant patient populations speaking in these languages

Communicating with Patients about the HCAHPS Survey

- Hospitals are allowed to inform **all** patients that they **may** receive the HCAHPS Survey after discharge. Patients should be encouraged to complete the survey and share their experiences.

  - However, cannot show the HCAHPS Survey or cover letter to patients prior to discharge from the hospital

- Hospitals may use posters or other written communications to notify patients that they may receive a survey and inform patients of the importance and value of their participation in the survey

- Hospitals are not allowed to introduce bias to HCAHPS Survey results

Program Requirements

- **Guidelines for using other hospital inpatient surveys with HCAHPS**
  - CMS strongly recommends that:
    - HCAHPS be the first inpatient survey patients receive about their experience of hospital care
    - Questions do not resemble any HCAHPS items or their response categories
  - **Refer to Section III *QAG V18.0* and Appendix BB**

Supplemental Questions

- May add a reasonable number of supplemental questions to the HCAHPS Survey but only after all of the HCAHPS Survey questions (Questions 1-29)
  - Supplemental questions will begin with Q30
- The stated number of minutes to complete the survey must be at least 7 minutes
  - *Note: For Telephone Only, Mixed and Active IVR Modes: If supplemental items are added to the Telephone/IVR survey, this should be increased accordingly.*

Supplemental Questions *(cont'd)*

- **Required:** The transition statement below is mandatory and **must** be used before any supplemental questions that are added at the end of the HCAHPS Survey

  - "Questions 1-29 in this survey are from the U.S. Department of Health and Human Services (HHS) for use in quality measurement. The following questions are from [NAME OF HOSPITAL] to gather additional feedback about your hospital stay and will not be shared with HHS."

- **Optional:** May include additional transition statements following the required transition statement. Examples include:

  - "Now [NAME OF HOSPITAL] would like to gather some additional detail on topics previously examined. These items use a somewhat different way of asking for your response since they are getting at a slightly different way of thinking about the topics."

  - "The following questions focus on additional care you may have received from [NAME OF HOSPITAL]."

Supplemental Questions *(cont'd)*

- When asking patients to provide their name, telephone number or other contact information
  - Explanatory text must appear before the requested information and state the purpose for the patient to *optionally* provide the requested information. It is NOT sufficient to only state that this information is optional.
  - The following are examples of permissible explanatory text:
    - "If you wish to be contacted by the hospital, please provide your name and telephone number. This information is not required."
    - "By providing your name and telephone number you may be contacted by the hospital. This information is not required."

Modes of Administration Overview

- Data collection begins between 48 hours and 6 weeks (42 calendar days) after discharge from hospital

- No proxy respondents

- No communication to patients that is intended to influence survey results

- No incentives of any kind

- If a patient is found to be ineligible, discontinue survey administration for that patient

Modes of Administration Overview *(cont'd)*

- Mail survey administration activities and telephone interviews/monitoring must not be conducted from a residence or non-business location unless an approved Exception Request is in place

- No changes are permitted to the content or order of the HCAHPS questions or answer categories

- All HCAHPS questions (1-29) must remain together

Modes of Administration Overview *(cont'd)*

- Copyright language must be added to the HCAHPS Survey on either the last page of the questionnaire (preferred) or on the cover letter, and may appear on both, in a readable font size at a minimum of 10-point

  – *"Questions 1-19 and 23-29 are part of the HCAHPS Survey and are works of the U.S. Government. These HCAHPS questions are in the public domain and therefore are NOT subject to U.S. copyright laws. The three Care Transitions Measure® questions (Questions 20-22) are copyright of Eric A. Coleman, MD, MPH, all rights reserved."*

Mail Only Mode

- Protocol
  - Send first questionnaire with initial cover letter to sampled patient(s) between 48 hours and 6 weeks (42 calendar days) after discharge
  - Send second questionnaire with follow-up cover letter to non-respondent(s) approximately 21 calendar days after the first questionnaire mailing
  - Complete data collection within 42 calendar days after the first questionnaire mailing
  - Submit data to CMS via the HQR system by the data submission deadline

Mail Only Mode *(cont'd)*

- Mail Materials
  - HCAHPS Cover Letters and questionnaires provided in Appendices A (English), B (Spanish), C (Chinese), D (Russian), E (Vietnamese), F (Portuguese), G (German), H (Tagalog), and I (Arabic) in *QAG V18.0* are available beginning with July 1, 2023 patient discharges and forward
  - Survey and Cover Letter Required Language, in all official HCAHPS Survey translations, is located in Appendices A through I

Mail Only Mode *(cont'd)*

- Required for Cover Letters
  - Name and address of sampled patient included
    - "To Whom It May Concern" is not acceptable salutation
  - Letter is not attached to the survey
  - Letter printed on hospital or survey vendor letterhead
  - Signed by hospital administrator (preferred) or hospital/survey vendor project director
    - The signature must correspond with the organization on the letterhead
    - Electronic signature acceptable
  - Must be in a readable font with a font size (i.e., Arial or Times New Roman) of 12-point at a minimum

Mail Only Mode *(cont'd)*

- Required for Cover Letters *(cont'd)*
  - OMB Language must be included on either the cover letter or the questionnaire *(placement preferred on the questionnaire)*
    - OMB Paperwork Reduction Act language: "According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0981 (Expires September 30, 2024). The time required to complete this information collected is estimated to average 7 minutes for questions 1-29 on the survey, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, C1-25-05, Baltimore, MD 21244-1850."

Mail Only Mode *(cont'd)*

- Required for Cover Letters *(cont'd)*
  - Hospital name and discharge date
    - The term "discharged on" must be used
  - The following sentences must appear verbatim:
    - "Questions 1-29 in the survey are sponsored by the United States Department of Health and Human Services and should take about 7 minutes to complete."
    - "Your participation is voluntary and your answers will be kept private."
    - "Your responses will help improve the quality of hospital care and help other people make more informed choices about their care. You can see current survey results and find hospital ratings on Care Compare on Medicare.gov (www.medicare.gov/care-compare)."
  - Customer support telephone number

Mail Only Mode *(cont'd)*

- Optional for Cover Letters
  - Reply-by date may be added to the <u>Follow-up</u> Cover Letter in the following two places:
    - Top of the Follow-up cover letter above the salutation
      - "Please reply-by: [DATE (mm/dd/yyyy)]"
    - In the fourth paragraph, may replace the sentence, "After you have completed the survey, please return it in the enclosed pre-paid envelope."
      - Such as, "Please fill out the enclosed survey and mail it by [DATE (mm/dd/yyyy)] in the pre-paid envelope."
    - It is recommended that the reply-by date be calculated as 35 days from the initial mailing to make sure the survey is returned before the data collection closes

Mail Only Mode *(cont'd)*

- Optional for Cover Letters *(cont'd)*
  - Wording indicating the purpose of the unique patient identifier must be printed either on the cover letter or after the survey instructions on the questionnaire *(placement preferred on the questionnaire)*
    - "You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders."

Mail Only Mode *(cont'd)*

- Required for Questionnaires
  - Question and answer category wording:
    - Must not be changed
    - Must remain together in the same columns and on the same page
  - No changes are permitted to the order of the response categories HCAHPS questions

Mail Only Mode *(cont'd)*

- Required for Questionnaires *(cont'd)*
  - Randomly generated unique identifiers for patient tracking purposes are placed on the first or last pages of the survey and may appear on all pages
    - Internal codes **must not** contain any patient identifiers such as the patient's discharge date, doctor or hospital unit

Mail Only Mode *(cont'd)*

- Required for Questionnaires *(cont'd)*
  - All instructions on the top of the survey are verbatim
  - The patient's name is not printed on the survey
  - Name and return address of hospital/survey vendor must be printed on the last page of questionnaire
    - If hospital/survey vendor name is used, must <u>not</u> use alias or tag line
  - The OMB control number (OMB #0938-0981) and expiration date must appear on the front page of the survey
  - The OMB language must appear on either the front or back page of the questionnaire (preferred) or on the cover letter, and may appear on both

Mail Only Mode *(cont'd)*

- Required for Questionnaires *(cont'd)*
  - Question and response options must be listed vertically
    - Response options listed horizontally or in a combined vertical and horizontal format are not allowed
    - No matrix formats allowed for question and answer categories
  - Wording that is <u>underlined</u> in the HCAHPS questionnaire must be <u>underlined</u> in the hospital or survey vendor questionnaire
  - Arrows **|➔|** that show skip patterns in the HCAHPS questions or response options must be included in hospital or survey vendor questionnaire
  - Must be in a readable font (e.g., Arial, Times New Roman) with a font size of 10-point or larger

Mail Only Mode *(cont'd)*

- Mail Out Requirements
  - Guidelines for mailings
    - Addresses acquired from hospital record
    - Addresses updated using commercial software
    - Mailings sent to patients by name
  - Mailing content
    - Survey mailings include:
      - Cover letter
      - Questionnaire
      - Self-addressed, stamped business reply envelope
      - Outgoing envelope, 10-point minimum font size, with first class postage or indicia, suggested

Mail Only Mode *(cont'd)*

- Required for Envelopes
    - The outgoing envelope must be printed with the hospital's/survey vendor's address as the return address
    - A self-addressed, stamped business return envelope must be enclosed in the survey envelope along with the cover letter and questionnaire
    - Must be in a readable font (i.e., Arial or Times New Roman) with a font size of 10-point at a minimum

- Optional for Envelopes
    - The outgoing envelope may be printed with the banner, "Important - Open Immediately."
    - The outgoing envelope may be printed with the hospital/survey vendor logo, or both
    - Window envelopes may be used

    Note: The return envelope may not include marketing or promotional text

Mail Only Mode *(cont'd)*

- Patients without mailing addresses
  - Hospitals/Survey vendors must make every reasonable attempt to obtain a patient's address, including recontacting the hospital client to inquire about an address update for patients with no mailing address
    - Hospitals/Survey vendors have flexibility in not sending mail surveys to patients without fixed mailing addresses, such as the homeless
      - *Note: these patients cannot be removed from the sample*
    - Attempts to obtain patient's address must be documented

Mail Only Mode *(cont'd)*

- Data receipt and entry
  - Key entry or scanning allowed for data capture
    - Key-entered data is entered a second time by different staff and any discrepancies between the two entries are identified; discrepancies should be reconciled
    - Programs verify that record is unique and has not been returned already
    - Programs identify invalid or out-of-range responses

Mail Only Mode *(cont'd)*

- Data receipt and entry *(cont'd)*
  - Record survey receipt in a timely manner
  - Surveys are date stamped
  - Ambiguous responses follow HCAHPS decision rules
  - Calculate lag time
  - Assign final survey status code
  - Capture mail wave attempt

Mail Only Mode *(cont'd)*

- Data retention and storage guidelines
  - Paper questionnaires that are key-entered must be stored in a secure and environmentally controlled location for a minimum of three years
  - Optically scanned questionnaire images must be retained in a secure manner for a minimum of three years and are easily retrievable
  - HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files, must be destroyed in a secure and environmentally safe location
    - Obtain a certificate of the destruction of data

Mail Only Mode *(cont'd)*

- Quality control guidelines
  - Hospitals/Survey vendors must:
    - Update address information
    - Check quality and inclusion of all survey materials
    - Check a sample of mailings for inclusion of all sampled patients
    - Provide ongoing oversight of staff and any subcontractor(s) such as printers and fulfillment houses
      - Hospitals/Survey vendors must conduct on-site verification of printing and mailing data collection processes
        - Must be performed on an annual basis, at a minimum

Mail Only Mode *(cont'd)*

- Quality control guidelines *(cont'd)*
  - Hospitals/Survey vendors must:
    - Perform interval checking of at least 10 percent of all printed mailing pieces on an ongoing and continuous basis throughout the survey administration period
    - Conduct seeded (embedded) mailings to designated hospital or survey vendor HCAHPS project staff on a quarterly basis to check for:
      - Timeliness of delivery
      - Accuracy of address
      - Accuracy and quality of mailing contents
    - Document results of all oversight activities

Telephone Only Mode

- Protocol
  - Initiate first telephone attempt with sampled patients between 48 hours and 6 weeks (42 calendar days) after discharge
  - Complete data collection within 42 calendar days after the first telephone attempt
    - Maximum of five telephone attempts made at different times of day, on different days of the week, spanning more than one week (**eight days or more**), between 9AM and 9PM patient time
    - It is strongly recommended that telephone attempts are made not only on weekdays, but on weekends also
  - Submit data to CMS via the HQR system by the data submission deadline

Telephone Only Mode *(cont'd)*

- Telephone Script
  - HCAHPS Telephone Script provided in Appendices J (English), K (Spanish), L (Chinese), and M (Russian) in *QAG V18.0*
  - Entire telephone script must be read verbatim
  - Question and answer category wording must <u>not</u> be changed nor the order of questions and answer categories
  - HCAHPS Questions (1-29) must remain together
  - Only one language (English, Spanish, Chinese, or Russian) may appear on the interviewing screen at a time

Telephone Only Mode *(cont'd)*

- Interviewing Systems
  - Electronic telephone interviewing, including CATI or other alternative systems (required of survey vendors and of hospitals conducting surveys for multiple sites)
    - Programmed with HCAHPS Telephone Script
    - Linked electronically to survey management system
  - Manual data collection (allowed only for hospitals self-administering surveys)
    - Follow HCAHPS Telephone Script using paper questionnaires to record responses
    - Key entry, scanning

Telephone Only Mode *(cont'd)*

- Interviewing Systems *(cont'd)*
  - Survey administration must be conducted in accordance with the Telephone Consumer Protection Act (TCPA) regulations
    - Cell phone numbers must be identified so that CATI systems with auto dialers do not call cell phone numbers without the permission of the respondent. Survey vendors may identify cell phone numbers through a commercial database and hospitals may identify cell phone numbers upon patient admission.
    - Predictive dialing may be used as long as there is a live interviewer to interact with the patient, and the system is compliant with Federal Trade Commission (FTC) and Federal Communications Commission (FCC) regulations

Telephone Only Mode *(cont'd)*

- Interviewing Systems *(cont'd)*
  - Monitoring and recording of telephone calls
    - Follow state regulations
  - Caller ID
    - May be programmed to display "on behalf of [HOSPITAL NAME]" with permission and compliance of hospital's HIPAA/Privacy officer
  - Every question should have a "MISSING/DON'T KNOW" option available
    - Interviewers should not read as a response option
  - All <u>underlined</u> content must be emphasized
  - Skip patterns and conventions should be programmed into system

Telephone Only Mode *(cont'd)*

- Obtaining Telephone Numbers
  - Main source of telephone numbers is the hospital discharge records
  - Strongly recommend that hospitals/survey vendors **collect and use the patient's** primary and secondary telephone numbers
    - If it is determined that primary telephone number does not connect to the patient, utilize the secondary telephone number
    - It is up to the hospital's/survey vendor's discretion to determine the number of attempts made to each telephone number; however, no more than a total of five call attempts can be made to a sampled patient

Telephone Only Mode *(cont'd)*

- Definition of a Telephone Attempt
  - Telephone rings six times with no answer
  - Interviewer reaches a wrong number
  - An answering machine or voice mail is reached (do not leave message)
  - Interviewer reaches the household and is told that the patient is not available to come to the telephone or has a new number
  - Interviewer reaches the patient and is asked to call back at a more convenient time
    - Hospitals/Survey vendors must schedule a telephone callback that accommodates a patient's request within a specific day and time
    - Callback must be scheduled at the patient's convenience between the hours of 9 AM and 9 PM respondent time within the data collection time period

Telephone Only Mode *(cont'd)*

- Definition of a Telephone Attempt *(cont'd)*
  - Busy signal
    - At the discretion of the hospital/survey vendor a telephone attempt can consist of three consecutive telephone attempts made at approximately 20-minute intervals
  - "Screening" number
    - If interviewer reaches a "screening" number (e.g., privacy screen, privacy manager, phone intercept or blocked call)
    - Count this as one telephone attempt and continue to make additional attempts (up to five) to reach the patient before dispositioning the call as "8 – Non-response after maximum attempts"

Telephone Only Mode *(cont'd)*

- Data Receipt and Data Entry
  - Maintain a crosswalk of interim disposition codes to HCAHPS Final Survey Status codes
  - Assign final survey status code
  - Capture the telephone attempt in which the final disposition of the survey is determined
  - Calculate lag time

Telephone Only Mode *(cont'd)*

- Data Retention and Data Storage
  - Data collected through electronic telephone interviewing systems and optically scanned paper questionnaire images must be maintained in a secure manner for a minimum of three years
  - Paper questionnaires collected manually and then key-entered must be stored in a secure and environmentally controlled location for a minimum of three years
  - HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files, must be destroyed in a secure and environmentally safe location
    - Obtain a certificate of destruction

Telephone Only Mode *(cont'd)*

- Quality Control Guidelines
  - Telephone monitoring and oversight of staff and subcontractors
    - At least 10% of HCAHPS call attempts and interviews must be monitored (on an ongoing and continuous basis throughout the survey administration period) by survey vendor and its subcontractor (if applicable)
    - All interviewers conducting HCAHPS Surveys must be monitored
    - All language translations in which the survey is administered must be monitored

Telephone Only Mode *(cont'd)*

- Quality Control Guidelines *(cont'd)*
  - Hospitals/Survey vendors are responsible for the quality of work performed by any subcontractor(s), such as call centers
    - Hospitals/Survey vendors must conduct on-site verification of call centers, including live call monitoring and floor rounding
      - **Must** be performed on an annual basis, at a minimum

Telephone Only Mode *(cont'd)*

- Interviewer Training
  - Formal interviewer training **is required** to ensure standardized, non-directive interviews
    - Interviewers should be knowledgeable about the survey and prepared to answer questions
    - See HCAHPS FAQs in Appendix Q
  - Survey Introduction
  - Interviewing Guidelines and Conventions
    - System Conventions
    - Avoiding Refusals
    - Probing for Complete Answers

Telephone Only Mode *(cont'd)*

- Survey Introduction
  - Introduction script provides survey purpose
  - Verifies eligibility of the respondent
    - Confirm hospital and discharge date
  - Informs respondent that survey will take about seven minutes or [HOSPITAL/SURVEY VENDOR SPECIFY]
  - Survey vendors that subcontract call center services must state survey vendor name in the CATI script introduction for the data collection contractor: "…calling from [DATA COLLECTION CONTRACTOR] on behalf of [HOSPITAL NAME]…"
  - Provides guidance for people wishing to act as a proxy for sampled patients

Telephone Only Mode *(cont'd)*

- Interviewing Guidelines and Conventions
  - System conventions
    - Text that appears in lower case letters must be read out loud
    - Text in UPPER CASE letters must **not** be read out loud
    - Text that is <u>underlined</u> must be emphasized
    - Characters in < > brackets must **not** be read out loud
    - [Square brackets] are used to show programming instructions that must not actually appear on the computerized interviewing screens
    - Skip patterns should be programmed into the electronic telephone interviewing system

Telephone Only Mode *(cont'd)*

- Interviewing Guidelines and Conventions *(cont'd)*
  - Asking questions and probing:
    - Questions, transitions and response choices are read *exactly* as worded on script
    - Do not provide extra information or lengthy explanations to respondent questions
    - End the survey by thanking the respondent for his or her time
  - Avoiding refusals
    - Be prepared to convert a soft refusal into a completed survey
    - Emphasize importance of participation
    - Never argue with or antagonize a patient
    - Remember! First moments of the interview are most critical for gaining participation

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Telephone Only Mode *(cont'd)*

- Interviewing Guidelines and Conventions *(cont'd)*
  - Probing for complete data
    - When respondent fails to provide adequate answer
    - Never interpret answers for respondents
    - Code "MISSING/DON'T KNOW" when respondent cannot/does not provide complete answer **after** probing
      - In instances where the patient is reluctant to answer "Yes" or "No" to the HCAHPS Survey question(s) and the patient's intended response(s), either positive or negative is clear, the patient's response should be accepted

Telephone Only Mode *(cont'd)*

- Interviewing Guidelines and Conventions *(cont'd)*
  - Types of probes:
    - Repeat question and answer categories
    - Interviewer may state:
      - "Take a minute to think about it"
      - "So would you say…"
      - "Which would you say is closer to the answer?"

Telephone Only Mode *(cont'd)*

- **Example of response probe: Overall Health (Question 24)**

  In general, how would you rate your overall health? Would you say that it is...

<1>	Excellent,
<2>	Very good,
<3>	Good,
<4>	Fair, or
<5>	Poor?
<M>	MISSING/DK

Telephone Only Mode *(cont'd)*

- **Example of response probe: Overall Health (Question 24)** *(cont'd)*

  - Patient 1 Answers
    - "My health is okay."

  - Probe for Patient 1
    - "We're asking you to choose one response. Would you say your overall health is…" **[Repeat all answer categories]**

  - Patient 2 Answers
    - "My health is great."

  - Probe for Patient 2
    - "Would you then rate your overall health as **Excellent, Very good or Good**?"

Telephone Only Mode *(cont'd)*

- **Example of response probe: Education (Question 26)**

What is the highest grade or level of school that you have **completed**? Please listen to all six response choices before you answer. Did you…

<1>	Complete the 8th grade or less,
<2>	Complete some high school, but did not graduate,
<3>	Graduate from high school or earn a GED,
<4>	Complete some college or earn a 2-year degree,
<5>	Graduate from a 4-year college, or
<6>	Complete more than a 4-year college degree?
<M>	MISSING/DK

Telephone Only Mode *(cont'd)*

- **Example of response probe: Education (Question 26)** *(cont'd)*

  - Patient 1 Answers
    - "I graduated from school."

  - Probe for Patient 1
    - "We're asking you about the highest grade or level of school that you completed. Would you say you completed…" **[Repeat all answer categories]**

  - Patient 2 Answers
    - "I graduated from college."

  - Probe for Patient 2
    - "We're asking you about the highest grade or level of school that you completed. So would you say **completed some college or earned a 2-year degree, graduated from a 4-year college, or completed more than a 4-year college degree?"**

Telephone Only Mode *(cont'd)*

Race Question (Question 28)

- When I read the following, please tell me if the category describes your race. I am required to read all five categories. <u>Please answer "Yes" or "No" to each of the categories</u>.

- Note for Q28A: if respondent replies, "Caucasian" code as "1 – YES/WHITE"

Q28A   Are you White?

Q28A	Are you White?	
	<1>	YES/WHITE
	<0>	NO/NOT WHITE
	<M>	MISSING/DK
Q28B	Are you Black or African- American?	
	<1>	YES/BLACK OR AFRICAN- AMERICAN
	<0>	NO/NOT BLACK OR AFRICAN- AMERICAN
	<M>	MISSING/DK
Q28C	Are you Asian?	
	<1>	YES/ASIAN
	<0>	NO/NOT ASIAN
	<M>	MISSING/DK
Q28D	Are you Native Hawaiian or other Pacific Islander?	
	<1>	YES/NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
	<0>	NO/NOT NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
	<M>	MISSING/DK
Q28E	Are you American Indian or Alaska Native?	
	<1>	YES/AMERICAN INDIAN OR ALASKA NATIVE
	<0>	NO/NOT AMERICAN INDIAN OR ALASKA NATIVE
	<M>	MISSING/DK

Telephone Only Mode *(cont'd)*

Language Speak Question (Question 29)

- What language do you mainly speak at home?
    - READ RESPONSE CHOICES IF NECESSARY AND STOP WHEN PATIENT PROVIDES A RESPONSE: Would you say that you <u>mainly</u> speak…

- Note: If the patient replies with multiple language, probe with: Would you say that you <u>mainly</u> speak [LANGUAGE A] or [LANGUAGE B]?

- Note: If the patient replies that they speak "American", code as "1 – ENGLISH"

<1> English,   [GO TO END]
<2> Spanish,   [GO TO END]
<3> Chinese,   [GO TO END]
<4> Russian,   [GO TO END]
<5> Vietnamese,   [GO TO END]
<6> Portuguese,   [GO TO END]
<7> German,   [GO TO END]
<8> Tagalog,   [GO TO END]
<9> Arabic, or   [GO TO END]
<20> Some other language?   [GO TO Q29A]

<M> MISSING/DK   [GO TO END]

Mixed Mode

- Protocol – Mail followed by Telephone
  - Follow guidelines for Mail Only mode
    - Use one questionnaire mailing instead of two
    - Send questionnaire with cover letter to sampled patients between 48 hours and six weeks (42 calendar days) after discharge
  - Follow guidelines for Telephone Only mode
    - Initiate first telephone attempt for all non-respondents approximately 21 calendar days after mailing the questionnaire
      - Maximum of five telephone attempts made at different times of day, on different days of the week spanning more than one week **(eight days or more)**, between 9AM and 9PM patient time
      - It is strongly recommended that telephone attempts are made not only on weekdays, but on weekends also
    - Complete telephone sequence within 42 calendar days of Mixed Mode initiation
  - Submit data to CMS via the HQR system by the data submission deadline

Mixed Mode *(cont'd)*

- Hospitals/Survey vendors <u>must</u> keep track of the mode and attempt in which each survey was completed (i.e., Mail or Telephone):

  1. For completed surveys, retain documentation in survey management system that the patient completed the survey in the <u>Mail phase</u> **or** <u>Telephone phase</u> of the Mixed Mode of survey administration, then

  2. Assign the appropriate "Survey Completion Mode" and the "Number of Survey Attempts – Telephone" in which the survey was completed or final survey status is determined

Active Interactive Voice Response (IVR) Mode

- Protocol
  - Initiate first IVR attempt with sampled patient(s) between 48 hours and six weeks (42 calendar days) after discharge
  - Complete data collection within 42 calendar days after the first IVR attempt
    - Maximum of five IVR attempts made at different times of day, on different days of the week spanning more than one week (**eight days or more**), between 9AM and 9PM patient time
    - It is strongly recommended that telephone attempts are made not only on weekdays, but on weekends also
  - Submit data to CMS via the HQR system by the data submission deadline

Active IVR Mode *(cont'd)*

- IVR Interviewing Systems
  - Programmed with HCAHPS IVR Script
    - HCAHPS IVR Script provided in Appendix N (English), and Appendix O (Spanish) of *QAG V18.0*
  - Follow Telephone Only mode system conventions
  - English and Spanish
  - Capable of recording and storing patient answers
  - Capable of touch tone key pad response
  - Telephone interviewing option must be available for patients who do not want to continue with IVR

Active IVR Mode *(cont'd)*

- Live Operator
  - Reads IVR introduction script, then transitions patient to IVR
  - Must be available to answer questions/FAQs
  - Must be available to triage patients to another electronic system (CATI) or to conduct the interview themselves for reluctant respondents

- Follow Telephone Only Mode Guidelines
  - Data collection, data receipt and retention
  - Quality control guidelines
    - Staff/Subcontractor training
    - Monitoring and oversight
    - Documentation

Active IVR Mode *(cont'd)*

- Hospitals/Survey vendors <u>must</u> keep track of the mode and attempt in which each survey was completed (i.e., IVR or Telephone):

  1. For completed surveys, retain documentation in the survey management system that the patient completed the survey in the <u>IVR mode **or** Telephone mode</u> of the IVR mode of survey administration, then

  2. Assign the appropriate "Survey Completion Mode" and "Number of Survey Attempts – Telephone" in which the survey was completed or final survey status is determined

Data Specifications & Coding

Data Coding Overview

- General Data Coding
- Decision Rules for Data Capture (Mail)
- Decision Rules for Screener and Dependent Questions (All Modes)
- Final Survey Status/Disposition Codes
  - Definition of a Completed Survey

General Data Coding

- Enter survey responses as answered by the patient

- For surveys with "Final Survey Status" codes of
  "1 – Completed Survey" or
  "6 – Non-response: Break-off"

  - A value must be entered for all survey questions

  - Appendix S: Data File Structure Version 4.6 (effective 3Q23 discharges) provides valid values

- Include decision rules and coding guidelines, and quality control procedures in materials and training

Decision Rules for Data Capture (Mail)

- Standardized rules ensure consistency across hospitals/survey vendors

- Apply decision rules to both scanned and key-entered data

- If a patient completes two surveys for the same hospital visit, use the first survey returned

Decision Rules for Data Capture *(cont'd)*

- If a mark falls between two choices and is obviously closer to one choice than another, select the choice to which the mark is closest

Example 1 (Mail)

☐ **Never**

x
☐ **Sometimes**

☐ **Usually**

☐ **Always**

Code as:

"2 - Sometimes"

Decision Rules for Data Capture *(cont'd)*

- If a mark falls equidistant between two choices, code the value of the item as "M – Missing/Don't Know"

- Do not impute a response

Example 2 (Mail)

☐ **Never**

x

☐ **Sometimes**

☐ **Usually**

☐ **Always**

Code as:

"M - Missing/Don't Know"

Decision Rules for Data Capture *(cont'd)*

- When more than one response choice is marked, code the value as "M – Missing/Don't Know"
  - Do not impute a response
- **Exception**: For Question 28 *(What is your race?)*, enter responses for ALL of the categories that the respondent selected

Example 3 (Mail)

☒ Never

☒ Sometimes

☐ Usually

☐ Always

Code as:

"M - Missing/Don't Know"

Decision Rules for Data Capture *(cont'd)*

- When more than one response choice is marked, but the respondent's intent is clear, code the intended response

Example 4 (Mail)

~~☒ Never~~

☒ Sometimes

☐ Usually

☐ Always

Code as:

"2 - Sometimes"

Decision Rules for Screener and Dependent Questions (All Modes)

- Screener Question – instructs patient to skip subsequent questions for select response choices
  - Questions 10, 12, 15

- Dependent Question – questions skipped based on patient's response to screener question
  - Questions 11, 13, 14, 16, 17

Decision Rules for Screener and Dependent Questions (All Modes) *(cont'd)*

- Code appropriately skipped questions as "8 – Not Applicable"

- Code other scenarios as answered by the patient (do not "clean" skip pattern errors)

- Hospitals/Survey vendors apply this rule to data collected via mail, telephone and IVR

Decision Rules for Screener and Dependent Questions *(cont'd)*

12. During this hospital stay, were you given any medicine that you had not taken before?

☒ Yes

☐ No → If no, Go to Question 15

Example 1 (Mail)

Code as:
"1 - Yes"

13. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

Code as:
"M - Missing/Don't Know"

Decision Rules for Screener and Dependent Questions *(cont'd)*

12. During this hospital stay, were you given any medicine that you had not taken before?

☒ Yes

☐ No → If no, Go to Question 15

Example 2 (Mail)

Code as:

"1 - Yes"

13. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

☐ Never

☐ Sometimes

☒ Usually

☐ Always

Code as:

"3 - Usually"

Decision Rules for Screener and Dependent Questions *(cont'd)*

12. During this hospital stay, were you given any medicine that you had not taken before?
☐ Yes
☒ No → If no, Go to Question 15

Example 3 (Mail)

Code as:

"2 - No"

13. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
☐ Never
☐ Sometimes
☐ Usually
☐ Always

Code as:

"8 - Not Applicable"

Decision Rules for Screener and Dependent Questions *(cont'd)*

12. During this hospital stay, were you given any medicine that you had not taken before?
☐ Yes
☒ No → If no, Go to Question 15

Example 4 (Mail)

Code as:
"2 - No"

13. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
☐ Never
☒ Sometimes
☐ Usually
☐ Always

Code as:
"2 - Sometimes"

Decision Rules for Screener and Dependent Questions *(cont'd)*

12. During this hospital stay, were you given any medicine that you had not taken before?
☐ Yes
☐ No → If no, Go to Question 15

Example 5 (Mail)

**Code as:
"M - Missing/Don't Know"**

13. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
☐ Never
☐ Sometimes
☒ Usually
☐ Always

**Code as:
"3 - Usually"**

Decision Rules for Screener and Dependent Questions *(cont'd)*

- For the **Telephone** and **IVR survey** modes, skip patterns should be programmed into the electronic telephone interviewing/IVR system
  - If screener questions are answered either "No" or "Another Health Facility," then the appropriately skipped dependent questions should be coded as "8 – Not applicable"
  - If screener questions are not answered ("Missing/Don't Know"), then the appropriately skipped dependent questions should be coded as "M – Missing/Don't Know"

Final Survey Status/ Disposition Codes

- 1 – <u>Completed</u> Survey
  - At least 50 percent of the 17 questions applicable to all patients are answered
  - Questions applicable to all patients are *included*
    - Questions 1 through 10, 12, 15, and 18-22
  - Questions not applicable to all patients (e.g., skip pattern and "About You" questions) are *excluded*
    - Questions 11, 13, 14, 16, 17, and 23–29
  - See Completed Survey Calculation Example in *QAG V18.0*

Final Survey Status/ Disposition Codes *(cont'd)*

Ineligible

- 2 – Deceased

  – Patient was alive at the time of discharge but deceased by time of survey administration

Final Survey Status/ Disposition Codes *(cont'd)*

Ineligible *(cont'd)*

- ## 3 – Not in Eligible Population

  - Patient's ineligibility is determined **after** the sample is drawn

Eligibility Criteria

- 18 years old or older at the time of hospital admission
- Admission includes at least one overnight stay in the hospital as an inpatient
- Non-psychiatric principal diagnosis at discharge
- Alive at the time of discharge

Exclusions

- "No-Publicity" patient
- Court/Law enforcement patient (i.e., prisoners) (does not apply to patients residing in halfway houses) (admission source code of 8; discharge status codes of 21, 87)
- Has a foreign home address
- Discharged to hospice (whether at home or another facility) (discharge status codes of 50, 51)
- Eliminated from participation based on State regulations
- Patients discharged to nursing home or skilled nursing facility (discharge status codes of 3, 61, 64, 83, 92)

Final Survey Status/ Disposition Codes *(cont'd)*

Ineligible *(cont'd)*

- 4 – Language barrier
  - Evidence that the patient does not read or speak the language in which the survey is being administered

Final Survey Status/ Disposition Codes *(cont'd)*

Ineligible *(cont'd)*

- 5 – Mentally or physically incapacitated
  - Patient is unable to complete the survey because he/she is mentally or physically incapacitated, or visually/hearing impaired
  - Do not automatically assign this code to patients discharged to health care facilities (e.g., long-term care facilities, assisted living facilities, rehab, etc.)
    - Hospitals/Survey vendors must attempt to contact these patients

Final Survey Status/ Disposition Codes *(cont'd)*

Non-Response

- 6 – Break-off

  - At least one HCAHPS Core question applicable to all patients is answered, but too few questions are answered to meet the criteria for a completed survey

    - Includes patients who refuse to complete the survey, but answered at least one HCAHPS Core question

  - See Break-off Survey Calculation Example in *QAG V18.0*

Final Survey Status/ Disposition Codes *(cont'd)*

Non-Response *(cont'd)*

- 7 – Refusal

  - When a patient returns a blank survey with a note stating they do not wish to participate, or when a patient verbally refuses to begin the survey

  - When it is determined a survey has been completed by a proxy respondent, which is not permitted for the HCAHPS Survey

    Note: If the patient answered some HCAHPS Core questions, but refused to complete the survey, the "Final Survey Status" is coded as either "1 – Completed Survey" or "6 – Non-response: Break-off," depending on the completion criteria

Final Survey Status/ Disposition Codes *(cont'd)*

Non-Response *(cont'd)*

- 8 – Non-response after maximum attempts
  - Patient has not completed the survey by the end of the survey administration time period
  - Lag time is greater than 84 calendar days

Final Survey Status/ Disposition Codes *(cont'd)*

Non-Response *(cont'd)*

- 9 – Bad address

- 10 – Bad/no phone number

  - Assume the contact information is viable unless there is sufficient evidence to suggest the contrary
    - Attempts must be made to contact every sampled patient whether or not there is a complete mailing address and/or telephone number
    - Hospitals/Survey vendors have flexibility in not sending mail surveys to patients without mailing addresses (i.e., homeless) after making every reasonable attempt to obtain an address

Introduction to HCAHPS Survey Training

Data Preparation Overview

- File Specifications Version
- File Layout
  - Header Record
  - Patient Administrative Data Record
  - Patient Response/Survey Results Record
- Preparing the Data File
- Data Submission Timeline

File Specifications Version

- Standardized file layouts
  - Appendix S – Data File Structure Version 4.6
  - Appendices T – XML File Layout Version 4.6

Note: Version 4.6 applies to 3Q23 discharges and forward

File Layout

1. Header Record
   - Complete once per monthly file
     - Survey Mode and Sample Type must be the same for all three months within a quarter. Once you have uploaded your first month of data, you have the ability to re-upload that month and change the survey mode or sample type.
     - Certain Header Record information (Survey Mode, Type of Sampling, Determination of Service Line) cannot be modified once two months of data in the quarter have been submitted and accepted in the HQR System

2. Patient Administrative Data Record
   - Complete for every patient in the sample
     - Number of Patient Administrative Data Records must equal the number of sampled patients ("Sample Size")

File Layout *(cont'd)*

3. Patient Response/Survey Results Record

– Complete for patients who responded to the survey

• Number of Patient Response/Survey Results Records must equal the number of Final Survey Status codes of "1 – Completed Survey" and "6 – Non-response: Break-off"

– Enter missing responses as "M – Missing/Don't Know" or "8 – Not Applicable"

Header Record

- Contains hospital identification and sampling information
- All fields in the Header Record must have a valid value
  - Exceptions:
    - NPI *(optional)*
    - DSRS Strata Name *(required only if DSRS)*
    - DSRS Eligible *(required only if DSRS)*
    - DSRS Sample Size *(required only if DSRS)*
    - DSRS Inpatient *(required only if DSRS)*
- Survey Mode, Sampling Type and Determination of Service Line must be the same for all three months within a quarter

Header Record *(cont'd)*

- CMS Certification Number (CCN)
  - Valid 6-digit CCN (formerly known as Medicare Provider Number)
  - Sample per unique CCN
  - Hospitals that share a common CCN must obtain a combined total of at least 300 completes per CCN per 12-month reporting period

Header Record *(cont'd)*

- Total Inpatient Discharges
  - Total number of inpatient discharges in the month for the hospital, whether or not they meet HCAHPS eligibility or exclusion criteria
    - Note: Do **NOT** include in the "Total Inpatient Discharges" field:
      - Patients who were not inpatients (e.g., observation, outpatient, emergency room)
      - Newborns (i.e., age 0) as they typically do not have an inpatient discharge

    In addition, repeat inpatient records for the same inpatient hospital stay [i.e., same admission and discharge dates for the same patient] should be counted as only one discharge.
  - Hospitals using DSRS must submit Total Inpatient Discharges per stratum (DSRS Inpatient)

Header Record *(cont'd)*

- Eligible Discharges
  - Number of eligible discharges in the sample frame
    - All eligible discharges are included in the count
    - Include eligible discharges even if the patients' information is received from the hospital with discharge dates that are beyond the 42 calendar day initial contact period
      - **However, these patients must NOT be included in the HCAHPS Survey sample nor included in the "Sample Size" field count**
      - **A Discrepancy Report must be filed when patient information is received beyond the 42 calendar day initial contact period**

Header Record *(cont'd)*

- Eligible Discharges *(cont'd)*
  - In calculating the "Eligible Discharges" field, do **not** include patients later determined to be ineligible or excluded, regardless of whether they are selected for the survey sample

Header Record *(cont'd)*

- Eligible Discharges *(cont'd)*
    - If a patient was selected for the survey sample and later determined to be ineligible (i.e., "Final Survey Status" code of "**3 – Ineligible: Not in eligible population**"), the patient must be subtracted when reporting the "Eligible Discharges" field (number of eligible discharges in sample in the month)
        - Does NOT apply to "Final Survey Status" codes of:
            - "2 – Ineligible: Deceased
            - "4 – Ineligible: Language barrier,"
            - "5 – Ineligible: Mental/Physical incapacity"
        - "Sample Size" can therefore be larger than the number of "Eligible Discharges"

Header Record *(cont'd)*

Example 1: Eligible Discharges Calculation

100	=	Number of eligible patients in original sample frame (Eligible Discharges)
100	=	Number of patients selected for sample (Sample size)
2	=	Number of patients with "Final Survey Status" code of "2 – Ineligible: Deceased"
-5	=	Number of patients with "Final Survey Status" code of "3 – Ineligible: Not in eligible population"
2	=	Number of patients with "Final Survey Status" code of "4 – Ineligible: Language barrier"
4	=	Number of patients with "Final Survey Status" code of "5 – Ineligible: Mental/Physical incapacity"
95	=	Number reported in the "Eligible Discharges" field

Header Record *(cont'd)*

- Eligible Discharges *(cont'd)*
  - If a patient was **not** selected for the survey sample, but later determined to be ineligible (i.e., received an update with an ineligible MS-DRG code for the patient), the patient must be subtracted when reporting the "Eligible Discharges"

Header Record *(cont'd)*

Example 2: Eligible Discharges Calculation

100	=	Number of eligible patients in original sample frame (Eligible Discharges)
50	=	Number of patients selected for sample (Sample size)
2	=	Number of patients with "Final Survey Status" code of "2 – Ineligible: Deceased"
-5	=	Number of patients with "Final Survey Status" code of "3 – Ineligible: Not in eligible population"
2	=	Number of patients with "Final Survey Status" code of "4 – Ineligible: Language barrier"
4	=	Number of patients with "Final Survey Status" code of "5 – Ineligible: Mental/Physical incapacity"
-10	=	Number of patients ineligible due to an updated MS-DRG code (These patients were NOT selected for the survey sample)
85	=	Number reported in the "Eligible Discharges" field

Header Record *(cont'd)*

- Sample Size
  - Number of sampled patient discharges in the month
    - Must equal the number of Patient Administrative Data Records
  - When 100% of the eligible population (census) is sampled, then "Eligible Discharges" equals the "Sample Size"

Patient Administrative Data Record

- All fields in the Patient Administrative Data Record must have a valid value
  - Use code "M – Missing/Don't Know" for all missing fields, with the following exceptions:
    - "Point of Origin for Admission or Visit"— code as "9 – Information not available"

- Number of Patient Administrative Data Records must equal the number of sampled patients ("Sample Size")

Patient Administrative Data Record *(cont'd)*

- Patient administrative information must be submitted for <u>all patients</u> selected in the survey sample
  - If a sampled patient is later found to be ineligible or excluded, the patient administrative information still must be submitted
    - The patient should be assigned a "Final Survey Status" code of "3 – Ineligible: Not in eligible population"

Patient Administrative Data Record *(cont'd)*

- Patient Identification (ID) Number
  - Hospital/Survey vendor is responsible for assigning a <u>random, unique, de-identified</u> Patient ID Number for each patient in the sample
  - Used to track and report whether the patient has returned the survey, or needs a repeat mailing or phone call
  - Does <u>not</u> disclose the patient's true identity
  - Does <u>not</u> include any existing identifiers that can be linked back to the patient (i.e., SSN, DOB, medical record number, discharge date (including the month and year), hospital unit, patient initials)
  - Assign a new Patient ID each month; numbers must <u>not</u> be repeated from month to month or used in a sequential numbering order unless the patient discharge list is randomized prior to the assignment of ID
  - Can be up to 16 characters in length (alphanumeric)
  - Do not use symbols or special characters (^*@#&) of any kind; not valid for data submission

Patient Administrative Data Record *(cont'd)*

- Service Line (Reason for Admission)
  - Based on one of the accepted methodologies for Determination of Service Line in the Header Record
  - *It is strongly recommended that hospitals/survey vendors assign the HCAHPS Service Line based on the hospital information (e.g., patient MS-DRG code at discharge)*
    - Missing or invalid MS-DRG code does not exclude a patient from being drawn into the sample frame
  - Should not be coded as "M – Missing/Don't Know"
  - Male patients should not be reported in the "Maternity Care" service line

Patient Administrative Data Record *(cont'd)*

- Final Survey Status
  - Disposition of survey
  - Patients with a "Discharge Status" of "Expired" (codes 20, 40, 41, 42)
    - Code "Final Survey Status" as "2 – Ineligible: Deceased"
    - Must <u>not</u> have "Final Survey Status" coded as "1 – Completed Survey" or "6 – Non-response: Break-off"

Patient Administrative Data Record *(cont'd)*

- Survey Completion Mode
  - Survey mode used to complete a survey administered in the Mixed or IVR modes

    1 – Mixed Mode-Mail

    2 – Mixed Mode-Phone

    3 – IVR Mode-IVR

    4 – IVR Mode-Phone

    8 – Not applicable

Patient Administrative Data Record *(cont'd)*

- Survey Completion Mode **<u>must</u>** correspond with Survey Mode in the Header Record

Patient Administrative Data Record	Header Record
Survey Completion Mode	**Survey Mode**
"1-Mixed Mode – Mail"	"3-Mixed Mode"
"2-Mixed Mode – Phone"	
"3-IVR Mode – IVR"	"4-IVR"
"4-IVR Mode – Phone"	

Patient Administrative Data Record *(cont'd)*

- Number Survey Attempts – Telephone
  - Telephone attempt upon which the final survey was completed or final survey status was determined
    - 1 - First telephone attempt
    - 2 - Second telephone attempt
    - 3 - Third telephone attempt
    - 4 - Fourth telephone attempt
    - 5 - Fifth telephone attempt
    - 8 - Not applicable
  - <u>Required</u> when:
    - "Survey Mode" is "2 – Telephone Only" or "4 – IVR"
    - "Survey Mode" is "3 – Mixed Mode" and "Survey Completion Mode" is "2 – Mixed Mode-Phone"

Patient Administrative Data Record *(cont'd)*

- Number Survey Attempts – Mail
  - Mail wave for which survey attempt was completed or final survey status determined
    - 1 - First wave mailing
    - 2 - Second wave mailing
    - 8 - Not applicable
  - Must differentiate between the first mail survey wave and the second mail survey wave in mailing materials
    - Unreturned surveys from the second wave mailing are coded as "2 – Second wave mailing"
  - **Required** when:
    - "Survey Mode" is "1 – Mail Only"

Patient Administrative Data Record *(cont'd)*

- Survey Language
  - Identify the language in which the survey was administered, even if the patient does not complete the survey
    - "1 – English" (All modes)
    - "2 – Spanish" (All modes)
    - "3 – Chinese" (Mail, Telephone)
    - "4 – Russian" (Mail, Telephone)
    - "5 – Vietnamese" (Mail only)
    - "6 – Portuguese" (Mail only)
    - "7 – German" (Mail only)
    - "8 – Tagalog" (Mail only)
    - "9 – Arabic" (Mail Only)
  - **All** patient records should contain the actual Survey Language in which the survey was administered or attempted to be administered

Patient Administrative Data Record *(cont'd)*

- Lag Time
  - Calculated for each patient in the sample
  - Defined as the number of days between the patient's **discharge date** from the hospital and the **date that data collection activities ended** for the patient
  - **<u>All</u>** patient records **<u>must</u>** contain the actual Lag Time
    - Do **NOT** use code "888 – Not Applicable"

Patient Administrative Data Record *(cont'd)*

- Supplemental Question Count
  - Count of maximum number of supplemental questions **available** to the patient **regardless of whether or not the questions** are asked and/or answered
    - Include skip pattern questions
    - Include open-ended questions
    - Include questions asked as sub-questions (each response item counts as one question)
  - Must be submitted for all sampled patients even if they did not complete survey

Patient Response/ Survey Results Record

- Required when "Final Survey Status" in the Patient Administrative Data Record is coded as "1 – Completed Survey" or "6 – Non-response: Break-off"
  - Number of Patient Response/Survey Results Records must equal the number of Final Survey Status codes of "1 – Completed Survey" and "6 – Non-response: Break-off"

- All fields must have a valid value, including "M – Missing/Don't Know" or "8 – Not Applicable"

Preparing the Data File

- Check data file
  - Check for missing values
  - Check for out of range values
  - Check frequency distributions of values
  - Check for valid file structure

- Submit data file via the HQR system

- Retain all survey-related documentation, e.g., paper surveys/scanned images, patient discharge files and de-identified electronic data files for a minimum of three years

Data Submission Timeline

Month of Patient Discharges	Data Submission Deadline	Review and Correct Period	File Specifications Version
July, August and September 2022 (3Q22)	January 4, 2023	January 5-11, 2023	Version 4.5
October, November, December 2022 (4Q22)	April 5, 2023	April 6-12, 2023	Version 4.5
January, February, March 2023 (1Q23)	July 5, 2023	July 6-12, 2023	Version 4.5
April, May, June 2023 (2Q23)	October 4, 2023	October 5-11, 2023	Version 4.5
July, August, September 2023 (3Q23)	January 3, 2024	January 4-10, 2024	Version 4.6

March 2023

HCAHPS Data Submission via the Hospital Quality Reporting (HQR) System

Overview

- Section XII *QAG V18.0*

- Public and Secure Page Access
  - QualityNet Resources and WebEx Training
  - Registration Process for the HQR System, Basic User and Security Administrator
  - Submission of HCAHPS Data via the HQR System
  - Authorizing/Switching Survey Vendors
  - HCAHPS Data Submission Reports
  - HCAHPS Feedback Reports

Introduction to HCAHPS Survey Training

QualityNet Public Access: https://qualitynet.cms.gov/

HQR System Secure Page Access

- URL: https://hqr.cms.gov/

- The HQR system is used to submit HCAHPS data to the HCAHPS Data Warehouse

  – Accessed via user's HARP (HCQIS Access Roles and Profile) account. New users will need to create a HARP account.

Introduction to HCAHPS Survey Training

HQR Users

- Types of Users:
    1. Security Administrator (Primary and Backup)
    2. Basic User

- Hospitals and Survey Vendors **cannot** delegate administrator role outside of their organization

- Check for existing Security Administrators within the organization

HQR Users *(cont'd)*

- Security Administrator Role:
  - Register or approve each new HQR Basic User
  - Edit users' access and suspend or restore access as needed
  - Monitor HQR secure access to maintain proper security and confidentiality measures
  - Serve as a point of contact at the organization for information regarding HQR

- Basic User Role:
  - Submit data, view Submission or Feedback Reports and/or authorize a survey vendor

Security Administrator or Basic User Registration for *Hospitals/Survey Vendors*

- Register as a Basic User or Security Administrator Registration via the HQR Web site: https://hqr.cms.gov
  1. Sign into the HQR system
  2. Go to "My Profile"
  3. Request Access or View Current Access
  4. Between the Basic User or Security Administrator/Official type, choose the appropriate user type
  5. For Security Administrator registration: Choose which permissions are needed as a Security Administrator.
  6. For Basic User registration: Choose which permissions are needed as a Basic User

  Note: Security Administrator will need to approve each new HQR Basic User

HQR HCAHPS Roles

- The following HCAHPS user roles are available to either hospitals or survey vendors, depending on the role:

  - **HCAHPS File Upload** – Hospital or survey vendor personnel who have this role can upload HCAHPS XML formatted data or submit data using the HCAHPS Data Form (Online Data Entry Tool) to the HCAHPS Data Warehouse

  - **HCAHPS Submission Results** – Hospital personnel who are assigned this role can view HCAHPS File Accuracy and Submission Results Reports

Authorizing Survey Vendor to Submit HCAHPS Data

- All hospitals must use the Vendor Management System on HQR to authorize their HCAHPS Survey vendors

  – Authorize at least 90 days prior to the data submission deadline

  – Authorization updates in real time

  – Approved survey vendors are listed on https://www.hcahpsonline.org

Vendor Authorization - New

Authorizing a New HCAHPS Survey Vendor

Discharge Start Quarter and Start Year	Data Submission Start Date (MM/DD/YYYY)
4Q 2023	10/01/2023
Discharge End Quarter and End Year	Data Submission End Date (MM/DD/YYYY)
(Strongly recommend that these fields remain blank until survey vendor authorization is terminated, by checking the box "Do not include an end date")	

Switching Survey Vendors

- Hospitals that choose to switch from one approved survey vendor to another can only do so at the beginning of a calendar quarter

- Survey vendors should work closely with their client hospitals, who are unfamiliar with the Hospital Quality Reporting (HQR) system, to complete the authorization at least 90 days prior to the data submission deadline

Switching Survey Vendors *(cont'd)*

- Understand the contract dates for current and new vendors
  - Current Vendor – Last discharge date for eligible patients
    - Must be at the end of a quarter
    - After Submission deadline and Review and Correct Period for that discharge quarter
    - The Submission End Date should be the last day for which the current survey vendor will be submitting data on the hospital's behalf
  - New Vendor – Submission Start Date for eligible patients must be:
    - At the beginning of a quarter
    - The first day that vendor can submit data for those patients

Vendor Authorization - Switch

Step 1 – Close Out "Current" HCAHPS Survey Vendor

Discharge Start Quarter and Year	Data Submission Start Date (MM/DD/YYYY)
4Q 2022	10/01/2022
Discharge End Quarter and Year	Data Submission End Date (MM/DD/YYYY)
3Q 2023	01/11/2024
(Last quarter and year current Survey Vendor will collect data)	(One day after HCAHPS data submission deadline Review and Correct Period)

The *Discharge Quarter and Year* CANNOT overlap between current and new survey vendors.

The *Data Submission Dates* CAN overlap between current and new survey vendors.

Step 2 – Authorize "New" HCAHPS Survey Vendor

Discharge Start Quarter and Year	Data Submission Start Date (MM/DD/YYYY)
4Q 2023	10/01/2023
Discharge End Quarter and Year	Data Submission End Date (MM/DD/YYYY)
(Strongly recommend that these fields remain blank until survey authorization is terminated)	
(Last quarter and year current Survey Vendor will collect data)	(One day after HCAHPS data submission deadline Review and Correct Period)

Submission Option 1

- XML File Upload
  - XML File Format – conversion commercial software
  - Files must meet proper version specifications
    - Version 4.6: 3Q23 patient discharges and forward

HCAHPS Data Upload – XML *(cont'd)*

- Log-in to the HQR system with an active HARP account and have appropriate HCAHPS File Upload permission

- Verify status of files – HCAHPS Warehouse Submission Reports

- Files **<u>must</u>** be successfully accepted to the HCAHPS Data Warehouse before the HCAHPS Data Submission Deadline

Submission Option 2

- HCAHPS Data Form Submission
  - An option for small self-administering hospitals who are not able to use XML File Upload
  - Not to be used by survey vendors

- Steps:
  - Log in to the HQR System
  - Click "Data Submissions" in the menu
  - Choose the "HCAHPS" tab and click on "Data Form"
  - Enter data one survey at a time and combine into one month's worth of survey data for one hospital

HCAHPS Data Submission Reports

1. Data Submission Detail Report
   - Includes the upload date and status of files (accepted or rejected) under a given Batch ID, and lists Patient IDs and any error codes with messages

2. Submission Summary Report
   - Includes the Provider ID and the number of files that were accepted or rejected under a given Batch ID

HCAHPS Data
Submission Reports *(cont'd)*

3. HCAHPS Submission Results Report *(formerly the Review and Correction Report)*

    - Contains the frequency of valid values submitted for a hospital for each month in the submission quarter. Hospitals/Survey vendors are strongly encouraged to review this report for possible data errors. If errors are identified in the HCAHPS data that have been submitted, hospitals/survey vendors have the opportunity to upload corrected files, excluding certain Header Record information, during the Review and Correct Period (one week following the data submission deadline).

Introduction to HCAHPS Survey Training

HCAHPS Warehouse Feedback Reports

1. Provider Survey Status Summary Report
   - Includes the number of surveys submitted for a provider for a discharge month. This report lists the accepted Administrative Data Records and the accepted Survey Results Records This summary report displays results submitted via either the HCAHPS Online Data Form or XML format.
2. Submission Detail Report
   - Includes the upload date and status of files (accepted or rejected) under a given Batch ID, and lists Patient IDs and any error codes with messages
3. HCAHPS Submission Results Report (formerly Review and Correction Report)
   - Contains the frequency of valid values submitted for a hospital for each month in the submission quarter. Hospitals/Survey vendors are strongly encouraged to review this report for possible data errors. If errors are identified in the HCAHPS data that had been submitted, hospitals/survey vendors have the opportunity to upload corrected files, excluding certain Header Record information, during the Review and Correct Period (one week following the data submission deadline).

Summary

- HQR registration required to participate

- Two types of HQR users

- HCAHPS-specific roles

- Two options to submit HCAHPS data

- Submitter has access to HCAHPS Warehouse Submission Reports to check status of uploaded files

- Hospital should review HCAHPS Warehouse Feedback Reports – ultimate responsibility

QualityNet Help Desk

Phone: 866-288-8912

Fax: 888-329-7377

E-mail: qnetsupport@cms.hhs.gov

Availability: 8 AM – 8 PM ET, Mon – Fri

Note: When opening a QualityNet Help Desk Incident Ticket for HCAHPS data-related issues, please forward the email correspondence with the Incident Ticket Number to the HCAHPS Technical Assistance email (hcahps@hsag.com) for tracking purposes

Data Quality Checks

Introduction to HCAHPS Survey Training

Goals

- Ensure integrity of HCAHPS data
  - Data collection
  - Minimize errors in data handling
  - Identify and explain unusual changes in data
  - Submission of complete and accurate final data files

Suggested Quality Checks

- Traceable Data Trail

- Review of Data Files

- Accuracy of Data Processing Activities

Traceable Data Trail

- **Must** save both original and processed versions of HCAHPS data files

  – Allows for easier backtracking when possible errors are found

- Version control for data files, reports, and software code

- Do not delete old data files

  – Keep for a minimum of three years

- All data files must be traceable throughout the entire HCAHPS Survey administration process, from receipt of the patient discharge list through data submission

Traceable Data Trail *(cont'd)*

- Track data file receipts with summary tables:

Received	CCN	Discharge Month	Patient Records	Comments/*Action*
2-11-2023	A	1	30	First receipt
2-14-2023	A	1	27	Updated file (why 3 fewer patients?) *Investigate.*
2-14-2023	B	1	110	Substantial change in # of records from previous month. *Investigate.*
2-15-2023	C	1	72	Count of patients as expected

Review of Data Files

- Unusual or unexpected changes in HCAHPS data elements
  - Verify that data is associated with the correct hospital CCN
  - Trending data for a hospital over time
    - Examine hospital-level counts (e.g., eligible counts), patient administrative records and survey responses

Review of Data Files *(cont'd)*

- ## Sampling protocol example:

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Total Inpatient Discharges	418	438	456	441	428	**150**
Ineligible Patients	40	51	61	50	44	**5**
Exclusions	34	25	27	31	38	**3**
De-Duplicated Patients	4	2	3	5	6	**0**
HCAHPS Sample Frame	340	360	365	355	340	**142**
Sampled Patients	255	270	274	266	255	**107**

- – Look for inconsistent patient counts and investigate substantial variation

Review of Data Files *(cont'd)*

- Patient administrative data example:

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Sample Size	247	284	265	254	291	257
Maternity	8%	11%	9%	12%	**31%**	**30%**
Medical	74%	71%	72%	70%	53%	43%
Surgical	18%	19%	17%	18%	15%	4%
Missing	1%	<1%	2%	<1%	1%	**23%**

- Notice a large increase in Maternity % for February 2023 and March 2023
- Why was Service Line coded as Missing for 23% of sampled patients in March 2023?

Review of Data Files *(cont'd)*

- Survey example: Question 1 – Nurse Courtesy and Respect

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Completed Surveys	140	134	157	127	132	139
Q1 = Never	2%	1%	2%	1%	2%	1%
Q1 = Sometimes	3%	4%	3%	2%	4%	2%
Q1 = Usually	13%	12%	14%	11%	13%	9%
Q1 = Always	81%	82%	80%	82%	81%	70%
Q1 Missing	0%	1%	0%	1%	0%	**18%**

– Note that Missing rate is high for March 2023

Accuracy of Data Processing Activities

- Ensure data processing was conducted in accordance with required HCAHPS protocols
  - Basic quality checks related to sampling
  - Evaluate frequency of break-off surveys and/or unanswered questions
  - Verification that errors did not occur during data submission process
    - HCAHPS Data Submission Reports
      - Data Submission Detail Report, Submission Summary Report and HCAHPS Submission Results Report (formerly the Review and Correction Report)

Accuracy of Data Processing Activities *(cont'd)*

- Sampling quality checks
  - Verify that each eligible discharge has a chance of being sampled
    - For SRS and PSRS, each eligible discharge should have the same probability of being sampled
    - For DSRS, eligible discharges may have unequal probabilities of being sampled
      - Verify that each stratum contains at least 10 sampled patients per month

Accuracy of Data Processing Activities *(cont'd)*

- ## Monitor Response Rates every month

  Response Rate = Completed Surveys/(Sample Size – Ineligible Patients*)

  *Determined Ineligible after sampling

	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Sample Size	247	284	265	254	291	**68**
Ineligible Patients (post-sampling)	0	2	1	3	2	0
Completed Surveys	75	78	71	73	85	**68**
Response Rate	30%	28%	27%	29%	29%	**100%**

- – Notice changes in Sample Size and Response Rate

Accuracy of Data Processing Activities *(cont'd)*

- HCAHPS Data Submission Reports
  - Summary and detail information about each data file submitted to the HCAHPS Warehouse

- HCAHPS Warehouse Feedback Reports
  - For hospitals to check the status of data being submitted on their behalf

Accuracy of Data Processing Activities *(cont'd)*

- HCAHPS Data Submission Results **Report**

  – Hospitals/survey vendors are <u>strongly urged to access and review</u> the HCAHPS Data Submission Results Report <u>every time</u> file is uploaded

  – Report shows eligible discharges, sample size and frequencies for all HCAHPS data elements

  – Available after every data upload

- HCAHPS Review and Correct **Period**

  – Review and Correct is the seven days immediately after the data submission deadline for a given quarter

  – If errors are identified <u>in the HCAHPS data in the warehouse</u> after the data submission deadline:

    - Hospitals/survey vendors have the opportunity to upload corrected files, excluding certain Header Record information, during the Review and Correct Period

Accuracy of Data Processing Activities *(cont'd)*

- HCAHPS Data Submission Results Report

HCAHPS Data Review and Correction Report
Submitter: 888888
Provider: 999999
Discharge Quarter: mm/dd/yyyy – mm/dd/yyyy

Survey Record Data

Q1 <nurse-courtesy-respect>	Valid Value	Frequency	%
Never	1	3	2.27%
Sometimes	2	5	3.79%
Usually	3	17	12.88%
Always	4	107	81.06%
Missing/Don't Know	M	0	0.00%
Total		**132**	**100.00%**

Summary of Data Quality Checks

- Traceable Data Trail
  - Detailed data file receipts
  - Data file storage and retention

- Review of Data Files
  - Unusual/Unexpected changes in HCAHPS data elements (use of trending)

- Accuracy of Data Processing Activities
  - Sampling protocols
  - HCAHPS reports

Data Adjustment and Public Reporting

Overview

- Care Compare on Medicare.gov and Measures Reported
- Data Adjustment
  - Adjust for Patient Mix
  - Adjust for Survey Mode
- Reporting HCAHPS Results
  - Hospitals with Five or Fewer HCAHPS Eligible Patients
  - Public Reporting Footnotes
- Forms for Public Reporting
- Suppression of Results

HCAHPS Results Updated Quarterly

- Composite measures publicly reported
  - Communication with Nurses (Q1, Q2, Q3)
  - Communication with Doctors (Q5, Q6, Q7)
  - Responsiveness of Hospital Staff (Q4, Q11)
  - Communication About Medicines (Q13, Q14)
  - Discharge Information (Q16, Q17)
  - Care Transition (Q20, Q21, Q22)

- Individual items publicly reported
  - Cleanliness of Hospital Environment (Q8)
  - Quietness of Hospital Environment (Q9)

- Global ratings publicly reported
  - Hospital Rating (Q18)
  - Recommend the Hospital (Q19)

Data Adjustment

- Purpose
  - Differences in hospital ratings should reflect differences in quality <u>only</u>
  - To permit valid comparison of all hospitals regardless of the mode
- Will adjust the results to "level the playing field"
  - That is, adjust for factors not directly related to hospital performance
- Adjusted as needed for data comparability:
  - Patient mix
  - Mode of administration

Adjust for Patient Mix

- Purpose
  - Certain patient characteristics impact how someone might respond to the survey

- Patient-Mix Adjuster Variables
  - Type of **Service** (Medical, Surgical and Maternity Care)
    - Gender
  - **Age**
  - **Education**
  - Self-reported **general health status**
  - **Language Spoken at Home** – English, Spanish, Chinese, Russian, Vietnamese, Portuguese, German, Tagalog, Arabic, Other
  - **Response Percentile** (All completed surveys for a given month and hospital are ranked by Lag Time)

- Adjustments updated quarterly and published on HCAHPS Web site (https://www.hcahpsonline.org)

Mode Experiments

- The 2006 HCAHPS Mode Experiment tested mode effects
  - Summary document of Mode Experiment results is available on HCAHPS Web site (https://www.hcahpsonline.org)
- The 2008 HCAHPS Mode Experiment tested a candidate internet survey administration mode
- The 2012 HCAHPS Mode Experiment tested new Care Transition survey items
- The 2016 HCAHPS Mode Experiment reassessed the effects of survey mode on response propensity and response patterns
- The 2021 HCAHPS Mode Experiment was conducted to evaluate existing and new candidate survey items, revised survey protocols, possible new candidate survey modes, and to update and develop mode adjustments for existing and candidate survey items

Adjust for Survey Mode

- Purpose
  - Patient responses are affected by mode of survey administration
  - Choice of mode affects cross-hospital comparisons
- Survey modes
  - Mail Only
  - Telephone Only
  - Mixed Mode (Mail with Telephone follow-up)
  - Active Interactive Voice Response (IVR)

Reporting HCAHPS Results

- Official HCAHPS Scores are publicly reported on Care Compare on Medicare.gov (https://www.medicare.gov/care-compare/)
  - Also available in the Provider Data Catalog: https://data.cms.gov/provider-data/dataset/dgck-syfz
- Results are reported for the six composites, two individual items and two global items
- Number of completed surveys and response rate also reported
- HCAHPS results include:
  - Top-box, middle-box, bottom-box
  - HCAHPS Star Ratings
    - 10 HCAHPS measures
    - HCAHPS Summary Star Rating
    - Linear mean scores

Reporting HCAHPS Results *(cont'd)*

- Results aggregated into rolling four quarters (12 months) by hospital

- Hospital's results are displayed with national and state averages

- Results are updated quarterly

Public Reporting Periods

- Reporting is based on 12 months of discharges
- Public Reporting occurs in April, July, October, and January

HCAHPS PUBLIC REPORTING: April 2023

- QUARTERS INCLUDED: 3Q21, 4Q21, 1Q22, 2Q22
- PREVIEW PERIOD: January 26 – February 24, 2023
- PUBLIC REPORTING: April 2023

Public Health Emergency (PHE) Adaptations

- CMS recognized that the continuing COVID-19 public health emergency affected survey operations

- Approved survey vendors are permitted to conduct survey operations from a remote location (other than their place of business)

  - Complete and submit an Exception Request Form online via the HCAHPS Web site (www.hcahpsonline.org)

- Survey vendors and self-administering hospitals should take necessary steps to protect staff's personal health and safety

Hospital Inpatient Accommodations

- In response to the COVID-19 PHE, state and local governments, hospitals, and others developed alternate care sites (ACS) to expand capacity and provide needed care to patients

  – Emergency 1135 Waivers & Health System Flexibility

    - Under its Hospitals Without Walls initiative, CMS waived several Medicare conditions of participation at 42 CFR Part 482 and provider-based rules at 42 CFR §413.65 on a national basis. These so-called "blanket" waivers give hospitals flexibilities to respond to the COVID-19 PHE and to furnish care in ACSs, including retrofitted locations (e.g., tents, gymnasiums, and even the patient's home).

    - Available at https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

Hospital Inpatient Accommodations *(cont'd)*

– NUBC created a new Point of Origin Code G: "Transfer from a Designated Disaster Alternate Care Site (ACS)"

- For more information about these changes in coding point of admission, please see the MLN Matters document at https://www.cms.gov/files/document/MM11836.pdf

- To learn more about ACS, visit the CMS Web site at https://www.cms.gov/files/document/covid-state-local-government-fact-sheet-hospital-alternate-care-sites.pdf

Introduction to HCAHPS Survey Training

Care Compare on Medicare.gov

Introduction to HCAHPS Survey Training

Care Compare Profile

Care Compare Profile *(cont'd)*

Hospitals with Five or Fewer HCAHPS Eligible Patients in a Given Month

- Hospitals are not required to collect and submit HCAHPS data for that month

  – A header record must be submitted to the HQR system through the HCAHPS Data Form (formerly the Online Data Entry Tool) or XML file submission

- These hospitals can voluntarily collect and submit data for these months

Public Reporting Footnotes

- Footnote 1
  - *The number of cases/patients is too few to report*
    - Since December 2016, Hospital Compare no longer displays HCAHPS scores for hospitals with fewer than 25 completed HCAHPS Surveys
      - In their stead, "N/A" and Footnote 1 appears
      - However, these hospitals continue to see their HCAHPS scores on their Hospital Compare Preview Reports

- Footnote 3
  - *Results are based on a shorter time period than required*
- Footnote 5
  - *Results are not available for this reporting period*

Public Reporting Footnotes *(cont'd)*

- Footnote 6
  - *Fewer than 100 patients completed the HCAHPS Survey. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.*

- Footnote 10
  - *Very few patients were eligible for the HCAHPS Survey. The scores shown reflect fewer than 50 completed surveys. Use these scores with caution, as the number of surveys may be too low to reliably assess hospital performance.*

Public Reporting Footnotes *(cont'd)*

- Footnote 11
  - *There were discrepancies in the data collection process*
    - Footnote 11 is applied when there have been deviations from HCAHPS data collection protocols. CMS is working with survey vendors and/or hospitals to correct any discrepancies.

- Footnote 15
  - *The number of cases/patients is too few to report a star rating*

Forms for Public Reporting

- Hospitals must submit the appropriate pledge form (Notice of Participation) to have their data displayed on Care Compare on Medicare.gov (https://www.medicare.gov/care-compare/)

- Forms are accessible on the HQR system https://hqr.cms.gov/

Suppression of Results: IPPS Hospitals

- IPPS hospitals **cannot** suppress their results from Care Compare on Medicare.gov
  - Must withdraw from Hospital Inpatient Quality Reporting (IQR) program to suppress

Suppression of Results: CAHs

- CAHs **may** suppress their results
  - Must suppress complete set of HCAHPS results
    - Will receive Footnote 5
- To suppress results, a CAH must complete the appropriate pledge form and submit it to QualityNet Help Desk

Exception Request and Discrepancy Report

Purpose

- Exception Request
  - Request alternative methodologies
  - Approval, if granted, will be for up to 2 years, unless otherwise specified

- Discrepancy Report
  - Notification of variation from HCAHPS protocols during survey administration

Exception Request

- Exception Request must include sufficient detail for the HPT to assess the exception

  – Include how the proposed exception will maintain the integrity of data collection

  – Timely approval of an Exception Request is contingent upon hospital/survey vendor including complete documentation

- *Exceptions not allowed for alternative modes of survey administration*

Exception Request *(cont'd)*

- Complete and Submit Exception Request Form(s) online

    – Submit Exception Request Form(s) online through: https://www.hcahpsonline.org

    – Exception Request must be submitted and approved **prior** to implementing

    – **Exception Request must be submitted by survey vendors on behalf of their client hospitals**

    – Do not use symbols or special characters (^*@#&) of any kind in any field when submitting an Exception Request

    – Approved Exception Requests are for internal hospital/survey vendor use only and must not be used for promotional or marketing purposes

Exception Request *(cont'd)*

- Common Exception Requests
  - Disproportionate Stratified Random Sampling (DSRS)
    - The following information must be submitted for each hospital
      - Name of each stratum to be used in the DSRS sample
      - Estimated total number of inpatient discharges for each stratum
      - Estimated number of eligible patients for each stratum
      - Estimated number of sampled patients for each stratum
      - A plan for sampling a minimum of 10 eligible discharges in each stratum

Exception Request *(cont'd)*

- Common Exception Requests *(cont'd)*
  - Determination of HCAHPS Service Line
    - Hospitals/Survey vendors must submit an Exception Request Form online for approval to use other means
    - Based on a Single Service Line (e.g., Medical, Surgical, Maternity). The following information must be submitted for each hospital:
      - Current electronic or written confirmation from the hospital that they are unable to provide MS-DRG codes or other preferred means of establishing the HCAHPS Service Line Category
      - Current electronic or written confirmation from the hospital delineating which patient populations are served (Medical, Surgical or Maternity)

Exception Request *(cont'd)*

- Common Exception Requests *(cont'd)*
  - Participating in Another CMS or CMS-Sponsored Initiative
    - If a hospital accepts an offer to participate in another CMS or CMS-sponsored project that includes an inpatient survey which may contravene HCAHPS protocols, the hospital/survey vendor should complete and submit an Exception Request to alert and inform the HCAHPS Project Team of participation

Exception Request *(cont'd)*

- Common Exception Requests *(cont'd)*
  - Survey Materials
    - An Exception Request must be filed for the use of survey materials that do not align with the examples provided in the HCAHPS *Quality Assurance Guidelines* V18.0 manual

Exception Request *(cont'd)*

- Common Exception Requests *(cont'd)*
  - Conducting Survey Operations from Remote Location
    - An Exception Request must be filed to request approval to conduct survey operations from a remote location (other than hospital's/survey vendor's place of business)
      - Hospitals/Survey vendors who were approved for remote operations during the public health emergency must submit a new Exception Request for approval to continue to conduct remote operations when the public health emergency ends

Exception Request *(cont'd)*

- Common Exception Requests *(cont'd)*
  - Other
    - Hospitals/Survey vendors must request an exception for alternative strategies not identified in the HCAHPS *Quality Assurance Guidelines*

Exception Request *(cont'd)*

- Approved Exception Requests will be limited to a two-year timeframe unless otherwise specified

- Approval of a renewal Exception Request will align with the beginning of a quarter and expire at the end of a quarter

- Survey administration activities of an approved Exception Request may only be implemented at the beginning of a quarter

Exception Request *(cont'd)*

I. Exception request
Please complete items 1 and 2 for each requested exception.

Unique Report ID	Submission Date
53496	01/14/2022

1. Exception Request For (Check one in each box)

○ New Exception

○ Renewal Exception

○ Update of List of Applicable Hospitals

○ Appeal of Exception Denial

○ Disproportionate Stratified Random Sampling

○ Determination of Service Line

○ Participating in another CMS or CMS-Sponsored Initiative

○ Survey Materials

○ Other Exception (specify)

2. List of Hospitals Applicable to this Exception Request
This section is to be completed by survey vendors or hospitals administering the survey for multiple sites.

Do you currently have hospitals applicable to this exception request?
○ Yes
◉ No

Exception Request *(cont'd)*

II. General Information

1. Organization (Survey vendor or self-administering hospital)

1a. Organization Name *

1b. Organization Type *
Choose One

1d. Mailing Address 1 *

1e. Mailing Address 2

1f. City *

1g. State *

1h. Zip Code *

1i. Telephone *

1j. Fax Number

1k. Website

2. Contact Person for this Exception Request (Confirmation email will be sent to the Contact Person)

2a. First Name *

2b. Middle Initial

2c. Last Name *

2d. Title *

2e. Degree (e.g. RN, MD, PhD)

2f. Mailing Address 1 *

2g. Mailing Address 2

2h. City *

2i. State *

2j. Zip Code *

2k. Telephone *

2l. Fax Number

2m. Email Address *

Exception Request *(cont'd)*

3. Description of Exception Request

3a. Purpose of Proposed Exception Requested (e.g. sampling, other) *

4000 characters remaining

3b. Rationale for Proposed Exception Requested *

4000 characters remaining

3c. Explanation of Implementation of Proposed Exception Requested *

4000 characters remaining

3d. Evidence that Exception Will Not Affect Results *

4000 characters remaining

Upon submission, a confirmation email will be sent to the email address listed in the Contact Person section. If a confirmation email is not received, please contact HCAHPS Technical Assistance at hcahps@hsag.com to verify submission was successful.

Please print this form for your records prior to submission. To print the Exception Request Form, click here.

Exception Request *(cont'd)*

- Appeals process for unapproved exception
  - Written notification with explanation provided by HCAHPS Project Team
  - Hospital/Survey vendor has five business days to appeal an unapproved exception
  - Use Exception Request Form

Discrepancy Report

- Notification of deviations from HCAHPS data collection protocols
  - Examples: missing eligible discharges from a particular date or computer programming issues that caused an otherwise eligible discharge to be excluded from the sample frame

- **Discrepancy Reports must be submitted by survey vendors on behalf of their client hospitals**
  - It is **strongly recommended** that survey vendors notify their client hospital prior to or upon the submission of a Discrepancy Report

- Do not use symbols or special characters (^*@#&) of any kind in any field when submitting the Discrepancy Report Form

Discrepancy Report *(cont'd)*

- Complete and submit report immediately upon discovery of issue(s)
  - Provide sufficient detail
    - Hospital name and CCN
    - How issue was discovered
    - Average monthly eligible count
    - Number of eligible discharges affected
    - Average monthly sample size
    - Number of sampled patients affected
    - Corrective action plan
    - Specific time period affected
    - Other details and information, including initial and follow up Discrepancy Report numbers

Discrepancy Report *(cont'd)*

Indicate whether this report is an Initial Discrepancy Report or an Updated Discrepancy Report.

🔘 **Initial Discrepancy Report** * (Must be submitted within 24 hours after the discrepancy has been discovered.)

⚪ **Updated Discrepancy Report** * (If needed, must be submitted within two weeks of initial Discrepancy Report.)

Section 1 is to be completed by the organization submitting this form. The requested information regarding the affected hospitals <u>must</u> be provided in Section 4 in order to complete the HCAHPS Discrepancy Report. THIS FORM MUST BE SUBMITTED ONLINE (**www.hcahpsonline.org**). All required fields are indicated with an asterisk (*).

1. General Information

Unique Report ID

119032

Submission Date

01/13/2023

1a. Name of Organization submitting the Discrepancy Report *

1b. Type of Organization *

Choose One ⌄

Discrepancy Report *(cont'd)*

2. Contact Person for this Discrepancy Report (Confirmation email will be sent to the Contact Person.)

2a. First Name *

2b. Last Name *

2c. Mailing Address 1 *

2d. Mailing Address 2

2e. City *

2f. State *

2g. Zip Code *

2h. Telephone *

Extension

2i. Fax Number

2j. Email *

Introduction to HCAHPS Survey Training

Discrepancy Report *(cont'd)*

3. Information about the Discrepancy

3a. Description of the discrepancy *

[text box]

2000 characters remaining

3b. Description of how the discrepancy was identified *

[text box]

2000 characters remaining

3c. Description of the Corrective Action to fix the discrepancy, including estimated time for implementation *

[text box]

2000 characters remaining

3d. Additional information that would be helpful that has not been included above *

[text box]

2000 characters remaining

Discrepancy Report *(cont'd)*

4. List of Hospitals Applicable to this Discrepancy

4a. Total number of Affected Hospitals *

> 0

4b. Add the information for the affected hospitals by populating the following 10 fields. A hospital may be added more than once if there are multiple time frames for the hospital. It is important that the affects of the Discrepancy Report are quantified, however "unknown" will be accepted as a valid response.

Name of Hospital *

CCN *

Hospital Contact Name *

Email Address for the Hospital Contact *

Number of Eligible Discharges Affected *

Average number of Eligible Discharges per month *

Count of Sampled Patients affected *

Average number of surveys administered per month (sampled patients) *

Time frame affected: Begin Date *

Time frame affected: End Date *

Add

Name Of Hospital ⌄	CCN ⌄	Hospital Contact Person ⌄	Email Address ⌄	Number Of Eligible Discharges Affected ⌄	Avg. Number Of Eligible Discharges/Month ⌄	Count Of Sampled Patients Affected ⌄	Avg. Number Of Surveys Admin/Month ⌄	Time Frame Affected: Begin Date ⌄	Time Frame Affected: End Date ⌄

Discrepancy Report *(cont'd)*

- Review Process

  – The Discrepancy Report(s) will be thoroughly reviewed by the HCAHPS Project Team, therefore there may be a delay before results of review are communicated

  – Review(s) may result in assignment of footnotes to publicly reported results

  – Additional information may be requested

  – Notification of review outcome

Oversight Activities

Overview

- Purpose of Oversight

- Description of Oversight Activities

- Quality Assurance Plan (QAP) Requirements

- On-Site Visits and Conference Calls

- Oversight and Compliance

Purpose of Oversight

- To ensure **compliance** with HCAHPS protocols
- To ensure that all data collected and submitted are complete, valid and timely
- To ensure standardization and transparency of publicly reported results
- *Increasing scrutiny with Hospital VBP*

Description of Oversight Activities

- The HCAHPS Project Team (HPT):

  – Reviews Quality Assurance Plans

  – Reviews survey materials

  – Analyzes submitted data

  – Conducts on-site visits and conference calls

Quality Assurance Plan (QAP)

- Documents understanding, application and compliance with HCAHPS protocols

- Serves as an organization-specific guide for administering and training project staff to conduct the HCAHPS Survey

  – Describes role of subcontractors, if any

- Must reflect *actual* survey processes and practices

- Provides a guide for the HPT on-site visit or call

- Ensures high quality data collection and continuity in survey processes

Quality Assurance Plan *(cont'd)*

- New QAP submitted *after participation approval* by CMS, and upon request thereafter, as a self-administering hospital, hospital administering multiple sites or survey vendor

- QAP must be **updated annually** *and* when changes in key events or key project staff occur

- HPT "*accepts*" the QAP
  - Acceptance does not imply approval of data collection processes

- For more information, see *QAG V18.0* Appendix U for the QAP Outline

On-site Visits/Conference Calls

- Purpose: To ensure compliance with HCAHPS Survey protocols
  - Visits and calls are scheduled by the HPT
- Site visits will be conducted at formal business locations

  FY 2014 IPPS Final Rule codified that:

  "Approved HCAHPS Survey vendors and self-administering hospitals must fully comply with all HCAHPS oversight activities, including allowing CMS and its HCAHPS Project Team to perform site visits at the hospitals' and survey vendors' company locations."

On-site Visits/Conference Calls *(cont'd)*

- HPT reviews survey systems, resources and facilities
- Discussions with project staff, *including subcontractors*
  - HCAHPS Project Manager/Director must be physically present during the site visit

- All materials related to survey administration are subject to review

  - Including survey forms, letters, outgoing/return envelopes, scripts, screen shots, monitoring procedures and practices, etc.

- HPT also reviews reports that survey vendors produce for client hospitals

On-site Visits/Conference Calls *(cont'd)*

- **Feedback Report** will include the HPT's observations on topics including:
  - Survey administration
  - Data preparation, specifications, coding and submission
  - Data quality checks
  - Staff training
  - Action items for follow-up
- Documentation of any corrections is required
- Follow-up review may occur

Analysis of Submitted Data

- Each quarter, the HPT carefully examines all data submitted to HCAHPS warehouse

  – Outliers, anomalies, trends, unusual patterns, etc.

- High rates of missingness

- Unusually high/low response rates

- High rates of "break-offs"

- Contact hospitals/survey vendors regarding submitted data and HCAHPS scores, as necessary

HCAHPS Oversight

- If a hospital *(or its survey vendor)* fails to adhere to HCAHPS protocols, it must develop and implement corrective actions
  - *Footnotes may be added to publicly reported HCAHPS scores, as appropriate*
- If problems persist, **the hospital** may not qualify as meeting the Annual Payment Update (APU) requirements for HCAHPS
  - *The hospital's APU may be jeopardized*
  - *Possible consequences for Hospital VBP*
- Survey vendors that are non-compliant with HCAHPS protocols may lose their approval status

HCAHPS Oversight *(cont'd)*

- HCAHPS and **Hospital VBP** Program
  - With pay-for-performance (Hospital VBP), increased scrutiny and greater emphasis on compliance for:
    - All participating hospitals
    - Multi-site hospitals
    - Survey vendors

HCAHPS Oversight *(cont'd)*

- **A participating hospital should:**
  - Work closely with its survey vendor (if using one)
  - Monitor HCAHPS Warehouse Feedback Reports
    - Including Review and Correct Period
  - Read the HCAHPS QAG
  - Visit the HCAHPS Web site for news, updates and announcements
  - Comply with all HCAHPS oversight activities

Next Steps

- Hospitals/Survey vendors:
  - Complete training requirements as outlined in the Training Instructions
    - Submit HCAHPS Confirmation of Training Completion Form
  - Submit Program Participation Form
    - March 3, 2023 through March 24, 2023
  - If approved:
    - Submit QAP and survey materials
    - Register for Hospital Quality Reporting (HQR) system
    - Begin data collection
    - Monitor HCAHPS data submission reports
    - Participate in future HCAHPS Update Training
    - Monitor HCAHPS Web site https://www.hcahpsonline.org
    - Contact us

More Information and Resources

- Registration, applications, background information, reports, and other information can be found on the official HCAHPS Survey Web site:

    https://www.hcahpsonline.org

- Submitting HCAHPS data:

    https://hqr.cms.gov/

- Publicly reported HCAHPS results on Care Compare on Medicare.gov:
    https://www.medicare.gov/care-compare/

- HCAHPS results in the Provider Data Catalog:

    https://data.cms.gov/provider-data/dataset/dgck-syfz

- HCAHPS in Hospital Value-Based Purchasing:

    https://qualitynet.cms.gov/inpatient/hvbp

Contact Us

HCAHPS Information and Technical Support

- Web site: https://www.hcahpsonline.org
- Email: hcahps@hsag.com
- Telephone: 1-888-884-4007