Introduction to HCAHPS Survey Training

March 2018

Welcome!

HCAHPS Training Objectives:

- Explain purpose and use of 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

Quality Assurance Guidelines

- This presentation is based on the HCAHPS *Quality Assurance Guidelines (QAG) V13.0*
- Survey vendors and hospitals are responsible for reviewing and familiarizing themselves with all of the content in the QAG

Background of the HCAHPS Survey

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Overview

- Background and Development of HCAHPS

- Composition of the Survey

- Roles and Responsibilities

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 and Critical Access Hospitals
      - IPPS hospitals penalized if don't participate
      - PPS-Exempt Cancer Hospitals can voluntarily participate
    - Excludes pediatric, psychiatric and specialty hospitals

How the Survey is Administered

Participating hospitals, second quarter 2017 (4,417):

- Mail: 2,658 hospitals; 60%
- Telephone: 1,747 hospitals; 40%
- Mixed Mode: 7 hospitals; 0.2%
- IVR: 5 hospitals; 0.2%

Who Administers the Survey

Second quarter 2017:

- 30 Approved survey vendors
  - 99.80% of surveys

- 41 Self-administering hospitals
  - .09% of surveys

- 1 Multi-site hospital
  - .09% of surveys

HCAHPS Never Rests

- April 2018 publicly reported scores are based on more than **3 million completed surveys** from patients at **4,364 hospitals**

- **Every day** more than 8,200 patients **complete** the HCAHPS Survey

Composition of HCAHPS Survey

HCAHPS contains **32 items**:

- **Items 1-25**: Core of HCAHPS (25 questions)
  - Beginning of survey; do not alter; keep together
    - *21 substantive questions*
    - *4 "screener" items*

- **Items 26-32**: "About You" (7 questions)
  - Place later; keep together; do not alter

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 timely manner

- Use survey versions in language of patients

- Review data warehouse reports

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

Roles and Responsibilities *(cont'd)*

<u>Hospitals Using a Survey Vendor</u>

- 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 QualityNet Secure Portal
  - Monitor submission reports
    - Including Review and Correction Reports
  - 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 the Hospital Compare Web site are the "official" scores**
  - **Scores derived from any other source are "unofficial" and must be labeled as such**

- 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**

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Advertising Guidelines

- The Hospital Compare Web site 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 the Hospital Compare Web site (http://www.medicare.gov/hospitalcompare)."
    - 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."
- CMS does not endorse hospitals or survey vendors
  - *Or commercial Hospital VBP tools, etc.*
- Hospital 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: The QualityNet Secure Portal Registration
  - Step 4: Data Collection
  - Step 5: Participate in Oversight Activities
  - Step 6: Public Reporting
  - Step 7: Future Update Training

- Minimum Requirements

HCAHPS Web site and Technical Support

http://www.hcahpsonline.org

- Official web site for content, announcements, *HCAHPS Bulletins*, updates, reminders

- Monitor weekly for "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

Introduction to HCAHPS Survey Training

HCAHPS Web site Home Page

HCAHPS Technical Support

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

Step 1: Introduction to HCAHPS Survey Training

- Who is required to participate?
  - Survey vendors
  - Hospitals conducting HCAHPS for multiple sites
  - Hospitals self-administering HCAHPS
  - Subcontractors and other organizations with responsibility for major survey administration functions
  - New project managers

- 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 http://www.hcahpsonline.org
  - Participation Forms available March 2, 2018 through March 23, 2018

- Who needs to submit a Participation Form?
  - Hospitals self-administering HCAHPS
  - Hospitals conducting HCAHPS for multiple sites
  - Survey vendors (administering on behalf of hospitals)
  - *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
  - 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 3: The QualityNet Secure Portal Registration

- Contact:
  - QualityNet Help Desk (hospitals)
  - HCAHPS Information and Technical Support (survey vendors)
- If already registered with QualityNet, register specifically for HCAHPS and obtain necessary roles
  - Contact QualityNet Help Desk for questions on how to complete the forms
    - qnetsupport@hcqis.org

Step 4: Data Collection

- Hospitals/Survey vendors will:
  - Adhere to the HCAHPS *QAG V13.0*
  - 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 HCAHPS data submission deadline

Step 5: Participate in Oversight Activities

- Submit 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 the Hospital Compare Web site (https://www.medicare.gov/hospitalcompare)

- The appropriate pledges 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 http://www.hcahpsonline.org
- Required for all approved survey vendors, hospitals conducting survey for multiple sites, self-administering hospitals, subcontractors and other organizations
- Recommended for hospitals using a survey vendor

Minimum Requirements

1. Relevant survey experience (also applies to subcontractor)

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

      • Survey experience
      • Number of years in business
      • Number of years conducting patient-specific surveys
      • Sampling experience

Minimum 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 Requirements *(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 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 or as needed)

Steps to Join HCAHPS in 2018

1. *Complete training requirements*
2. *Submit the HCAHPS Participation Form*
   - For self-administering hospitals, hospitals administering the survey for multiple sites, and survey vendors
   - Form available online, **March 2, 2018**
3. *If approved, collect and submit HCAHPS Survey data on a continuous basis*

Sampling Protocol

Overview

- Steps of Sampling Process
- Methods of Sampling
- Quality Control for Sampling
- Sampling Facts

Steps of Sampling Process

A. Population (All Patient Discharges)

B. Identify *Initially* Eligible Patients

C. Remove Exclusions

D. Perform De-Duplication

E. HCAHPS Sample Frame

F. Draw Sample

See *QAG V13.0*, **HCAHPS Sampling Protocol Illustration**

Step A: Population
(All Patient Discharges)
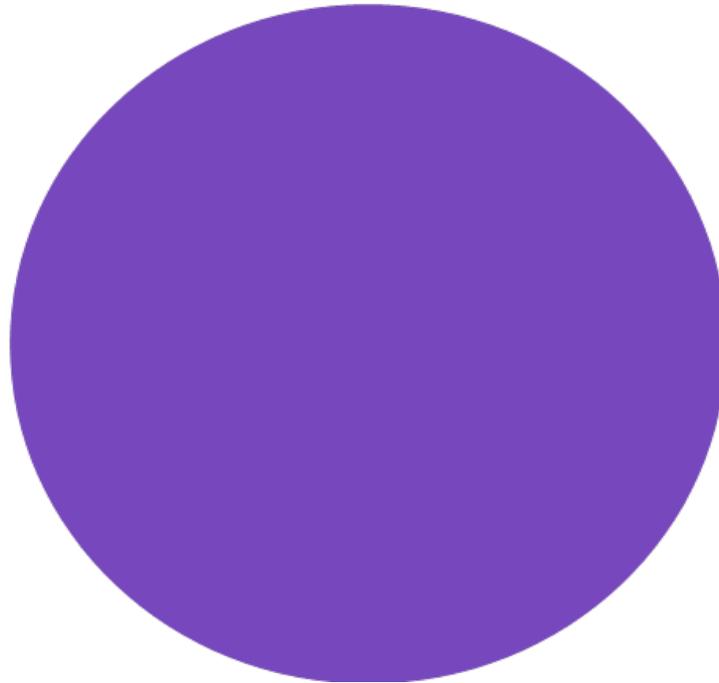
Step B: Identify *Initially* Eligible Patients

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**
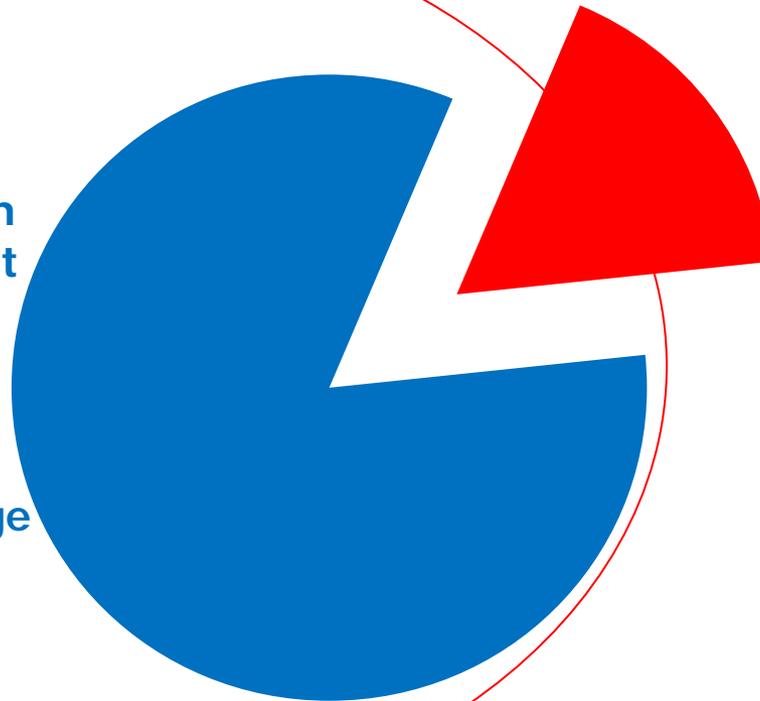
Ineligible Patients
- *Record count of ineligible patients*

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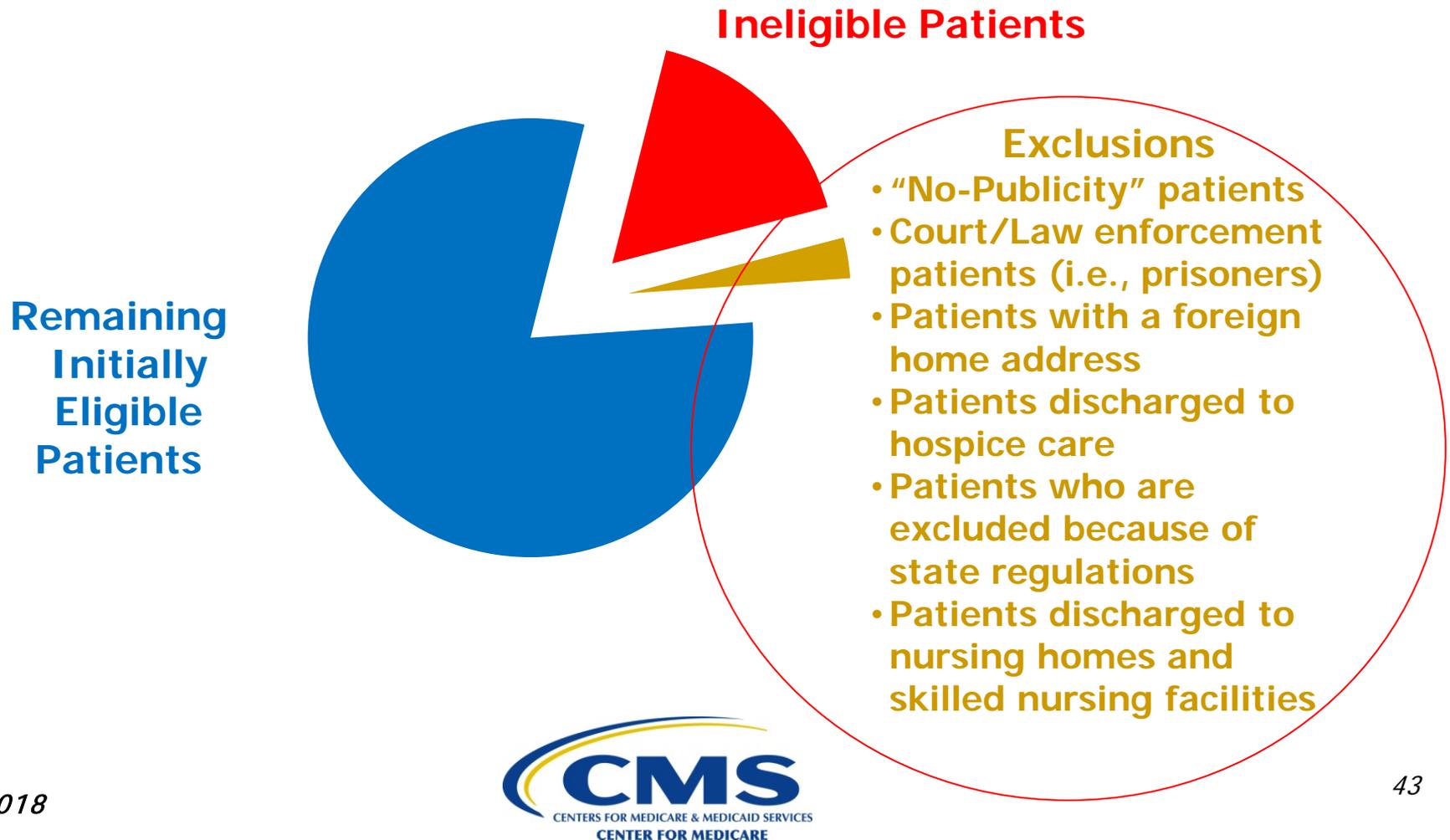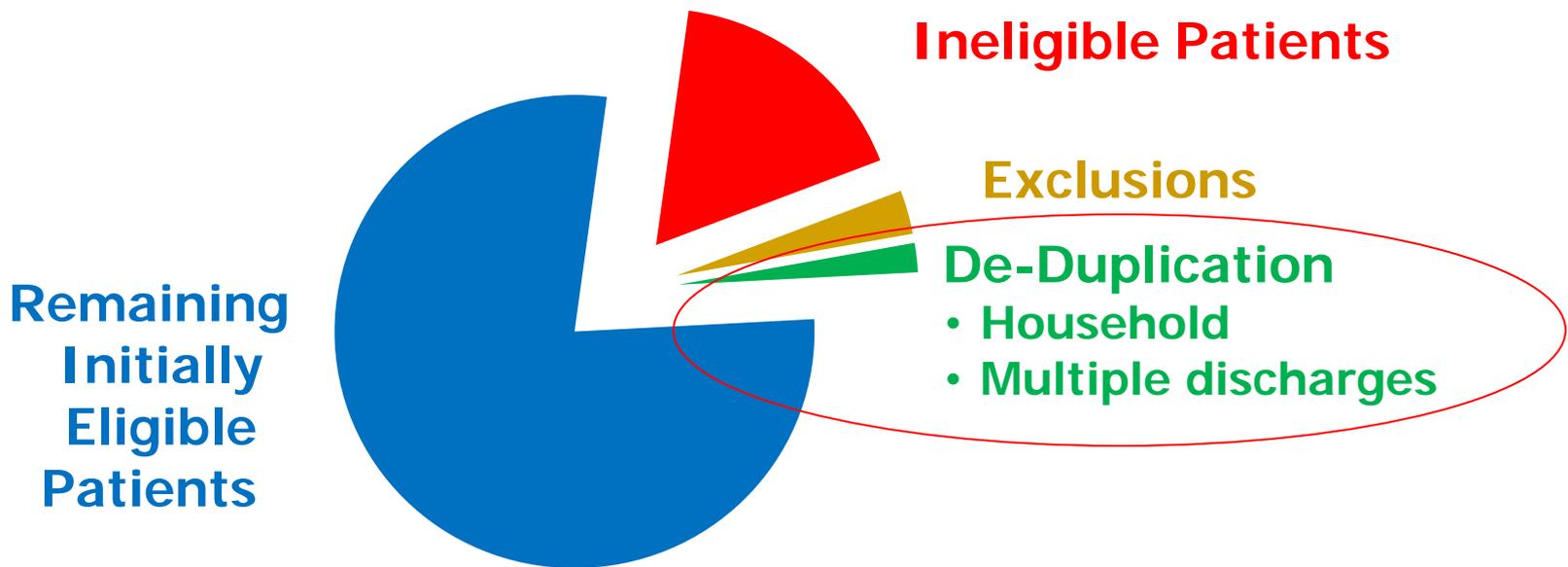
Note: De-duplication must be performed using the **sample frame, not the sample,** within each calendar month, utilizing address information (or telephone number for Telephone, Mixed and IVR modes) and the patient's medical record number (or other unique identifier)
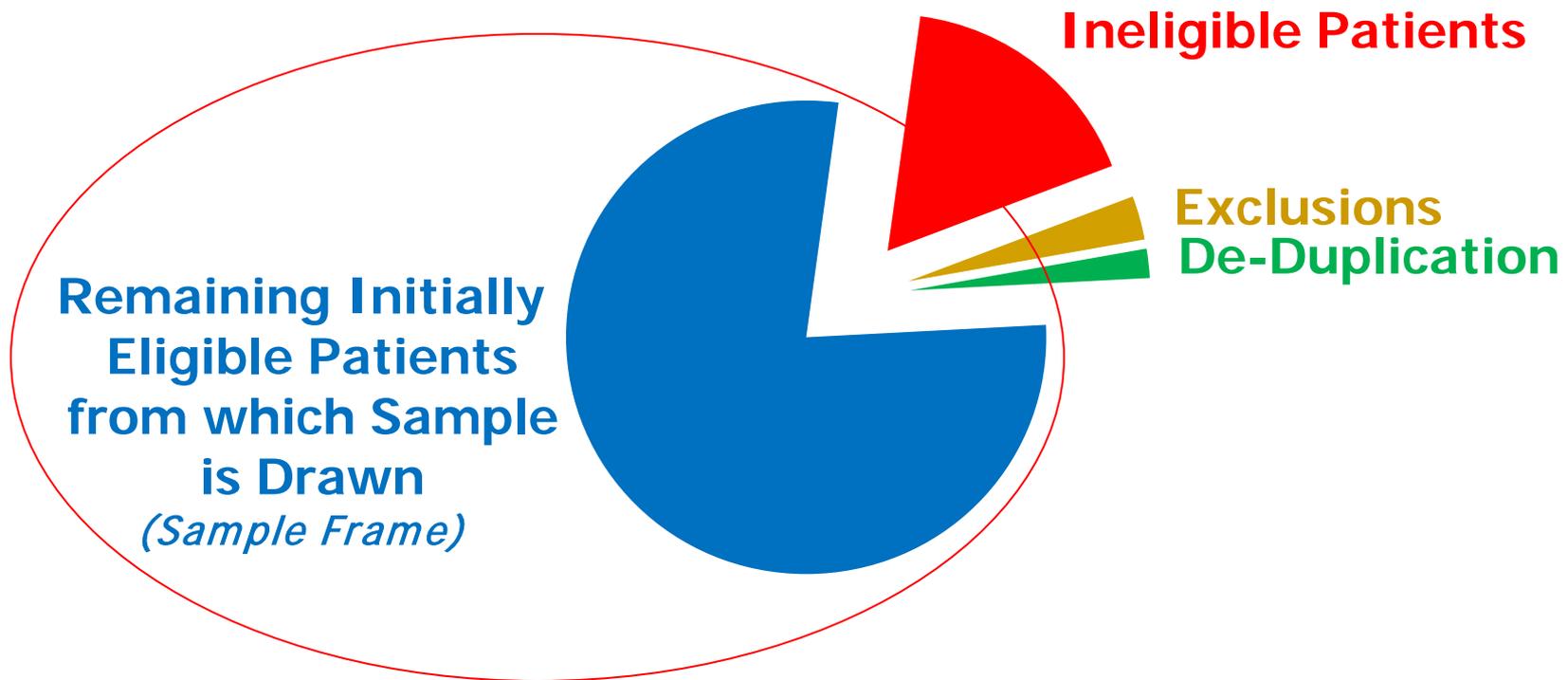
Step E: HCAHPS Sample Frame

Ineligible Patients

Exclusions

De-Duplication

Remaining Initially Eligible Patients from which Sample is Drawn
(Sample Frame)
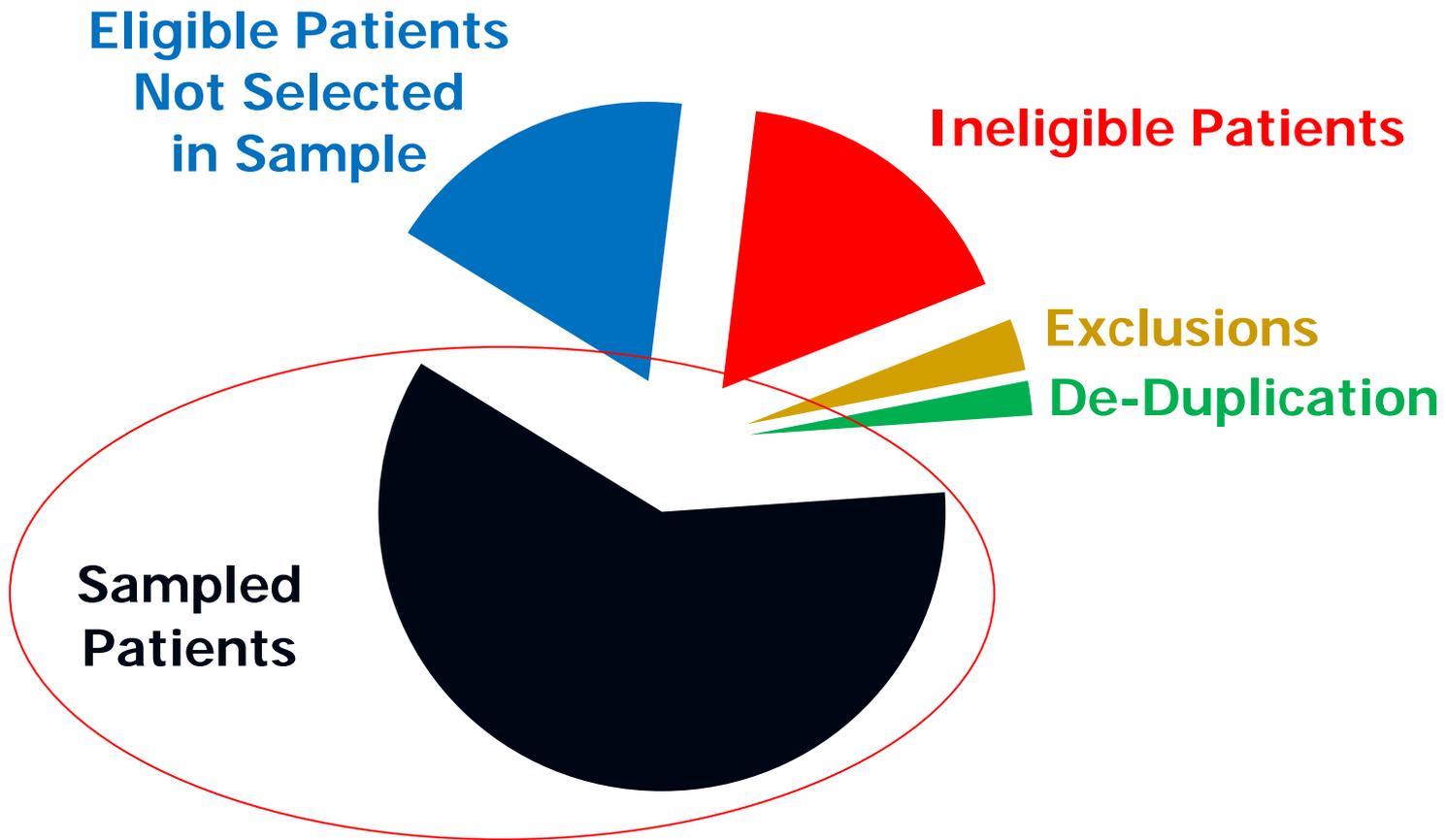
Step F: Draw Sample

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

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

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
- ~32% of eligible patients will respond to the survey
  - Source: Historical 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:

$$P = (1 - I) \times R$$
$$= (1 - 0.170) \times 0.320$$
$$= 0.266$$

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

Example: Sample Size Calculation

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

Per 12-month	**Per month**
$N_{12} = C/P$	$N_1 = N_{12}/12$
$\quad = 335/0.266$	$\quad = 1{,}259/12$
$\quad = 1{,}259$	$\quad = 105$

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 Hospital Compare Web site
  - 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

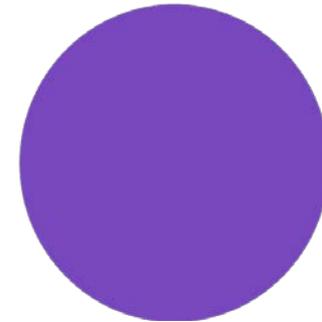| Stratum	Week	Eligible Discharges	Sampling Rate	Sampled Patients
1	1	100	0.10	100 * 0.10 = **10**
2	2	108	0.50	108 * 0.50 = **54**
3	3	102	0.50	102 * 0.50 = **51**
4	4	110	0.10	110 * 0.10 = **11**
5	5	30	0.50	30 * 0.50 = **15**

Population, Sample Frame and Sample

Hospital Population (All Patient Discharges) = 1 + 2 + 3 + 4 + 5

HCAHPS Sample Frame = 1 + 2

Sampled Patients = 1

Population (All Patient Discharges)

Sample Drawn

2
Eligible Patients Not Selected in Sample

3
Ineligible Patients

4
Exclusions

5
De-Duplication

1
Sampled Patients
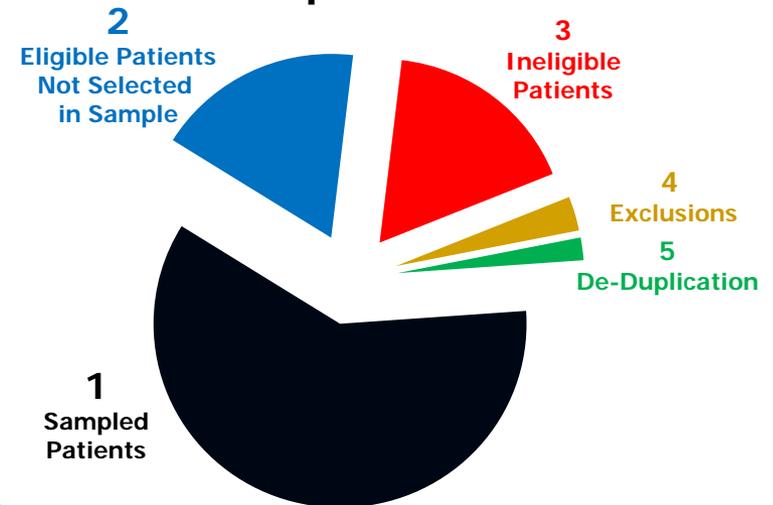
Quality Control for Sampling

- Receipt of patient discharge list
  - Within 42-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
- 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 V13.0)*
  - 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)*

- 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
  - 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 N, Section I *QAG V13.0,* 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
  - Restrict access to confidential data
  - 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

Survey Management *(cont'd)*

- Patient confidentiality and 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
  - 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

- HCAHPS Survey
  - 32 question survey
    - Questions 1-25 are Core questions
    - Questions 26-32 are "About You" questions
  - Mail questionnaire, translations and materials found in QAG Appendices A through F
  - Telephone and IVR scripts and translations found in QAG Appendices G through L

Communication with Patients about the HCAHPS Survey

- Cannot show the HCAHPS Survey or cover letter to patients prior to discharge from the hospital

- Cannot mail any pre-notification letters or postcards after discharge informing patients about the HCAHPS Survey

- See Section III *QAG V13.0*

Program Requirements

- **Guidelines for using other hospital inpatient surveys with HCAHPS**
  - HCAHPS should be the <u>first</u> survey patients receive about their hospital experience
  - Questions must not resemble any HCAHPS items or their response categories
  - Refer to HCAHPS Bulletin Number 2009-01 Revised which is posted on the HCAHPS Web site
  - **Section III *QAG V13.0* and Appendix Y**
    - Examples provided of not permissible and alternate questions

Supplemental Questions

- May add a reasonable number of supplemental questions to the HCAHPS Survey

  – Questions may be added after the set of Core items or may be added before or after the set of "About You" items

- Use appropriate phrasing to transition from the HCAHPS Survey to the supplemental items

  – Examples: *"The following questions focus on additional care you may have received from Hospital X." [OR]*

    "This next set of questions is to provide the hospital additional feedback about your hospital stay."

Supplemental Questions *(cont'd)*

- When asking patients to provide their name, telephone number or other contact information
  - There must be explanatory text identifying why the request to *optionally* provide the patient name, telephone number or other contact information is included on the survey
  - This 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 regarding your survey responses. 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)*

- No changes are permitted to the content or order of the HCAHPS questions or answer categories for the Core or "About You" questions

- The "About You" questions must remain as one block of questions, regardless of whether they follow the Core or supplemental questions

- Final data files are submitted to CMS via the QualityNet Secure Portal by the data submission deadline

Modes of Administration Overview *(cont'd)*

- Copyright language must be added to the HCAHPS Survey:

    – *"Questions 1-22 and 26-32 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 23-25) 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 QualityNet Secure Portal by the data submission deadline

Mail Only Mode *(cont'd)*

- Cover letter specifications
  - Name and address of sampled patient included
    - "To Whom It May Concern" is not acceptable salutation
  - OMB language included
  - Letter is not attached to the survey
  - Customization is acceptable; cannot add content that would introduce bias
  - Letter printed on hospital or survey vendor letterhead
  - Signed by hospital administrator or survey vendor project director
    - Electronic signature acceptable

Mail Only Mode *(cont'd)*

- Cover letter specifications *(cont'd)*
  - Language indicating the purpose of the unique patient identifier must be printed either on the cover letter or after the survey instructions on the questionnaire (or on both)
    - "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."
  - Hospital name and discharge date to make certain that the patient completes the survey based on the hospital stay associated with that particular discharge date
  - The term "discharged on" must be used in the cover letters

Mail Only Mode *(cont'd)*

- Cover letter language requirements
  - Purpose of survey
    - "Questions 1-25 in the enclosed survey are part of a national initiative sponsored by the United States Department of Health and Human Services to measure the quality of care in hospitals."
  - Participation is voluntary
  - Hospital name and discharge date of patient
  - Patient's health benefits will not be affected by participation in the survey
  - Customer support number
  - If applicable, add language that answers will be shared with hospitals for purposes of quality improvement

Mail Only Mode *(cont'd)*

- Cover letter requirements

  - <u>OMB Paperwork Reduction Act language</u>: "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. The time required to complete this information collected is estimated to average 8 minutes for questions 1-25 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)*

- Questionnaire guidelines and formatting <u>requirements</u>
  - Question and answer category wording is not changed nor is the order of Core HCAHPS questions or answer categories
  - "About You" questions follow the Core HCAHPS questions and remain as one block
  - Question and answer categories remain together in the same columns and on the same pages
  - 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

Mail Only Mode *(cont'd)*

- Questionnaire guidelines and formatting <u>requirements</u> *(cont'd)*
  - All instructions on the top of the survey are copied 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) must appear on the front page of the survey or on the cover letter

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Mail Only Mode *(cont'd)*

- Questionnaire guidelines and formatting <u>requirements</u> *(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
  - Survey materials 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
      - First class postage or indicia, suggested

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

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
        - It is **strongly recommended** that this is performed on an annual basis, at a minimum

Mail Only Mode *(cont'd)*

- Quality control guidelines *(cont'd)*
  - Hospitals/Survey vendors must:
    - 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 QualityNet Secure Portal by the data submission deadline

Telephone Only Mode *(cont'd)*

- Telephone Script
  - Standardized HCAHPS telephone script provided in Appendices G (English), H (Spanish), I (Chinese), and J (Russian) in *QAG V13.0*
    - 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
  - Core survey questions must be placed at the beginning of the survey
  - "About You" questions are placed anywhere after the Core survey questions and must remain together as one block of questions
  - 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 standardized HCAHPS telephone script
    - Linked electronically to survey management system
  - Manual data collection (allowed only for hospitals self-administering surveys)
    - Follow standardized 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 hospital discharge records
  - Attempts must be made to update missing or incorrect telephone numbers using:
    - *Commercial software*
    - *Internet directories*
    - *Directory assistance*
    - *Other tested methods*

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 call back that accommodates a patient's request within a specific day and time, between the hours of 9 AM and 9 PM respondent time
  - 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

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

Telephone Only Mode *(cont'd)*

- Quality Control Guidelines
  - Telephone monitoring and oversight of staff and subcontractors
    - At least 10% of HCAHPS attempts and interviews must be monitored by survey vendor and its subcontractor (if applicable)
    - All interviewers conducting HCAHPS Surveys must be monitored
    - All 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
      - It is **strongly recommended** that this is 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 N
  - 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 eight 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 < > 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

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 27)**

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 27)** *(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 29)**

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 29)** *(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 31)

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>.

Q31A   Are you White?
<1>   YES/WHITE
<0>   NO/NOT WHITE
<M>   MISSING/DK

Q31B   Are you Black or African- American?
<1>   YES/BLACK OR AFRICAN- AMERICAN
<0>   NO/NOT BLACK OR AFRICAN- AMERICAN
<M>   MISSING/DK

Q31C   Are you Asian?
<1>   YES/ASIAN
<0>   NO/NOT ASIAN
<M>   MISSING/DK

Q31D   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

Q31E   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

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 QualityNet Secure Portal 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 QualityNet Secure Portal by the data submission deadline

Active IVR Mode *(cont'd)*

- IVR Interviewing Systems
  - Programmed with standardized HCAHPS IVR script provided in Appendices K and L of *QAG V13.0*
  - 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</u> **or** <u>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 Coding and Preparation

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 P: Data File Structure Version 4.1 (effective 3Q 2018) 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 Race Question, enter responses for ALL of the categories that the respondent selected

Example 3 (Mail)

[x]	**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, 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, 18

- Dependent Question – questions skipped based on patient's response to screener question
  - Questions 11, 13, 14, 16, 17, 19, 20

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, did you have any pain?

☒ Yes

☐ No → If no, Go to Question 15

13. During this hospital stay, how often did hospital staff talk with you about how much pain you had?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

Example 1 (Mail)

Code as: "1 - Yes"

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

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

12. During this hospital stay, did you have any pain?

☒ Yes

☐ No → If no, Go to Question 15

Example 2 (Mail)

Code as:

"1 - Yes"

13. During this hospital stay, how often did hospital staff talk with you about how much pain you had?

☐ Never

☐ Sometimes

☒ Usually

☐ Always

Code as:

"3 - Usually"

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

12. During this hospital stay, did you have any pain?

☐ Yes

☒ No → If no, Go to Question 15

Example 3 (Mail)

Code as:

"2 - No"

13. During this hospital stay, how often did hospital staff talk with you about how much pain you had?

☐ Never
☐ Sometimes
☐ Usually
☐ Always

Code as:

"8 - Not Applicable"

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

12. During this hospital stay, did you have any pain?
☐ Yes
☒ No → If no, Go to Question 15

Example 4 (Mail)

Code as:
"2 - No"

13. During this hospital stay, how often did hospital staff talk with you about how much pain you had?
☐ Never
☒ Sometimes
☐ Usually
☐ Always

Code as:
"2 - Sometimes"

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

12. During this hospital stay, did you have any pain?

□ Yes

□ No → If no, Go to Question 15

Example 5 (Mail)

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

13. During this hospital stay, how often did hospital staff talk with you about how much pain you had?

□ 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 18 questions applicable to all patients are answered
  - – Questions applicable to all patients are *<u>included</u>*
    - Questions 1 through 10, 12, 15, 18, and 21-25
  - – Questions not applicable to all patients (e.g., skip pattern and "About You" questions) are *<u>excluded</u>*
    - Questions 11, 13, 14, 16, 17, 19, 20, and 26–32
  - – See Completed Survey Calculation Example in *QAG V13.0*

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	Exclusions
• 18 years old or older at the time of hospital admission	• "No-Publicity" patient
• Admission includes at least one overnight stay in the hospital as an inpatient	• 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)
• Non-psychiatric principal diagnosis at discharge	• Has a foreign home address
• Alive at the time of discharge	• 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)

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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 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 V13.0*

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
  - If patient is selected for the sample and the discharge date is beyond the 42 calendar day initial contact period
    - *Discrepancy Report must be filed*

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

Data Preparation

- File Specifications Version
- File Layout
- Preparing the Data File
- Data Submission Timeline

File Specifications Version

- Standardized file layouts
    - Appendix P – Data File Structure Version 4.1
    - Appendix Q – XML File Layout Version 4.1

Note: Version 4.1 applies to 3Q 2018 discharges and forward

File Layout

1. Header Record
   – Complete once per monthly file
     - The 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.
     - Once you have uploaded data for two months within a given quarter, you are **locked** into that survey mode and sample type and **cannot** change it for that quarter.

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)*

- Survey Mode and Sampling Type 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)*

- 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, 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 the Patient ID

  - Can be up to 16 characters in length (alphanumeric)

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
  - 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"
  - <u>Required</u> 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)
  - **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 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 QualityNet Secure Portal

- 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
October, November and December 2017 (4Q17)	April 4, 2018	April 5-11, 2018	Version 3.9
January, February and March 2018 (1Q18)	July 5, 2018	July 6-12, 2018	Version 4.0
April, May and June 2018 (2Q18)	October 3, 2018	October 4-10, 2018	Version 4.0
July, August and September 2018 (3Q18)	January 3, 2019	January 4-10, 2019	Version 4.1

HCAHPS Data Submission via the QualityNet Secure Portal

Overview

- Section XII *QAG V13.0*
  - Public and Secure Page Access
  - Registration Process for QualityNet Security Administrators and Non-Administrators
  - Submission of HCAHPS Data via the QualityNet Secure Portal
  - Authorizing/Switching Survey Vendors
  - HCAHPS Warehouse Submission Reports
  - HCAHPS Warehouse Feedback Reports

Introduction to HCAHPS Survey Training

QualityNet
Public Access: https://www.qualitynet.org

Introduction to HCAHPS Survey Training

QualityNet Resources

- QualityNet User's Guide

- QualityNet Help Desk

- QualityNet WebEx Recorded Sessions

Introduction to HCAHPS Survey Training

QualityNet WebEx Training

QualityNet Secure Portal

- URL: http://www.qualitynet.org

- The QualityNet Secure Portal is used to submit HCAHPS data to the HCAHPS Data Warehouse

- QualityNet account becomes deactivated after 120 days of inactivity

QualityNet Secure Portal *(cont'd)*
(Log in to Secure Location)

QualityNet Secure Portal Registration

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

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

- Check for existing Security Administrators within the organization

Administrator Registration for all *Hospitals*

- Obtain the QualityNet Security Administrator Registration Form and Instructions via the QualityNet Web site: http://www.qualitynet.org

- Complete the form
  - Highest-level executive at your organization sign and date the Administrator Authorization Form

Administrator Registration
Survey Vendor

- Request the QualityNet Security Administrator Form and Instructions from the HCAHPS Project Team

- Complete the form
  - Highest-level executive at your organization sign and date the Security Administrator Authorization Form
  - Mail the completed form to the HCAHPS Project Team

Non-Administrator Registration
Hospital/Survey Vendor

- Notify the Security Administrator at your organization that you need to become a new user

- Provide information to the Security Administrator or designee who enters the registration online and prints a registration form

- Mail the **<u>original</u>** registration form to the QualityNet Help Desk

Submission Option 1

- XML File Upload
  - XML File Format – conversion commercial software
  - *50MB file size limit*
  - Files must meet proper version specifications
    - Version 4.0: 1Q18 through 2Q18 discharges
    - Version 4.1: 3Q18 discharges and forward

HCAHPS Data Upload – XML

HCAHPS Data Upload – XML *(cont'd)*

- Log-in to the QualityNet Secure Portal

- 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

HCAHPS Data Upload – XML *(cont'd)*

- One XML file per Month per Provider
  - File must include all data for the month

- Valid resubmitted data will overwrite previously submitted data

- Valid data included in the latest file upload will be the *final* data in the warehouse

Submission Option 2

- HCAHPS Online Data Entry Tool
  - 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 QualityNet Secure Portal
    - Click on the Patient Satisfaction (HCAHPS) Data Entry link
    - Create a new or edit an existing survey month
    - Click on Add Patient Survey
    - Enter Administrative data and Survey data results (if available)
    - Exit the HCAHPS Online Data Entry Tool

HCAHPS Online Data Entry Tool

Authorizing Survey Vendor to Submit HCAHPS Data

- All hospitals must authorize their HCAHPS approved survey vendor via the QualityNet Secure Portal
  - Authorization updates in real time
  - QualityNet Secure Portal – *Authorize Vendors to Submit Data*
  - Approved survey vendors are listed on http://www.hcahpsonline.org

Vendor Authorization - New

Authorizing a New HCAHPS Survey Vendor

	Discharge Date	Data Transmission Date (MM/DD/YYYY)
Start Date	**10/1/2017**	**10/1/2017**
End Date		

Strongly recommended that the End Date fields be left
blank until survey authorization is terminated

Switching Survey Vendors

- Know and 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
    - Submission deadline and review and correct period for that discharge quarter
  - New Vendor – First discharge date for eligible patients
    - Must be at the beginning of a quarter
    - First date that vendor can submit for those patients

Vendor Authorization - Switch

Day 1 – Close Out "Current" HCAHPS Survey Vendor

	Discharge Date	Data Transmission Date (MM/DD/YYYY)
Start Date	07/01/2007	07/01/2007
End Date	09/30/2017	01/12/2018
	(Last day of the month for eligible discharge data collection)	(One day after HCAHPS Data Submission Deadline Review and Correct Period)

*Discharge Dates **CANNOT** Overlap between old and new survey vendors*

*Data Transmission Dates **CAN** Overlap between old and new survey vendors*

Day 2 – Authorize "New" HCAHPS Survey Vendor

	Discharge Date	Data Transmission Date (MM/DD/YYYY)
Start Date	10/1/2017	10/1/2017
End Date		

Strongly recommend that the End Date fields be left blank until survey authorization is terminated

HCAHPS Warehouse Submission Reports

1. Hospitals Authorizing Vendor to Upload Data

2. HCAHPS Warehouse Data Submission Detail

3. HCAHPS Warehouse Submission Summary

4. HCAHPS Review and Correction Report

   • HCAHPS Data Upload Role – **required**

   • Submission Reports available to submitter of data

Introduction to HCAHPS Survey Training

Introduction to HCAHPS Survey Training

Introduction to HCAHPS Survey Training

Introduction to HCAHPS Survey Training

HCAHPS Warehouse Feedback Reports

1. Provider Survey Status Summary

2. Data Submission Detail

3. Hospital Inpatient Quality Reporting (IQR) Provider Participation Report

4. HCAHPS Review and Correction Report

Summary

- QualityNet Secure Portal registration required to participate

- Two types of QualityNet Secure Portal 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@hcqis.org

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

Data Quality Checks

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

- **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

Traceable Data Trail *(cont'd)*

- Track data file receipts with summary tables:

Received	CCN	Discharge Month	Patient Records	Comments/*Action*
2-12-2018	A	1	30	First receipt
2-15-2018	A	1	27	Updated file (why 3 fewer patients?) *Investigate.*
2-15-2018	B	1	110	Substantial change in # of records from previous month. *Investigate.*
2-16-2018	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 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
All Patients	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 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
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 Feb 2018 and Mar 2018
- Why was Service Line coded as Missing for 23% of sampled patients in Mar 2018?

Review of Data Files *(cont'd)*

- Survey example: Question 1 – Nurse Courtesy and Respect

	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
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 Mar 2018

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 Warehouse
      - Feedback Reports
      - Submission Reports
      - 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 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
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 Warehouse 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 Review and Correction Report
  - To check the status of submitted data
  - Reports show frequencies for all HCAHPS data elements
  - Available within 48 hours after data submission via QualityNet
    - Available after *every* data upload

- HCAHPS Review and Correct Period
  - Review and Correct is the seven days after the warehouse closes for a given quarter
  - May re-submit data **previously submitted** based on issues discovered during the Review and Correct Period

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

- HCAHPS Review and Correction 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 Warehouse reports

Data Adjustment
and Public Reporting

Overview

- CMS Hospital Compare Web site and Measures Reported
- Data Adjustment
  - Adjust for Patient-Mix
  - Adjust for Mode of Survey Administration
- Reporting HCAHPS Results
- Hospitals with Five or Fewer HCAHPS Eligible Patients
- Footnotes
- Forms for Public Reporting
- Suppression of Results

Measures Reported

- Results updated on a quarterly basis

- Composite measures
  - Communication with nurses (Q1, Q2, Q3)
  - Communication with doctors (Q5, Q6, Q7)
  - Responsiveness of hospital staff (Q4, Q11)
  - Pain management (Q13, Q14)*
  - Communication about medicines (Q16, Q17)
  - Discharge information (Q19, Q20)
  - Care transition (Q23, Q24, Q25)

*The Pain Management measure will be reported until December 2018. The new Communication About Pain measure will be reported on Hospital Compare beginning in October 2020.

Measures Reported *(cont'd)*

- Individual items
  - Cleanliness of hospital environment (Q8)
  - Quietness of hospital environment (Q9)
- Global items
  - Rating of hospital (Q21)
  - Willingness to recommend hospital (Q22)

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** – English, Spanish, Chinese, RVPO (Russian, Vietnamese, Portuguese, Other)
    - **Response Percentile** (All completed surveys for a given month and hospital are ranked by Lag Time)
- Adjustments updated quarterly and published on
    http://www.hcahpsonline.org

Introduction to HCAHPS Survey Training

Mode Experiments

- Conducted a Mode Experiment in Spring 2006 to test mode effects
  - Summary document of Mode Experiment results is available on HCAHPS Web site (http://www.hcahpsonline.org)
- Conducted a Mode Experiment in late 2008 to test possibility of Internet mode of survey administration
- Conducted a Mode Experiment in 2012 to test new Care Transition survey items
- Conducted a Mode Experiment in 2016 to assess the effect of mode of survey administration on response propensity and response patterns

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 Hospital Compare https://www.medicare.gov/hospitalcompare
  - Also available in the Downloadable Data Base (DDB) located on https://Data.Medicare.gov
- Results are reported for the seven composites, two individual items and two global items
- Number of completed surveys and response rate also reported
- HCAHPS scores are reported
  - Top-box, middle-box, bottom-box
  - HCAHPS Star Ratings
    - 11 HCAHPS measures*
    - HCAHPS summary Star Rating
    - Linear mean scores

*The Pain Management measure will be reported until December 2018. The new Communication About Pain measure will be reported on Hospital Compare beginning in October 2020.

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 December

HCAHPS PUBLIC REPORTING: April 2018

- QUARTERS INCLUDED: 3Q16, 4Q16, 1Q17, 2Q17
- PREVIEW PERIOD: January 2018
- PUBLIC REPORTING: April 2018

Hospital Compare

Hospital Compare Profile

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 QualityNet Secure Portal through the HCAHPS 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 will appear
      - However, these hospitals will 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 to have their data displayed on Hospital Compare

  https://www.Medicare.gov/HospitalCompare

- Forms are accessible on the QualityNet Secure Portal

  https://www.qualitynet.org

Suppression of Results: IPPS Hospitals

- IPPS hospitals **cannot** suppress their results from Hospital Compare
  - 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
- Discrepancy Report
  - Notification of variation from HCAHPS protocols during survey administration

Exception Request

- Common Exception Requests
  - Disproportionate Stratified Random Sampling (DSRS)
  - HCAHPS Service Line determination
  - Notification of participation in another CMS/CMS-sponsored inpatient initiative
- Exception Request must include how the proposed exception will maintain the integrity of data collection
- *Exceptions not allowed for alternative modes of survey administration*

Exception Request *(cont'd)*

- Request for exception
  - Submit Exception Request Form(s) online
    - Submit Exception Request Form through http://www.hcahpsonline.org
  - Exception Request must be submitted and approved **prior** to implementing
  - **Exceptions must be submitted by survey vendors on behalf of their contracted hospitals**

HCAHPS Survey
EXCEPTION REQUEST FORM

To complete and submit the Exception Request Form online, visit the HCAHPS Web site at www.hcahpsonline.org. Section I is to be completed by the organization submitting this form. The hospital(s) for which this Exception Request relates to must be listed in Section II along with each hospital's CMS Certification Number (CCN). All required fields are indicated with an asterisk (*).

I. General Information

1. Organization

1a. Organization Name: *

1b. Medical Provider Number (CCN): *

1c. Mailing Address 1: *

1d. Mailing Address 2:

1e. City: *

1f. State: *

1g. Zip Code: *

1h. Telephone: * (xxx-xxx-xxxx)

EXT:

1i. Website:

2. Contact Person

2a. First Name: *

2a. Middle Initial:

2a. Last Name: *

2b. Title: *

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

2d. Mailing Address 1: *

2e. Mailing Address 2:

2f. City: *

2g. State: *

2h. Zip Code: *

2i. Telephone: *   EXT:

Fax Number:

2j. Email Address: *

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3. Survey Vendor Organization
This section is to be completed for hospitals using survey vendor to conduct the survey.

3a. Organization Name:

3b. Contact Person:

First Name:	Middle Initial:	Last Name:

3c. Title: **3d. Degree (e.g., RN, MD, PhD)**

3e. Mailing Address 1: **3f. Mailing Address 2:**

3g. City: **3h. State** **3i. Zip Code:**

3j. Telephone: EXT. **Fax:** **3k. E-mail Address**

II. Exception Request
Please complete items 1, 2 and 3 below for each requested exception.
1. Exception Request For (Check one in each box):

☐ New 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 Inpatient Initiative
☐ 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 Exceptions Request? ○ Yes ○ No

Note: the fields to add detailed information for each hospital will appear after completing section 3
"Description of Exceptions Request" below and clicking the "Submit Form" button.

3. Description of Exception Request

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

3b. Rationale for Proposed Exception Requested: *

3c. Explanation of Implementation of Proposed Exception Requested: *

3d. Evidence that Exception Will Not Affect Results: *

| Submit Form |

Hospital Name: *	CCN: *

The Exception Request Form must be completed and submitted online at www.hcahpsonline.org.

Exception Request *(cont'd)*

- Request to use 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 number of eligible patients for each stratum in a given month
    - 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)*

- 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 contracted hospitals**

Discrepancy Report *(cont'd)*

- Complete and submit report immediately upon discovery of issue(s)
  - Provide sufficient detail
    - Hospital 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
    - Other details and information, including time period affected
    - Initial and follow up DR numbers

HCAHPS Survey
DISCREPANCY REPORT FORM

Section 1 is to be completed by the organization submitting this form. The requested information regarding the affected hospitals must 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 (*). Enter "To be updated" in "*" required fields, only if an updated Discrepancy Report submission will be necessary.

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.)

Date of initial Discrepancy Report submission: *

Initial Discrepancy Report ID: *

1. General Information

Unique ID

Submission Date

1a. Name of Organization submitting Discrepancy Report *

1b. Type of Organization: *
Check one:
☐ Survey Vendor
☐ Multi-Site
☐ Self-Administering Hospital
☐ Hospital Contracted with a Survey Vendor:
Name of Survey Vendor

☐ Other

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: * (xxx-xxx-xxxx)

EXT:

2i. Fax Number:

2j. Email Address: *

3. Information about the Discrepancy

3a. Description of the discrepancy: *

3b. Description of how the discrepancy was identified: *

3c. Description of the corrective action to fix the discrepancy, including estimated time for implementation: *

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

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4. List of Hospitals Applicable to this Discrepancy

4a. Total number of Affected Hospitals: * [   ]

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 effects of the Discrepancy Report are quantified; however "unknown" will be accepted as a valid response.

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* xx/xx/xx	Time Frame Affected: End Date* xx/xx/xx

Note: Please print completed Discrepancy Report form before submitting.

[Print Discrepancy Report]   [Submit Form]

This form must be submitted online via the HCAHPS Web site (www.hcahpsonline.org).

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

- 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 as 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

On-Site Visits/Conference Calls

- Purpose: To ensure compliance with HCAHPS Survey protocols

  - Visits and calls are scheduled by the HPT

- Site visits must 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 survey 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 HCAHPS Project Team 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 Program Participation Form
    - March 2 – 23, 2018
  - If approved:
    - Submit QAP and survey materials
    - Submit QNet Registration Form
    - Begin data collection
    - Monitor Submission/Feedback Reports
    - Participate in future HCAHPS Update Training
    - Monitor our Web site http://www.hcahpsonline.org
    - Contact us

More Information and Resources

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

   http://www.hcahpsonline.org

- Submitting HCAHPS data:

   https://www.qualitynet.org

- Publicly reported HCAHPS results:

   https://www.medicare.gov/hospitalcompare

- HCAHPS results Downloadable Database (DDB):

   https://Data.Medicare.gov

Contact Us

HCAHPS Information and Technical Support

- Web site: http://www.hcahpsonline.org
- Email: hcahps@hcqis.org
- Telephone: 1-888-884-4007