CAHPS® Hospital Survey (HCAHPS)

Quality Assurance Guidelines

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CAHPS® Hospital Survey (HCAHPS)

Quality Assurance Guidelines

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CMS would like to acknowledge that the "Point of Origin for Admission" and "Visit and Patient Discharge Status" codes are reprinted from the National Uniform Billing Committee *Official UB-04, Data Specifications Manual* by permission, Copyright 2020, by the American Hospital Association.

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Reader's Guide

Purpose of Quality Assurance Guidelines

The *Quality Assurance Guidelines V16.0* manual has been developed by the Centers for Medicare & Medicaid Services (CMS) to standardize the survey data collection process and to ensure comparability of data reported through the CAHPS®[1] Hospital Survey (also known as Hospital CAHPS or HCAHPS). The Hospital Consumer Assessment of Healthcare Providers and Systems, or HCAHPS (pronounced "*H-caps*") Survey is part of a larger Consumer Assessment of Healthcare Providers and Systems (CAHPS) initiative sponsored by the Agency for Healthcare Research and Quality (AHRQ). This Reader's Guide provides hospitals and survey vendors with a high-level overview and reference for essential information presented in the *Quality Assurance Guidelines V16.0*. Readers are directed to the related chapters of the *Quality Assurance Guidelines V16.0* for more detail.

Quality Assurance Guidelines V16.0 Contents

The *Quality Assurance Guidelines V16.0* contains chapters that address HCAHPS Survey administration requirements. These include:

Introduction and Overview

This chapter includes a "New for 2021" section which highlights key changes in the HCAHPS Survey administration, a description of the HCAHPS initiative and the history of its development. It also includes an overview of the HCAHPS data collection and public reporting timeline.

Program Requirements

This chapter presents the Program Requirements, including the purpose of the HCAHPS Survey, use of HCAHPS with other hospital inpatient surveys, communicating with patients about the HCAHPS Survey, the roles and responsibilities for participating organizations (i.e., CMS, hospitals and survey vendors), Rules of Participation, and Minimum Survey Requirements to administer the HCAHPS Survey.

Communications and Technical Support

This chapter includes information about communications and technical support available to hospitals/survey vendors administering the HCAHPS Survey.

Survey Management

Hospitals/Survey vendors must establish a survey management process to administer the HCAHPS Survey. This chapter reviews guidelines that pertain to system resources, location of survey operations, customer support lines, personnel training, monitoring and quality oversight, safeguarding patient confidentiality, data security, and data retention.

Sampling Protocol

This chapter describes the process and requirements for selecting a random sample of patients to respond to the HCAHPS Survey. Several illustrations and examples of the HCAHPS sampling protocol are included in this chapter. Sampling can be conducted one time at the end of the month

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

or continuously throughout the month, provided that a random sample is generated for the entire month.

Modes of Survey Administration

There are four chapters that describe each of the allowed modes of survey administration: Mail Only, Telephone Only, Mixed methodology of Mail with Telephone follow-up, and Active Interactive Voice Response (IVR). Each survey administration chapter begins with a "New for 2021" section which highlights important changes. These chapters address the administration of the HCAHPS Survey, data receipt and retention, and quality control guidelines for each of the four modes. Each mode of administration requires adherence to a standardized protocol and timeline.

Data Specifications and Coding

The HCAHPS Survey uses a standardized approach for the coding of all data. This chapter describes the random, unique, de-identified patient identification number, the file specifications, decision rules and data coding guidelines, the procedure for assigning HCAHPS disposition codes, the definition of a completed survey, and the procedure for calculating the survey response rate.

Data Preparation and Submission

This chapter reviews the processes for preparation of data for submission, hospital/survey vendor registration for data submission via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal, survey vendor authorization, data submission via the HQR system, and interpretation of the associated HCAHPS Data Submission and HCAHPS Warehouse Feedback Reports.

Oversight Activities

This chapter provides information on the oversight activities that the CMS-sponsored HCAHPS Project Team conducts to verify compliance with HCAHPS protocols. These oversight activities include, but are not limited to: review of hospital's/survey vendor's HCAHPS Quality Assurance Plan, analysis of submitted data, on-site visits/teleconference calls, additional activities related to the administration of the HCAHPS Survey, and possible outcomes of non-compliance.

Data Reporting

This chapter describes the process for public reporting of HCAHPS Survey results on Care Compare (https://www.medicare.gov/care-compare/).

Exception Request/Discrepancy Report Processes

This chapter describes the process for reviewing methodologies that vary from standard HCAHPS protocols. The exception request process is designed to allow for flexibility while maintaining the integrity of the data. In addition, this chapter describes the process for notifying CMS of any discrepancies from standard HCAHPS protocols during the survey administration process.

Data Quality Checks

This chapter provides an overview describing the importance of data quality checks and examples of data quality check activities.

Index

The Index provides an alphabetical listing of frequently used topics and terms in the HCAHPS *Quality Assurance Guidelines* manual.

Appendices

The Appendices include the HCAHPS Surveys and mailing materials (multiple translations); telephone scripts (multiple translations); IVR scripts (English and Spanish); supporting interviewing documents; data file layout specifications; the hospital/survey vendor quality assurance plan outline; the forms for applying for survey administration participation, submitting requests for protocol exception, submitting discrepancy reports, and attestation statement; and guidance for the use of HCAHPS with other hospital inpatient surveys.

For More Information

For program information and to view important updates and announcements, visit the HCAHPS Web site at: https://www.hcahpsonline.org.

To Provide Comments or Ask Questions

For information and technical assistance, contact HCAHPS Information and Technical Support via email at hcahps@hsag.com or call 1-888-884-4007.

Introduction and Overview

New for 2021

Beginning with July 1, 2021 discharges, there will be one version of the HCAHPS cover letters and telephone/IVR scripts (previously the Optional Modified version with revisions).

- HCAHPS Initial and Follow-up Cover Letters (see Appendices A through G), including new required and optional elements
- HCAHPS Telephone Script and HCAHPS Active IVR Script (see Appendices H through M), including new required and optional elements

In addition, survey and cover letter language, in all official HCAHPS Survey translations, is located in Appendices A through M.

Overview of the CAHPS Hospital Survey (HCAHPS)

HCAHPS Background and Purpose

The Hospital Consumer Assessment of Healthcare Providers and Systems Survey, better known as HCAHPS (pronounced "*H-caps*"), is part of a larger Consumer Assessment of Healthcare Providers and Systems (CAHPS) program sponsored by the Agency for Healthcare Research and Quality (AHRQ). CAHPS was initiated by AHRQ in 1995 to establish survey and reporting products that provide consumers with information on health plan and provider performance. Since 1995, the initiative has grown to include a range of health care services at multiple levels of the delivery system. HCAHPS was developed by AHRQ in response to the Centers for Medicare & Medicaid Services' (CMS) request for a survey that supports the assessment of patients' perspectives on hospital care.

The purpose of HCAHPS is to uniformly measure and publicly report patients' perspectives on their inpatient care. While many hospitals collected information on patients' satisfaction with care, there was no national standard for collecting this information that would yield valid comparisons across all hospitals. HCAHPS represents the first national standard for the collection of information on patients' perspectives about their inpatient care. Three broad goals have shaped the HCAHPS Survey. First, the survey is designed to produce comparable data on patients' perspectives of care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful and practical. This methodology and the information it generates is made available to the public.

Official HCAHPS Survey scores are published on Care Compare (https://www.medicare.gov/care-compare/). CMS emphasizes that HCAHPS scores are designed and intended for use at the hospital level for the comparison of hospitals (designated by their CMS Certification Number) to each other. CMS does not review or endorse the use of HCAHPS scores for comparisons within hospitals, such as comparison of HCAHPS scores associated with a particular ward, floor, individual staff member, etc. to others. Such comparisons are unreliable unless large sample sizes

are collected at the ward, floor or individual staff member level. In addition, since HCAHPS questions inquire about broad categories of hospital staff (such as doctors in general and nurses in general rather than specific individuals), HCAHPS is not appropriate for comparing or assessing individual hospital staff members. Using HCAHPS scores to compare or assess individual staff members is inappropriate and is strongly discouraged by CMS.

Official HCAHPS scores are reported on Care Compare (https://www.medicare.gov/care-compare/). 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:

1. The introduction or executive summary of such reports must include the following statement:
   - "This report has been produced by [Survey Vendor] and does not represent official HCAHPS results, which are published on Care Compare (https://www.medicare.gov/care-compare/)."
2. 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."

Hospital Quality Initiative

CMS has several efforts in progress to provide hospital quality information to consumers and others, and to improve the care provided by the nation's hospitals. These initiatives build upon previous CMS and Quality Improvement Organization/Network (QIO/QIN) strategies to identify illnesses and/or clinical conditions that affect patients in order to promote the best medical practices associated with the targeted clinical disorders; prevent or reduce further instances of these selected clinical disorders; and prevent related complications.[2]

The Hospital Quality Initiative is a subset of CMS' larger Quality Initiative. The Quality Initiative was launched nationally in November 2002 for nursing homes, and was expanded in 2003 to the nation's home health care agencies and hospitals.[3] The Hospital Quality Initiative uses a variety of tools to stimulate and support significant improvement in the quality of hospital care. This initiative aims to improve hospitals' quality of care by distributing objective, easy to understand data on hospital performance. The public availability of this information will encourage consumers and their physicians to discuss and make better informed decisions on how to get the best hospital care, create incentives for hospitals to improve care and support public accountability.[4]

CMS has worked closely with the Hospital Quality Alliance (HQA), a public-private collaboration on hospital measurement and reporting, to operationalize the Hospital Quality Initiative. The HQA includes the American Hospital Association, the Federation of American Hospitals and the Association of American Medical Colleges. It is supported by AHRQ, CMS and other nationally

[2] Centers for Medicare & Medicaid Services. *Hospital Quality Initiative Overview.* Baltimore, MD. March 10, 2005. Available online at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/index.html

[3] CMS. March 10, 2005.

[4] CMS. March 10, 2005.

recognized organizations, such as the National Quality Forum (NQF), The Joint Commission, the American Medical Association, the Consumer-Purchaser Disclosure Project, AFL-CIO, and AARP.

In addition to the clinical measures of quality included in the Hospital Quality Initiative, CMS and its collaborators aim to provide consumers with measures that reflect patients' perspectives on hospital care and services. In order to fulfill this goal, CMS requested that AHRQ develop and test a survey that would capture hospital inpatients' perspectives on the quality of hospital care. Many hospitals were already conducting some type of patient survey. However, for public reporting purposes, CMS required a standardized instrument that would allow patients' perspectives on the quality of care to be compared fairly and reliably across hospitals. CMS also wanted an instrument that met high standards for scientific rigor and salience with consumers.[5] The HCAHPS Survey provides CMS with a standardized instrument for collecting and reporting patient perspectives on care that can be used to compare all participating hospitals nationally.

Through the Hospital Quality Initiative, a robust, prioritized set of hospital quality measures has been refined for use in public reporting. CMS and its collaborators have launched Care Compare (https://www.medicare.gov/care-compare/), which contains HCAHPS Survey results and many other measures, and is a streamlined redesign of eight existing CMS healthcare compare tools. The tool is developed to publicly report valid, credible and user-friendly information about the quality of care delivered in the nation's hospitals. The results of the HCAHPS Survey are publicly reported on Care Compare. For additional information on Care Compare, please visit https://www.medicare.gov/care-compare/.

The Development of HCAHPS

In July 2002, AHRQ published a "Call for Measures" in the Federal Register in which it asked organizations to submit items for consideration in development of the HCAHPS instrument. AHRQ reviewed each instrument submitted as part of the "Call for Measures," and found items in each one that stimulated their thinking about items that should appear in the HCAHPS questionnaire and how they might be phrased. In developing the draft HCAHPS Survey, AHRQ also drew on the following sources of information: items from the CAHPS Health Plan Survey; questions and comments from an October 24, 2002 web chat on HCAHPS; input from the Stakeholders Meeting on November 7, 2002; feedback from the Vendors Meeting on November 18, 2002; responses to the HCAHPS LISTSERV® mailbox; a literature review conducted by the CAHPS grantees; and the results of initial cognitive testing.

After reviewing these sources of information, AHRQ developed a draft HCAHPS instrument and submitted it to CMS on January 15, 2003. The draft instrument was subsequently refined based on a multi-step process that included consumer testing, additional stakeholder and public input, a CMS-directed three state pilot test, and additional field-testing. In the course of developing HCAHPS, CMS published several Federal Register Notices and used the public comments elicited by these notices to make revisions to the survey instrument and data collection protocols.

[5] Centers for Medicare & Medicaid Services. *HCAHPS Fact Sheet*. Baltimore, MD. Available online at https://www.hcahpsonline.org/en/facts/.

HCAHPS Three State Pilot Test

After obtaining clearance from the Office of Management and Budget (OMB), CMS pilot tested the January 15, 2003 version of the HCAHPS instrument through a contract with Quality Improvement Organizations (QIOs) in three states (Arizona, Maryland and New York).[6] The pilot test included 132 hospitals and resulted in over 19,000 completed surveys. Testing began in June 2003 and ended in August 2003. The results of the CMS pilot test were used to refine the survey instrument.[7] Following the pilot in these three states, the survey instrument was tested in Connecticut as an additional test state.

Focus Groups

AHRQ and CMS conducted 6 focus groups with consumers in October 2003 and another 10 in March 2004. These focus groups, conducted in four cities, included adults who had a recent experience in a hospital or were a caregiver for someone who had been in the hospital. Information obtained from the focus groups was used to further refine the survey instrument.

Additional Field Testing

Over a 6-month period beginning in fall 2003, AHRQ tested the instrument in 5 volunteer sites encompassing over 375 hospitals: Calgary Health Region; California Institute for Health System Performance; California Regions of Kaiser Permanente; Massachusetts General Hospital; and Premier Incorporated. The CAHPS team used these field tests to learn more about the hospital survey implementation process, including the survey instrument, sampling processes, data collection processes, and other related issues.[8]

Pre-Implementation Testing

In the summer of 2004, AHRQ provided an opportunity for hospitals and survey vendors to test the current instrument on their own. The purpose of this test was to help identify ways to minimize the potential burden and disruption posed by the integration of the HCAHPS Survey into existing survey efforts. Through these test sites, researchers formally and scientifically investigated various approaches to integrating the survey items with existing questionnaires, as well as alternative protocols for administering the survey.

Submission of Final Instrument to CMS and the National Quality Forum

In fall 2004, having concluded the testing processes described above, AHRQ provided CMS with recommendations for the final questionnaire and national implementation administration guidelines. Based on these recommendations, CMS submitted a 25-item instrument to the NQF for consideration through their consensus process. The NQF is a voluntary consensus and standard-setting organization established to standardize healthcare quality measurement and reporting, as defined by the National Technology Transfer and Advancement Act of 1995 and the Office of Management and Budget Circular A-119. On December 1, 2004, the NQF Review Committee met publicly to discuss HCAHPS. Based on feedback provided at the initial committee meeting and

[6] The Three State Pilot Study analysis results are available at the CMS Hospital Quality Initiatives webpage, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/Hospital3State_Pilot_Analysis_Final200512.pdf

[7] Westat. *CAHPS-SUN Web site: Development and Testing of the CAHPS Hospital Survey*. April 20, 2005. https://www.ahrq.gov/cahps/.

[8] Agency for Healthcare Research and Quality. *AHRQ Web site: Voluntary Testing of HCAHPS.* December 2004. https://www.ahrq.gov/cahps/.

during subsequent NQF Review Committee deliberations, the NQF recommended that CMS make a number of changes in the HCAHPS specifications, including reinstating two questions that had been deleted after the additional testing (doctors and nurses showing courtesy and respect); adding a script for the telephone version of the survey; and providing more response options for the demographic questions relating to ethnicity and race.

On May 11, 2005, upon the recommendation of its four Member Councils, the Board of Directors of the NQF formally endorsed the 27-item HCAHPS Survey. NQF endorsement represents the consensus of many healthcare providers, consumer groups, professional associations, purchasers, federal agencies, and research and quality organizations. The Board of Directors' approval was the final step of vetting through the NQF's formal Consensus Development Process, which included input from multiple stakeholder groups, review and voting. HCAHPS thereby achieved special legal standing as a voluntary consensus standard.[9]

Upon the recommendation of the NQF, CMS further examined the costs and benefits of HCAHPS. Abt Associates Inc. conducted this cost-benefit analysis of HCAHPS. The report from this analysis can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/HCAHPSCostsBenefits200512.pdf.

The NQF reviewed the HCAHPS Survey and its implementation protocols again in 2009. The HCAHPS Survey received endorsement renewal in 2015 and in 2019.

Office of Management and Budget and Public Comment Process

In addition to the NQF endorsement process, CMS obtained clearance from the Office of Management and Budget (OMB) for HCAHPS in December 2005. The OMB's Paperwork Reduction Act clearance process for HCAHPS required three Federal Register Notices. The initial notice was published in December 2003. Based on feedback received through this initial notice, CMS responded to public comments and worked with AHRQ to refine the survey instrument. A second 60-day Federal Register Notice was published in November 2004, and once again, CMS responded to all public comments received. After NQF endorsement was received in May 2005, a final 30-day Federal Register Notice was published in November 2005. OMB clearance was granted in December 2005, and CMS began final preparations for the National Implementation shortly thereafter. In 2008 and 2018, OMB again reviewed and approved HCAHPS.

HCAHPS and the Hospital Inpatient Quality Reporting (Hospital IQR) Program

The Deficit Reduction Act of 2005 required the Secretary of the Department of Health and Human Services to expand the set of measures that the Secretary determines to be appropriate for the measurement of the quality of care furnished by hospitals in the inpatient setting. The statute further specified that the payment update for fiscal year (FY) 2007 and each subsequent FY will be reduced for any "subsection (d) hospital" that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary.

In expanding the set of measures for the Hospital IQR Program (formerly known as Reporting Hospital Quality Data for Annual Payment Update [RHQDAPU] Program), CMS began to adopt

[9] Pursuant to the National Technology and Transfer Advancement Act of 1995 and the OMB Circular A-119, the NQF's endorsement of HCAHPS can be found in its report entitled "Standardizing a Measure of Patient Perspectives of Hospital Care" https://www.qualityforum.org.

the baseline set of performance measures as set forth in the 2005 report *Performance Measurement: Accelerating Improvement*, issued by the Institute of Medicine (IOM) of the National Academy of Sciences, effective for payments beginning in FY 2007. For FY 2007, participating hospitals were required to collect and submit 21 clinical quality measures for payment purposes. For FY 2008 and subsequent fiscal years, the set of measures was expanded to include HCAHPS.

For more information about the Inpatient Hospital Update in the current fiscal year, refer to: https://www.govinfo.gov/content/pkg/FR-2020-09-18/pdf/2020-19637.pdf.

HCAHPS and Hospital Value-Based Purchasing

Section 3001 of the Patient Protection and Affordable Care Act of 2010 names HCAHPS as one measure to be included in the Hospital Value-Based Purchasing (VBP) program for FY 2013. CMS introduced Hospital VBP for Inpatient Prospective Payment System (IPPS) hospitals, beginning with inpatients discharged in October 2012. HCAHPS performance accounted for 30 percent of the Hospital VBP Total Performance Score in FY 2013, FY 2014 and FY 2015. HCAHPS performance accounted for 25 percent of the Hospital VBP Total Performance Score in FY 2016 and subsequent fiscal years. In July 2011, CMS conducted an "Open Door Forum" on the Hospital VBP program. The slide set used in that presentation can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/downloads/HospVBP_ODF_072711.pdf. A summary of the "Patient Experience of Care" domain (HCAHPS) and how this score is calculated can be found on slides 35-61.

In the FY 2018 Hospital VBP program, the HCAHPS Pain Management dimension was removed and the HCAHPS Care Transition Dimension was added.

For more information about the Hospital VBP program in the current fiscal year, refer to the CMS Web site (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Hospital-Value-Based-Purchasing-.html).

HCAHPS Mode Experiment I

In order to achieve the goal of fair comparisons across all hospitals that participate in HCAHPS, it is necessary to adjust for factors that are not directly related to hospital performance but do affect how patients answer HCAHPS Survey items. To ensure that publicly reported HCAHPS scores allow fair and accurate comparisons of hospitals, in 2006 CMS undertook Mode Experiment I to examine whether mode of survey administration, the mix of patients in participating hospitals, or survey non-response systematically affect HCAHPS Survey results and then developed necessary statistical adjustments.

Mode Experiment I addressed three important sources of potential bias in hospital-level HCAHPS results. First, hospitals participating in the HCAHPS Survey have the option of choosing among four different modes of data collection: Mail Only, Telephone Only, Mail combined with Telephone follow-up (also known as Mixed Mode), and Active Interactive Voice Response (IVR). If patient responses differ systematically by mode of survey administration, it is necessary to adjust for survey mode.

Second, certain patient characteristics that are not under the control of the hospital, such as age and education, may be related to the patient's survey responses. For example, several studies have found that younger and more educated patients provide less positive evaluations of healthcare. If such differences occur in HCAHPS data, it is necessary to adjust for such respondent characteristics before comparing hospitals' HCAHPS results. Third, we examined whether the patients who respond to the HCAHPS Survey differ from those who are sampled and do not respond to the survey.

Mode Experiment I included a random nationwide sample of short-term acute care hospitals. A hospital's probability of being selected for the sample was proportional to its volume of discharges, which guaranteed that each patient would have an equal probability of being sampled for the experiment. The participating hospitals contributed patient discharges from a four-month period: February, March, April, and May 2006. Within each hospital, patients were randomly assigned to one of the four modes of survey administration.

Results from HCAHPS Mode Experiment I can be found in a report "Mode and Patient-mix Adjustments of the CAHPS® Hospital Survey (HCAHPS)," posted on the HCAHPS Web site (https://www.hcahpsonline.org/en/mode--patient-mix-adj/). Documents that provide the patient-mix adjustment coefficients applicable to current and previously reported HCAHPS scores can be found on this web site as well. Further information about the design and results of the HCAHPS Mode Experiment I are available in "The Effects of Survey Mode, Patient Mix and Nonresponse on CAHPS Hospital Survey (HCAHPS) Scores." M.N. Elliott, A.M. Zaslavsky, E. Goldstein, W. Lehrman, K. Hambarsoomian, M.K. Beckett, and L. Giordano. *Health Services Research*. 44:501-518.2009.

HCAHPS Mode Experiment II

In 2008, CMS recruited hospitals to voluntarily participate in a second mode experiment. Mode Experiment II was designed to evaluate the feasibility of two new candidate modes of HCAHPS Survey administration: Active Speech Enabled Interactive Voice Response (SE-IVR) and Internet. Eligible patients discharged from 29 volunteer hospitals in July, August and September 2008, were randomly assigned to an experimental mode or the existing Mail Only mode. Based on the thorough analysis of the two experimental modes, including response rates, respondent characteristics, data quality, and survey administration, CMS decided not to approve any new survey modes for HCAHPS at this time.

HCAHPS Mode Experiment III

In 2012, CMS conducted a third HCAHPS mode experiment in connection with five new survey items that are now part of the HCAHPS Survey. These items are:

- Hospital considered patient's preferences regarding post-discharge health care needs
- Patient understood own responsibilities in managing health post-discharge
- Patient understood the purpose of post-discharge medications
- Patient admitted through the emergency room
- Patient's self-rating of mental or emotional health

This mode experiment provided the information for CMS to develop survey mode adjustments for the first three items and allowed examination of the remaining two items for possible use in patient-

mix adjustment. To conduct the mode experiment, CMS randomly selected a set of hospitals that agreed to voluntarily participate in this experiment.

HCAHPS Mode Experiment IV

In 2016, CMS conducted a fourth HCAHPS mode experiment to assess the effect of mode of survey administration on response propensity and response patterns, along with the testing of supplemental items and new pain management survey items. CMS randomly selected 51 hospitals that agreed to voluntarily participate in this experiment. The mode experiment helps CMS achieve the goal of fair and standardized comparisons across all hospitals that participate in the HCAHPS Survey by establishing the guidelines for survey mode adjustments across survey modes.

HCAHPS Mode Experiment V

In 2021, CMS will conduct a fifth HCAHPS mode experiment to evaluate existing and new candidate survey items, evaluate revised survey protocols, evaluate possible new modes of survey administration, update mode adjustments for existing items and develop mode adjustments for candidate survey items. This mode experiment will also provide the HCAHPS Project Team the opportunity to test and evaluate mixed modes that incorporate an emailed survey as the initial mode.

Preparation for HCAHPS Data Collection

Hospitals interested in self-administering the survey and survey vendors interested in administering HCAHPS (referred to as hospitals/survey vendors) must apply to participate in HCAHPS and must participate in the Introduction to HCAHPS Training, as well as all subsequent HCAHPS Update Training sessions. At a minimum, the hospital's/survey vendor's Project Manager must participate in the HCAHPS training sessions. In addition, subcontractors **and any other organization(s)** that are responsible for major functions of HCAHPS Survey administration must participate in HCAHPS training.

All approved hospitals/survey vendors that participate in HCAHPS are encouraged to take part in a dry run prior to the official start of HCAHPS Survey administration, to become familiar with the survey and its implementation protocols. Hospitals/Survey vendors will also have an opportunity to submit their dry run data through CMS' Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal. This will permit hospitals/survey vendors to fully test the data submission system. There will, however, be no public reporting of a hospital's dry run data. HCAHPS dry runs take place in the last month of each calendar quarter (March, June, September, and December). The hospital/survey vendor must notify the HCAHPS Project Team of their intent to submit data as a dry run. Please note that dry run data are "real" data collected using the HCAHPS protocols.

HCAHPS Public Reporting

Official HCAHPS scores are publicly reported four times each year on Care Compare (https://www.medicare.gov/care-compare/). Public reporting of HCAHPS results is comprised of a rolling four quarters of survey data, with hospitals/survey vendors submitting data on a monthly or quarterly basis through the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/). The HCAHPS data submitted by each hospital/survey vendor is reviewed, cleaned, scored, and adjusted (including adjustments for patient-mix and survey mode). HCAHPS results are available

for preview by the participating hospital before public reporting on Care Compare (https://www.medicare.gov/care-compare/).

The first public reporting of HCAHPS results on Care Compare (https://www.medicare.gov/care-compare/) (previously Hospital Compare) occurred in March 2008 with 2,521 hospitals voluntarily reporting their HCAHPS scores, based on 1.1 million completed surveys from patients discharged between October 2006 and June 2007. Most recently, the October 2020 public reporting of HCAHPS results included the scores of 4,517 hospitals based on 2.8 million completed surveys from patients discharged between January 2019 and December 2019 (https://www.medicare.gov/care-compare/). The schedule of public reporting for 2021 can be found in the *Data Reporting* chapter.

CMS regularly publishes supplemental information about survey results on the HCAHPS Summary Analyses page of the HCAHPS Web site (https://www.hcahpsonline.org), including a summary table of state and national "top-box" scores for each HCAHPS measure, HCAHPS "top-box" and "bottom-box" percentile scores, a table of patient level Pearson "top-box" correlations among HCAHPS measures, and HCAHPS Hospital Characteristics Comparison Charts.

CMS and its HCAHPS partners continually review and analyze HCAHPS data. A bibliography of published articles based on the HCAHPS Project Team's research can be found on the HCAHPS Web site (https://www.hcahpsonline.org).

HCAHPS Star Ratings

Eleven HCAHPS Star Ratings appear in the new Provider Data Catalog (https://data.cms.gov/provider-data/): one for each of the 10 publicly reported HCAHPS measures, plus the HCAHPS Summary Star Rating. The HCAHPS Summary Star Rating, which combines the 10 HCAHPS measure star ratings, is also displayed on the new Care Compare Web site, where it is called the "Patient Survey Rating" (https://www.medicare.gov/care-compare/). Hospitals are able to preview their individual measure HCAHPS Star Ratings in their 30-day Public Reporting Preview Report.

HCAHPS Measures Receiving HCAHPS Star Ratings

HCAHPS Star Ratings are applied to each of the 10 publicly reported HCAHPS measures. Measures are created from specific questions on the HCAHPS Survey, as follows:

- HCAHPS Composite Measures
  1. Communication with Nurses (Q1, Q2, Q3)
  2. Communication with Doctors (Q5, Q6, Q7)
  3. Responsiveness of Hospital Staff (Q4, Q11)
  4. Communication About Medicines (Q13, Q14)
  5. Discharge Information (Q16, Q17)
  6. Care Transition (Q20, Q21, Q22)
- HCAHPS Individual Items
  7. Cleanliness of Hospital Environment (Q8)
  8. Quietness of Hospital Environment (Q9)
- HCAHPS Global Items
  9. Hospital Rating (Q18)
  10. Recommend the Hospital (Q19)

100 Completed Survey Minimum for HCAHPS Star Ratings
Hospitals must have at least 100 completed HCAHPS Surveys over a given four-quarter period in order to receive HCAHPS Star Ratings. In addition, hospitals must be eligible for public reporting of HCAHPS measures. Hospitals with fewer than 100 completed HCAHPS Surveys will not receive Star Ratings; however, their HCAHPS measure scores will be publicly reported on Care Compare (https://www.medicare.gov/care-compare/).

For additional information on HCAHPS Star Ratings, including Technical Notes and Frequently Asked Questions (FAQs), please visit the HCAHPS Star Ratings page on the HCAHPS Web site (https://www.hcahpsonline.org).

HCAHPS Results Beyond Care Compare

Since CMS began publicly reporting HCAHPS results in March 2008, HCAHPS scores have appeared in a wide variety of publications and have been incorporated in a number of hospital rating tools. Please note, however, that the full, complete and official HCAHPS results are those publicly reported on Care Compare (https://www.medicare.gov/care-compare/).

CMS Expands Use of HCAHPS Results

Several CMS programs include the use of HCAHPS results. The Comprehensive Care for Joint Replacement (CJR) model aims to support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries for Medicare beneficiaries. For more information please visit the following web sites: https://innovation.cms.gov/initiatives/CJR and https://www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals.
Established by the Affordable Care Act, the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) program collects and publishes data on an announced set of quality measures, including HCAHPS. For more information please visit:
https://www.qualityreportingcenter.com/en/inpatient-quality-reporting-programs/pps-exempt-cancer-hospital-quality-reporting-pchqr-program/.

HCAHPS Bulletins

As a means of quickly and directly communicating with hospitals and survey vendors participating in HCAHPS, CMS began to issue *HCAHPS Bulletins* in 2008 (these bulletins are posted on the HCAHPS Web site [https://www.hcahpsonline.org]). *HCAHPS Bulletins* are released, when needed, to provide uniform guidance or clarification to all hospitals and survey vendors on HCAHPS protocols. It is incumbent upon all approved HCAHPS Survey vendors, self-administering hospitals and multi-site hospitals to promptly read all *HCAHPS Bulletins*, review their procedures for handling the matters addressed and where necessary institute changes to comply with HCAHPS protocols. The *HCAHPS Bulletins* supplement training; their instructions and clarifications are subsequently incorporated into the published HCAHPS *Quality Assurance Guidelines*.

Reviewing and Revising the HCAHPS Survey

Beginning in Fall 2019, CMS initiated a multi-faceted review of HCAHPS Survey content and design. Focus groups and cognitive interviews were conducted with recent hospital inpatients, discussing their experience of care and assessment of existing, revised and potential survey items.

Following this, CMS gathered input from stakeholders more broadly on potential changes to HCAHPS.

In July 2020, a Technical Expert Panel (TEP) Meeting was conducted to discuss the goals of the HCAHPS Survey revision efforts. In the fall of 2020, nationwide hospital recruitment occurred and the HCAHPS mode experiment data collection is set to begin in 2Q 2021.

HCAHPS Survey Instrument

Components of the HCAHPS Survey Instrument

The standardized 29-question HCAHPS Survey instrument is composed of the following measures:

- Six Composite Measures
  - Communication with Nurses (comprised of three HCAHPS Survey items)
  - Communication with Doctors (comprised of three HCAHPS Survey items)
  - Responsiveness of Hospital Staff (comprised of two HCAHPS Survey items)
  - Communication About Medicines (comprised of two HCAHPS Survey items)
  - Discharge Information (comprised of two HCAHPS Survey items)
  - Care Transition (comprised of three HCAHPS Survey items)
- Two Individual Items
  - Cleanliness of Hospital Environment
  - Quietness of Hospital Environment
- Two Global Items
  - Hospital Rating
  - Recommend the Hospital

The HCAHPS Survey is currently available in English (Mail Only, Telephone Only, Mixed, Active IVR modes), Spanish (Mail Only, Telephone Only, Mixed, and Active IVR modes), Chinese (Mail Only, Telephone Only and Mixed Modes), Russian (Mail Only, Telephone Only and Mixed Modes), Vietnamese (Mail Only), Portuguese (Mail Only), and German (Mail Only). Hospitals/Survey vendors are not permitted to make or use any other language translations.

HCAHPS Development, Data Collection and Public Reporting Timeline

The following timeline outlines major events in the HCAHPS development process, as well as anticipated dates for future national implementation events.

2002

- *July 2002* – AHRQ publishes call for measures in the Federal Register
- *Fall 2002* – The CAHPS team reviews the literature and response to the call for measures on patient assessment of hospital care related to survey content, sampling, data collection, and reporting
- *November 2002* – AHRQ and CMS hold a Stakeholders Meeting
- *November 2002* – AHRQ and CMS hold a Survey Vendors Meeting

2003

- *February 2003* – A Federal Register Notice is published soliciting comments on the draft pilot instrument

- *June 2003* – Data collection begins for the CMS Three State Pilot (Arizona, Maryland and New York)
- *June 2003* – A Federal Register Notice is published soliciting comments on the draft HCAHPS Survey and requesting input on implementation issues
- *Fall 2003* – CMS selects Health Services Advisory Group (HSAG), the Arizona Quality Improvement Organization (QIO), to coordinate the National Implementation of HCAHPS. HSAG assembles a team comprised of the National Committee for Quality Assurance (NCQA), RAND, Westat, and expert consultants from Harvard Medical School to support the National Implementation.
- *October 2003* – Six consumer focus groups are conducted in California and Maryland to obtain consumer feedback on the HCAHPS Survey content and domains
- *November 2003* – HCAHPS Stakeholders Meeting is held to provide an update on the development process and to discuss implementation issues
- *December 2003* – CMS publishes the draft 32-item HCAHPS instrument in the Federal Register
- *December 2003* – The Three State Pilot Final Report is issued

2004

- *January 2004* – AHRQ begins additional HCAHPS testing at five sites
- *February 2004* – AHRQ announces Pre-National Implementation Testing in the Federal Register
- *March 2004* – Additional consumer focus groups are held in Arizona and Florida to address issues raised in comments to the initial National Implementation of HCAHPS Federal Register Notice
- *June 2004* – AHRQ Pre-National Implementation Testing begins
- *November 2004* – CMS issues second 60-day Federal Register Notice announcing the National Implementation of HCAHPS (25-item HCAHPS instrument)
- *November 2004* – CMS submits HCAHPS to the NQF's Consensus Development process for its endorsement
- *December 2004* – The NQF Review Committee recommends adding the "doctors and nurses showing courtesy and respect" items back into the HCAHPS Survey, which increases the number of survey items from 25 to 27

2005

- *January 2005* – The second Federal Register Notice closes; CMS proceeds to respond to the public comments received through the Federal Register
- *March 2005* – NQF public comment period
- *May 2005* – The four NQF Member Councils and Executive Board formally endorse HCAHPS
- *November 2005* – The final Federal Register Notice, a 30-day notice, is published
- *December 2005* – HCAHPS receives final clearance from OMB

2006

- *February 2006* – The first HCAHPS *Quality Assurance Guidelines* manual is released
- *February 2006* – The first *HCAHPS Hospital/Survey Vendor Training* sessions are held at the CMS Central Office in Baltimore, and also via Webinar

- *April - June 2006* – The first HCAHPS dry run is conducted, which allows hospitals to test the survey and data submission process without public reporting
- *April 2006* – The second *HCAHPS Hospital/Survey Vendor Training* is conducted via Webinar
- *October 2006* – Data collection for the National Implementation of HCAHPS for Public Reporting commences

2007

- *January 2007* – The HCAHPS *Quality Assurance Guidelines V2.0* is released
- *January 2007* – The third *HCAHPS Hospital/Survey Vendor Training (Introduction to HCAHPS Training*) is conducted via Webinar
- *March 2007* – A second HCAHPS dry run is conducted, for hospitals/survey vendors that did not participate in 2006
- *May 2007* – A Chinese translation of the survey instrument is made available for Mail Only mode of survey administration
- *May 2007* – The first *HCAHPS Update Training* sessions are conducted via Webinar
- *July 1, 2007* – HCAHPS Data Collection and Public Reporting for Annual Payment Update purposes (APU era) begins
- *August 22, 2007* – The IPPS Final Rule is published, which stipulates that IPPS hospitals must participate in and publicly report HCAHPS in order to qualify for their full APU for FY 2008 ("pay for reporting")

2008

- *January 2008* – The HCAHPS *Quality Assurance Guidelines V3.0* is released
- *January 2008* – The fourth *Introduction to HCAHPS Training* and second *HCAHPS Update Training* sessions are conducted via Webinar
- *January 17 – February 15, 2008* – First preview period for HCAHPS public reporting
- *February 2008* – OMB re-approved HCAHPS
- *March 28, 2008* – The First Public Reporting of HCAHPS results (Patients discharged October 2006 – June 2007) on the Hospital Compare Web site
- *July 2008* – Data collection begins for Mode Experiment II
- *August 2008* – Second Public Reporting of HCAHPS results (Patients discharged October 2006 – September 2007)
- *August 19, 2008* – The IPPS Final Rule is published, which stipulates that IPPS hospitals must continuously collect and submit HCAHPS data to the QIO Clinical Warehouse by the data submission deadlines which are posted on the HCAHPS Web site (https://www.hcahpsonline.org)
- *September 2008* – Third Public Reporting of HCAHPS results (Patients discharged January 2007 – December 2007)
- *October 2008* – CMS releases *HCAHPS Bulletin 2008-01*, "Application of the HCAHPS Lag Time Variable"
- *December 2008* – Fourth Public Reporting of HCAHPS results (Patients discharged April 2007 – March 2008)

2009

- *February 2009* – The HCAHPS *Quality Assurance Guidelines V4.0* is released

- *February 2009 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted via Webinar
- *February 2009* – Russian and Vietnamese translations of the survey instrument are made available for Mail Only mode of survey administration
- *February 2009* – CMS releases HCAHPS Bulletin 2009-01, "The Use of HCAHPS in Connection with Other Hospital Inpatient Surveys," which is posted on the HCAHPS Web site (https://www.hcahpsonline.org)
- *March 2009* – Fifth Public Reporting of HCAHPS results (Patients discharged July 2007 – June 2008). IPPS hospitals must report their HCAHPS results, and can no longer suppress public reporting.
- *May 2009* – CMS releases *HCAHPS Bulletin 2009-01 Revised*, "The Use of HCAHPS in Conjunction with Other Hospital Inpatient Surveys," which is posted on the HCAHPS Web site (https://www.hcahpsonline.org)
- *July 2009* – Sixth Public Reporting of HCAHPS results (Patients discharged October 2007 – September 2008)
- *August 27, 2009* – The IPPS Final Rule is published, which stipulates the continued requirement for IPPS hospitals to continuously collect and submit HCAHPS data to the QIO Clinical Warehouse by the data submission deadlines which are posted on the HCAHPS Web site (https://www.hcahpsonline.org)
- *September 2009* – Seventh Public Reporting of HCAHPS results (Patients discharged January 2008 – December 2008)
- *December 2009* – Eighth Public Reporting of HCAHPS results (Patients discharged April 2008 – March 2009)

2010

- *March 2010* – The HCAHPS *Quality Assurance Guidelines V5.0* is released
- *March 2010 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted via Webinar
- *March 2010* – Ninth Public Reporting of HCAHPS results (Patients discharged July 2008 – June 2009)
- *April 2010* – HCAHPS is named in Section 3001 of the Patient Protection and Affordable Care Act of 2010
- *June 2010* – Tenth Public Reporting of HCAHPS results (Patients discharged October 2008 – September 2009)
- *August 16, 2010* – The IPPS Final Rule is published, which stipulates the continued requirement for IPPS hospitals to continuously collect and submit HCAHPS data to the QIO Clinical Warehouse by the data submission deadlines which are posted on the HCAHPS Web site (https://www.hcahpsonline.org)
- *September 2010* – Eleventh Public Reporting of HCAHPS results (Patients discharged January 2009 – December 2009)
- *December 2010* – Twelfth Public Reporting of HCAHPS results (Patients discharged April 2009 – March 2010)
- *December 2010* – CMS releases the *HCAHPS Bulletin 2010-01* "HCAHPS and Hospital Value-Based Purchasing"

2011

- *March 2011* – The HCAHPS *Quality Assurance Guidelines V6.0* is released
- *March 2011 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted via Webinar
- *April 2011* – Thirteenth Public Reporting of HCAHPS results (Patients discharged July 2009 – June 2010)
- *May 6, 2011* – The final Hospital Value-Based Purchasing rule is published *(Federal Register / Vol. 76, No. 88 / Friday, May 6, 2011 / Rules and Regulations)*
- *July 2011* – Fourteenth Public Reporting of HCAHPS results (Patients discharged October 2009 – September 2010)
- *August 18, 2011* – The IPPS Final Rule is published *(Federal Register / Vol. 76, No. 160 / Thursday, August 18, 2011 / Rules and Regulations)*
- *October 2011* – Fifteenth Public Reporting of HCAHPS results (Patients discharged January 2010 – December 2010)

2012

- *January 2012* – Sixteenth Public Reporting of HCAHPS results (Patients discharged April 2010 – March 2011)
- *March 2012* – The HCAHPS *Quality Assurance Guidelines V7.0* is released
- *March 2012 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted via Webinar
- *Spring 2012* – Seventeenth Public Reporting of HCAHPS results (Patients discharged July 2010 – June 2011)
- *July 2012* – Eighteenth Public Reporting of HCAHPS results (Patients discharged October 2010 - September 2011)
- *July 1, 2012* – Voluntary use of the HCAHPS 32-item Expanded survey begins with July 1, 2012 discharges
- *August 31, 2012* – The IPPS Final Rule is published (*Federal Register / Vol. 77, No. 170 / Friday, August 31, 2012 / Rules and Regulations*)
- *October 1, 2012* – Hospital Value-Based Purchasing program begins; HCAHPS "top-box" scores used to create the Patient Experience of Care Domain score
- *October 2012* – Nineteenth Public Reporting of HCAHPS results (Patients discharged January 2011 – December 2011)
- *December 2012* – Twentieth Public Reporting of HCAHPS results (Patients discharged April 2011 – March 2012)

2013

- *January 2013* – Required use of the 32-item HCAHPS Survey, which includes the Care Transition Measure
- *March 2013* – The HCAHPS *Quality Assurance Guidelines V8.0* is released
- *March 2013 – Introduction to HCAHPS Training and HCAHPS Update Training* are conducted via Webinar
- *April 2013* – Twenty-first Public Reporting of HCAHPS results (Patients discharged July 2011 – June 2012)
- *July 2013* – Twenty-second Public Reporting of HCAHPS results (Patients discharged October 2011 – September 2012)

- *August 19, 2013* – The IPPS Final Rule is published (*Federal Register / Vol. 78, No. 160 / Friday, August 19, 2013 / Rules and Regulations*)
- *September 2013* – CMS releases the Portuguese translation of the HCAHPS Survey for Mail Only mode of survey administration
- *October 2013* – Language spoken at home patient-mix adjustment applied to October 1, 2013 and forward discharges
- *December 2013* – Twenty-third Public Reporting of HCAHPS results (Patients discharged January 2012 – December 2012)

2014

- *January 2014* – Twenty-fourth Public Reporting of HCAHPS results (Patients discharged April 2012 – March 2013)
- *March 2014* – The HCAHPS *Quality Assurance Guidelines V9.0* is released
- *March 2014 – Introduction to HCAHPS Training and HCAHPS Update Training* are conducted via Webinar
- *April 2014* – Twenty-fifth Public Reporting of HCAHPS results (Patients discharged July 2012 – June 2013
- *July 2014* – Twenty-sixth Public Reporting of HCAHPS results (Patients discharged October 2012 – September 2013)
- *August 22, 2014* – The IPPS Final Rule is published (*Federal Register / Vol. 79, No. 163 / Friday, August 22, 2014 / Rules and Regulations*)
- *December 2014* – Twenty-seventh Public Reporting of HCAHPS results (Patients discharged January 2013 – December 2013)
  - First public reporting of Care Transition Measure composite

2015

- *March 2015 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted via Webinar
- *March 2015* – The HCAHPS *Quality Assurance Guidelines V10.0* is released
- *April 2015* – Twenty-eighth Public Reporting of HCAHPS results (Patients discharged July 2013 – June 2014)
  - First public reporting of HCAHPS Star Ratings
- *July 2015* – Twenty-ninth Public Reporting of HCAHPS results (Patients discharged October 2013 – September 2014)
- *August 17, 2015* – The IPPS Final Rule is published (*Federal Register / Vol. 80, No. 158 / Friday, August 17, 2015 / Rules and Regulations*)
- *October 2015* – Thirtieth Public Reporting of HCAHPS results (Patients discharged January 2014 – December 2014)
- *December 2015* – Thirty-first Public Reporting of HCAHPS results (Patients discharged April 2014 – March 2015)

2016

- *March 2016 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted via Webinar
- *March 2016* – The HCAHPS *Quality Assurance Guidelines V11.0* is released

- *April 2016* – Thirty-second Public Reporting of HCAHPS results (Patients discharged July 2014 – June 2015)
- *July 2016* – Thirty-third Public Reporting of HCAHPS results (Patients discharged October 2014 – September 2015)
- *August 22, 2016* – The IPPS Final Rule is published (*Federal Register / Vol. 81, No. 162 / Friday, August 22, 2016 / Rules and Regulations*)
- *October 2016* – Thirty-fourth Public Reporting of HCAHPS results (Patients discharged January 2015 – December 2015)
- *November 2016* – The OPPS Final Rule is published (*Federal Register / Vol. 81, No. 219 / Monday, November 14, 2016*), which stipulates that beginning in FY 2018, the HCAHPS Pain Management dimension will be removed from the Hospital VBP program. In addition, the HCAHPS Care Transition Dimension will be added to the Hospital VBP Program. (https://federalregister.gov/d/2016-26515)
- *December 2016* – Thirty-fifth Public Reporting of HCAHPS results (Patients discharged April 2015 – March 2016). Public reporting of HCAHPS scores restricted to hospitals with 25 or more completed surveys.

2017

- *February - March 2017 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted via Webinar
- *March 2017* – The HCAHPS *Quality Assurance Guidelines V12.0* is released and CMS releases the Chinese and Russian translations of the HCAHPS Telephone Scripts
- *April 2017* – Thirty-sixth Public Reporting of HCAHPS results (Patients discharged July 2015 – June 2016)
- *July 2017* – Thirty-seventh Public Reporting of HCAHPS results (Patients discharged October 2015 – September 2016)
- *August 2017* – The FY 2018 IPPS Final Rule is published (*Federal Register / Vol. 82, No. 155 / Monday, August 14, 2017*), in which CMS announced plans to replace the pain management questions with three new questions that focus on Communication About Pain
- *October 2017* – Thirty-eighth Public Reporting of HCAHPS results (Patients discharged January 2016 – December 2016)
- *November 2017* – Release of the first HCAHPS Podcast entitled "Successfully Transitioning to the New *Communication About Pain* Items on the HCAHPS Survey"
- *December 2017* – Thirty-ninth Public Reporting of HCAHPS results (Patients discharged April 2016 – March 2017)

2018

- *January 2018* – The new HCAHPS pain items are required to be used for all patient discharges January 2018 and forward. These items comprise a new composite measure Communication About Pain and replace the original pain items 12, 13 and 14.
- *February - March 2018 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted
- *March 2018* – The HCAHPS *Quality Assurance Guidelines V13.0* is released
- *April 2018* – Fortieth Public Reporting of HCAHPS results (Patients discharged July 2016 – June 2017)
- *May 2018* – CMS removed the Pain Management composite from the April 2018 Hospital Compare Refresh

- *July 2018* – Forty-first Public Reporting of HCAHPS results (Patients discharged October 2016 – September 2017)
- *August 2018* – The FY 2019 IPPS Final Rule is published (Federal Register / Vol. 83, No. 160 / August 17, 2018)
- *October 2018* – Forty-second Public Reporting of HCAHPS results (Patients discharged January 2017 – December 2017)
- *November 2018* – The CY 2019 OPPS Final Rule is published (Federal Register / Vol. 83, No. 225 / *November 21, 2018*), in which CMS announced the removal of the Communication About Pain composite measure effective with October 1, 2019 patient discharges for the FY 2021 payment determination and subsequent years
- *November 2018* – OMB re-approved HCAHPS with addition of the Expiration Date of November 30, 2021 displayed on the front page of the questionnaire and in the OMB Paperwork Reduction Action Language statement

2019

- *January 2019* – Forty-third Public Reporting of HCAHPS results (Patients discharged April 2017 – March 2018). Refreshed in February 2019.
- *February 2019* – The HCAHPS *Quality Assurance Guidelines V14.0* is released
- *February 2019 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted
- *April 2019* – Forty-fourth Public Reporting of HCAHPS results (Patients discharged July 2017 – June 2018)
- *June 2019* – Release of the HCAHPS Podcast entitled "HCAHPS Linear Mean Scores and Star Ratings Calculations"
- *July 2019* – Forty-fifth Public Reporting of HCAHPS results (Patients discharged October 2017 – September 2018)
- *July 2019* – Release of three HCAHPS Podcasts entitled "Updated Patient-Mix Adjustment: Self-Rated Mental Health," "Recommended HCAHPS Data Quality Checks" and "Advanced HCAHPS Data Quality Checks"
- *August 2019* – The FY 2020 IPPS Final Rule is published (Federal Register / Vol. 84, No. 159 / August 16, 2019)
- *October 2019* – CMS releases the German translation of the HCAHPS Survey for Mail Only mode of survey administration
- *October 2019* – The removal of the Communication About Pain composite from the HCAHPS Survey effective with October 1, 2019 patient discharges
- *October 2019* – The NQF renewed its endorsement of the HCAHPS Survey
- *October 2019* – Forty-sixth Public Reporting of HCAHPS results (Patients discharged January 2018 – December 2018)
- *December 2019* – Focus Groups were conducted in the initial stage of a multi-faceted review of HCAHPS Survey content and design

2020

- *January 2020* – Forty-seventh Public Reporting of HCAHPS results (Patients discharged April 2018 – March 2019)
- *February 2020* – The HCAHPS *Quality Assurance Guidelines V15.0* is released

- *February 2020 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted
- *March 2020* – CMS grants exceptions for hospitals participating in quality reporting programs in response to COVID-19. Survey vendors and self-administering hospitals could request approval to conduct survey operations from a remote location (other than their place of business), via the HCAHPS Exception Request process.
- *April 2020* – Forty-eighth Public Reporting of HCAHPS results (Patients discharged July 2018 – June 2019)
- *July 2020* – Forty-ninth Public Reporting of HCAHPS results (Patients discharged October 2018 – September 2019)
- *July 2020* – Release of two HCAHPS Podcasts entitled "Total Inpatient Discharges" and "Changes to QualityNet Data File Submission"
- *September 2020* – CMS launched Care Compare (https://www.medicare.gov/care-compare/ [previously Hospital Compare]), which contains HCAHPS Survey results and many other measures, and is a streamlined redesign of eight existing CMS healthcare compare tools available on https://www.medicare.gov
- *September 2020* –The FY 2021 IPPS Final Rule is published (Federal Register / Vol. 85, No. 182 / September 18, 2020)
- *October 2020* – Fiftieth Public Reporting of HCAHPS results (Patients discharged January 2019 – December 2019)

2021

- *February 2021* – The HCAHPS *Quality Assurance Guidelines V16.0* is released
- *March 2021 – Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted
- *July 2021* – The Fifty-first Public Reporting will display HCAHPS results for patients discharged October 2019 – December 2019 and July 2020 – September 2020 (due to the COVID-19 Public Health Emergency)
- *October 2021* – The Fifty-second Public Reporting will display HCAHPS results for patients discharged July 2020 – December 2020 (due to the COVID-19 Public Health Emergency)

Program Requirements

Overview

This chapter describes the Program Requirements, which include the purpose of the CAHPS Hospital Survey (HCAHPS), use of HCAHPS with other hospital inpatient surveys, communicating with patients about the HCAHPS Survey, roles and responsibilities for participating organizations, the Rules of Participation, and Minimum Survey Requirements to administer HCAHPS. The HCAHPS Rules of Participation listed below apply to hospitals self-administering the HCAHPS Survey, hospitals administering the HCAHPS Survey for multiple sites and survey vendors. In addition, there are two different sets of Minimum Survey Requirements: one for self-administering hospitals and one for survey vendors. A hospital self-administering the HCAHPS Survey (without using a survey vendor) must meet the *Self-administering Hospital* Minimum Survey Requirements. Survey vendors and hospitals administering the HCAHPS Survey for multiple sites must meet the *Survey Vendor* Minimum Survey Requirements.

Purpose of the HCAHPS Survey

The HCAHPS Survey and its administration protocols are designed to produce standardized information about patients' perspectives of care that allows objective and meaningful comparisons of hospitals on topics that are important to consumers. Public reporting of HCAHPS results creates incentives for hospitals to improve the quality of care while enhancing accountability in healthcare by increasing transparency.

In order to fulfill these goals, it is essential that, to the fullest extent possible:

1. Patients respond to the HCAHPS Survey, and
2. Patients' responses are informed only by the care they receive during the hospital stay

CMS carefully developed the HCAHPS Survey and its administration protocols to achieve the following outcomes:

- To increase the likelihood that patients will respond to the survey, HCAHPS should be the first survey patients receive about their experience of hospital care (for more information see *Use of HCAHPS with Other Hospital Inpatient Surveys* below and Appendix Z)
- To ensure that responses to the HCAHPS Survey are based on the patient's own experience of care, proxy respondents are never permitted to respond to the survey
- To ensure that the patient's responses are unbiased and reflect only his or her experience of care, hospitals and survey vendors (and anyone acting on their behalf) must not attempt to influence how the patient responds to HCAHPS Survey items (for more information see *Communicating with Patients about the HCAHPS Survey* below)

Official HCAHPS Survey scores are published on Care Compare (https://www.medicare.gov/care-compare/). CMS emphasizes that HCAHPS scores are designed and intended for use at the hospital level for the comparison of hospitals (designated by their CMS Certification Number) to each other. **CMS does not review or endorse the use of HCAHPS scores for comparisons within hospitals, such as comparison of HCAHPS scores associated with a particular ward, floor, individual staff member, etc. to others**. Such comparisons are unreliable unless large sample

sizes are collected at the ward, floor, or individual staff member level. In addition, since HCAHPS questions inquire about broad categories of hospital staff (such as doctors in general and nurses in general rather than specific individuals), HCAHPS is not appropriate for comparing or assessing individual hospital staff members. Using HCAHPS scores to compare or assess individual staff members is inappropriate and is strongly discouraged by CMS. HCAHPS Survey results are intended to be used for quality improvement purposes, not for marketing or promotional activities. Only the HCAHPS scores published on Care Compare (https://www.medicare.gov/care-compare/) are the "official" scores. Scores derived from any other source are "unofficial" and should 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.). When used in an unofficial capacity, the HCAHPS OMB language, HCAHPS OMB number and expiration date must not be used, all references to HCAHPS and the "United States Department of Health and Human Services" sponsorship must be removed, and the copyright statement for the Care Transition Measure (CTM) items must be used.

Use of HCAHPS with Other Hospital Inpatient Surveys

In this section, CMS provides guidelines to employ when asking patients questions regarding their hospital stay. CMS' intent is to minimize the burden on patients, prevent the introduction of bias to HCAHPS Survey responses and not deteriorate the likelihood that patients will complete the HCAHPS Survey.

In general, activities and encounters that are intended to provide or assess clinical care or promote patient/family well-being are permissible. However, activities and encounters that are primarily intended to influence how patients, or which patients, respond to HCAHPS Survey items must be avoided. If patients are asked questions during their inpatient stay, we suggest that such questions be worded in a neutral tone and not tilted toward a particular outcome. In addition, **questions must not resemble HCAHPS items or their response categories.** Hospitals should focus on overall quality of care rather than the measures reported to CMS.

Inpatients should not be given any **survey** during their hospital stay or at the time of discharge. The word "survey" in this instance refers to a formal, HCAHPS-like, patient experience/ satisfaction survey. A formal survey, regardless of the mode employed, is one in which the primary goal is to ask standardized questions of a significant portion of a hospital's patient population.

- When asking non-HCAHPS Survey questions, do not use HCAHPS-like response categories (for instance, "Always," "Usually," "Sometimes," "Never")
- It is permissible for patients to be asked about their hospital experience during their hospital stay or during discharge calls where this is a normal part of clinical rounds, leadership rounds, or patient treatment/care activities
- Patient-initiated or hospital-initiated (including the hospital's agents) contact, comment, response, or communication, whether before, during or after the hospital stay, must not influence the likelihood of a patient receiving the HCAHPS Survey
- The following are examples of the types of questions that are **NOT** permissible:
  - "Did the nurses always answer your questions?"
  - "On a scale of 0 to 10, how would you rate your hospital stay?"
  - "Is there a way we could always….?"

- "Did your doctor/nurse explain things in a way you could understand?"
- "Overall, how would you rate the care you received from your doctors/nurses?"

➢ Alternative questions that would not violate HCAHPS protocols include:
- "Are the nurses answering your questions?"
- "Please share with us how we could improve your hospital stay."
- "Tell us about your stay."
- "Did your doctor/nurse address any communication barriers regarding information about your healthcare?"
- "Was our staff attentive to your needs?"

The HCAHPS Survey should be administered prior to any other inpatient survey. As noted above, it is permissible for patients to be asked about their hospital experience during their hospital stay when the focus is on the clinical care of the individual patient. The hospital or its agents must not seek to influence which patients receive the HCAHPS Survey or how patients answer HCAHPS Survey items. For additional guidance in the use of HCAHPS in conjunction with other inpatient surveys refer to *HCAHPS Bulletin Number 2009-01 Revised* which is posted on the HCAHPS Web site (https://www.hcahpsonline.org/en/quality-assurance/) and Appendix Z.

While the over-riding goal of CMS is to minimize survey burden and prevent introducing potential bias to the HCAHPS Survey responses, on occasion CMS may initiate and implement projects or studies to investigate and improve the healthcare of patients. If a hospital accepts an offer to participate in another CMS or CMS-sponsored project that includes an inpatient survey which may contravene HCAHPS, the hospital must file an Exception Request to alert and inform the HCAHPS Project Team of its participation (see the *Exception Request/Discrepancy Report Processes* chapter).

Communicating with Patients about the HCAHPS Survey

HCAHPS guidelines allow hospitals/survey vendors to communicate about the HCAHPS Survey before or at discharge; for example, hospitals may inform patients that they may receive this survey after discharge asking about their stay in the hospital. Patients should be encouraged to complete the survey and share their experiences during the hospital stay. Hospitals may use posters or other written communications to notify patients that they may receive a survey and to promote participation in the survey. However, certain types of communications (oral, written or in the HCAHPS Survey materials, e.g., cover letters and telephone/IVR scripts) are not permitted because they may introduce bias in the survey results. For instance, hospitals/survey vendors or their agents are not allowed to:

- ➢ ask any HCAHPS or HCAHPS-like questions of patients prior to administration of the survey after discharge
- ➢ attempt to influence or encourage patients to answer HCAHPS questions in a particular way
- ➢ wear buttons or display signage denoting "Always" or "10"
- ➢ imply that the hospital, its personnel or agents will be rewarded or gain benefits for positive feedback from patients by asking patients to choose certain responses, or indicate that the hospital is hoping for a given response, such as a "10," "Definitely yes," or an "Always"

- ask patients to explain why he or she chose their specific response; for example, it is not acceptable to ask patients why they indicated that they would not recommend the hospital to friends and family
- indicate that the hospital's goal is for all patients to rate them as a "10," "Definitely yes," or an "Always"
- offer incentives of any kind for participation in the survey
- show or provide the HCAHPS Survey or cover letters to patients while they are in the hospital or at any time prior to the administration of the survey
- mail any pre-notification letters or postcards informing patients about the HCAHPS Survey; however, it is permissible to notify the patient while in the hospital or at discharge that they may receive the survey after discharge

Other Communications with Patients

When communicating with patients while in the hospital regarding their healthcare, hospitals/survey vendors should take care to avoid introducing bias in the way a patient may answer questions on the HCAHPS Survey. Many of the guidelines above in the *Use of HCAHPS with Other Hospital Inpatient Surveys* and *Communicating with Patients about the HCAHPS Survey* sections apply to general communications with patients.

- Examples of statements that **comply** with HCAHPS protocols include:
  - "We are looking for ways to improve your stay. Please share your comments with us."
  - "What can we do to improve your care?"
  - "We want to hear from you, please share your experience with us."
  - "Please let us know if you have any questions about your treatment plan."
  - "Let us know if your room is not comfortable."
- Hospitals/Survey vendors or their agents should **not**:
  - Wear buttons, stickers, etc. that state "Always" or "10."
  - Emphasize HCAHPS response options in posters, white boards, rounding questions, in room television, or other media accessible to patients:
    - "We expect to be the best hospital possible."
    - "Our goal is to always address your needs."
    - "Let us know if we are not listening carefully to you."
    - "We treat our patients with courtesy and respect."
    - "In order to provide the best possible care, please tell us how we can always…"
    - "Our doctors and nurses always listen carefully to you."
    - "We want to always explain things to you in a way you can understand."
    - "We want you to recommend us to family and friends."

Roles and Responsibilities

The following content clarifies the roles and responsibilities of participating organizations.

CMS Roles and Responsibilities

CMS supports the standardization of the survey administration and data collection methodologies for measuring and publicly reporting patients' perspectives on hospital care as follows:

- Provide HCAHPS Survey administration protocols through the *Quality Assurance Guidelines*
- Train hospitals/survey vendors to administer the HCAHPS Survey

- Provide technical assistance via HCAHPS Information and Technical Support and distribute information about survey administration procedures and policy updates on the HCAHPS Web site (https://www.hcahpsonline.org)
- Process data files submitted by hospitals/survey vendors
- Calculate and adjust HCAHPS data for mode and patient-mix effects prior to public reporting
- Generate preview reports containing HCAHPS Survey results for participating hospitals prior to public reporting
- Report HCAHPS Survey results publicly on Care Compare (https://www.medicare.gov/care-compare/)
- Provide quality oversight to ensure that the HCAHPS Survey is credible, useful and practical to allow for valid comparisons to be made across hospitals

Hospital Roles and Responsibilities

Since FY 2008, as part of the Hospital Inpatient Quality Reporting Program (formerly known as Reporting Hospital Quality Data Annual Payment Update [RHQDAPU] program), hospitals that are subject to IPPS payment provisions must collect and submit HCAHPS data in order to receive their full APU. IPPS hospitals that fail to report the required quality measures, which include the HCAHPS Survey, may receive an APU that is reduced. Non-IPPS hospitals, such as Critical Access Hospitals, may voluntarily participate in HCAHPS.

Note: IPPS Hospitals with zero eligible HCAHPS patient discharges ("zero cases") must submit monthly or quarterly, an HCAHPS Header Record (Survey Month Data) online via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal. Please visit the HCAHPS Web site for more details or contact HCAHPS Information and Technical Support for more information.

Note: IPPS Hospitals with five or fewer eligible HCAHPS patient discharges in a month may choose not to survey those patients for that given month. If patients are not surveyed, an HCAHPS Header Record (Survey Month Data) will still need to be submitted online via the HQR system (https://hqr.cms.gov/). Please visit the HCAHPS Web site for more details or contact HCAHPS Information and Technical Support for more information.

Note: The zero cases and five or fewer eligible HCAHPS patient discharges submission protocols must not be used when hospitals or survey vendors missed surveying eligible patients, such as when hospitals do not submit discharge lists for the month to their survey vendor in a timely manner. In instances such as this, a Discrepancy Report must be completed and submitted.

Hospitals should monitor the HCAHPS Web site (https://www.hcahpsonline.org), as well as the HQR system (https://hqr.cms.gov/), for program updates, information and announcements regarding the completion/submission of required notice of participation and/or pledge forms.

Hospitals must ensure that their communications with patients do not violate HCAHPS requirements with regard to attempting to influence the way a patient might respond to the HCAHPS Survey. In particular, hospitals must not use HCAHPS wording and/or response categories in their communication with patients.

In addition, hospitals are responsible for ensuring the confidentiality of patients responding to the survey. While the data from HCAHPS may be used for quality improvement purposes, the patient's identity should not be shared with direct care staff.

CMS provides the HCAHPS Survey in several languages. In the FY 2014 IPPS Final Rule, CMS strongly encourages hospitals with significant patient populations that speak any of the official HCAHPS languages (Spanish, Chinese, Russian, Vietnamese, Portuguese, and/or German) to offer the HCAHPS Survey in these languages. Only the official translations of the HCAHPS Survey instrument are permitted for HCAHPS Survey administration.

Hospitals participating in HCAHPS have the following options for conducting the survey: (1) contract with an approved HCAHPS Survey vendor; (2) self-administer their own HCAHPS Survey, provided they meet the Program Requirements (Rules of Participation and Minimum Survey Requirements); or (3) administer the survey for multiple sites, provided they meet the Program Requirements (Rules of Participation and Minimum Survey Requirements).

Hospital Contracting with a Survey Vendor to Conduct HCAHPS

- Contract with an HCAHPS-approved Survey Vendor or Hospital Administering Surveys for Multiple Sites (hospitals acting as a survey vendor) to conduct HCAHPS Surveys
- Provide a primary and secondary (backup) HCAHPS contact person to HCAHPS-approved Survey Vendor (strongly recommended)
- Ascertain from the survey vendor the date the patient discharge list must be received. If a hospital excludes patients from the discharge list, then they must submit the total number of inpatient discharges in the month and a count of patients by exclusion category to the survey vendor, at a minimum on a monthly basis. Survey vendors set deadlines independently based on many factors, including survey administration timelines, due date for data file submission, and time they need to draw the random sample and generate the data file.
- Deliver the patient discharge list to their survey vendor by their specified date and according to the specified file layout, which allows the survey vendor to administer the survey and submit data files to the HQR system (https://hqr.cms.gov/) by the data submission deadline
    - As noted in the FY 2014 IPPS Final Rule, hospitals must provide the administrative data that is required for HCAHPS in a timely manner to their survey vendor. This includes the patient MS-DRG code at discharge, or alternative information that can be used to determine the patient's service line.
        - Hospitals are strongly encouraged to submit their entire patient discharge list to their survey vendor, excluding patients who had requested "no publicity" status or who are excluded because of State regulations

Note: If the hospital is unable to provide the patient discharge list by the survey vendor's specified date, the survey vendor may not be able to proceed with survey administration for that hospital according to the HCAHPS timeline. As a result, the hospital's HCAHPS scores may not be publicly reported, which could affect the hospital's APU for the fiscal year.

- Strive to obtain 300 completed surveys in a 12-month period when there are sufficient eligible discharges from the hospital

  Note: In the FY 2014 IPPS Final Rule, CMS stated that hospitals paid under the IPPS system must submit at least 300 completed HCAHPS Surveys in a rolling four-quarter period. The absence of a sufficient number of HCAHPS-eligible patient discharges is the only acceptable reason for submitting fewer than 300 completed surveys.

- Authorize the survey vendor or hospital acting as a survey vendor to submit data via the HQR system (https://hqr.cms.gov/) on the hospital's behalf
- Review the HCAHPS Warehouse Feedback Reports to verify that the survey vendor has submitted the data accurately and on time. These reports include: HCAHPS Warehouse Provider Survey Status Summary Report, HCAHPS Warehouse Data Submission Detail Report and Hospital IQR Reporting – Provider Participation Report.
- Review the HCAHPS Submission Results Report (formerly the Review and Correction Report)
- Preview HCAHPS results prior to public reporting

Hospital Self-administering HCAHPS

The FY 2014 IPPS Final Rule codified HCAHPS Self-administering Hospital compliance with CMS oversight activities:

- "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." *Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations, Section. 412.140*

In addition, hospitals self-administering HCAHPS are subject to the following requirements:

- Complete the Participation Form for Hospitals Self-administering Survey and become approved to administer the HCAHPS Survey
- Follow the Rules of Participation to administer the HCAHPS Survey
- Comply with all requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security and Privacy Rules in conducting all survey administration and data collection processes
  - https://www.hhs.gov/HIPAA/
- Meet all HCAHPS due dates (including submission of Quality Assurance Plans and survey materials for review) or risk revocation of approval to administer the HCAHPS Survey
- Have appropriate organizational back-up staff for coverage of key staff to administer the HCAHPS Survey
- Sample patients according to the sampling protocols contained in the *Quality Assurance Guidelines V16.0*
- Strive to obtain 300 completed surveys in a 12-month period when there are sufficient eligible discharges from the hospital

  Note: In the FY 2014 IPPS Final Rule, CMS stated that hospitals paid under the IPPS system must submit at least 300 completed HCAHPS Surveys in a rolling four-quarter

period. The absence of a sufficient number of HCAHPS-eligible patient discharges is the only acceptable reason for submitting fewer than 300 completed surveys.

- When updated patient information is received, prior to data submission, the hospital should update all patient administrative information available. In addition, the hospital must perform quality checks to review and verify changes from the original list.
- Administer the HCAHPS Survey and oversee the quality of work of staff and subcontractors, if applicable, according to protocols contained in the *Quality Assurance Guidelines V16.0*
- Submit data files to the HQR system (https://hqr.cms.gov/) in accordance with the required survey file layouts by the data submission deadline
- Review HCAHPS Data Submission Reports and HCAHPS Warehouse Feedback Reports and confirm successful upload of the hospital's data files to the HQR system (https://hqr.cms.gov/)
- Review the HCAHPS Submission Results Report (formerly the Review and Correction Report)
- Preview HCAHPS results prior to public reporting
- Perform quality checks of all survey administration processes
- Assign appropriate back-up responsibilities within organization for coverage of key staff
- Hospitals conducting Telephone Only and Mixed Modes of survey administration should use telephone interviewers who do not know patients either professionally or personally
- Complete and submit an annual Attestation Statement by the due date specified during HCAHPS training and posted on the HCAHPS Web site (https://www.hcahpsonline.org)

Note: If a hospital self-administering the HCAHPS Survey is non-compliant with program requirements, the hospital's HCAHPS results may not be publicly reported, which could affect the hospital's APU for the fiscal year. In addition, the hospital may lose their approved HCAHPS Survey administration status.

Hospital Administering HCAHPS for Multiple Sites

In the FY 2014 IPPS Final Rule, CMS codified requirements for Hospital Administering HCAHPS for Multiple Sites (also referred to as an HCAHPS Survey vendor). These requirements are listed below:

- "CMS approves an application for an entity to administer the HCAHPS Survey as an approved HCAHPS Survey vendor on behalf of one or more hospitals when an applicant has met the Minimum Survey Requirements and Rules of Participation that can be found on the official HCAHPS Online Web site, and agrees to comply with the current survey administration protocols that can be found on the official HCAHPS Online Web site. An entity must be an approved HCAHPS Survey vendor in order to administer and submit HCAHPS data to CMS on behalf of one or more hospitals." *Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations, Section. 412.140*

The FY 2014 IPPS Final Rule also codified Hospital Administering HCAHPS for Multiple Sites compliance with CMS oversight activities:

- "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." *Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations, Section. 412.140*

In addition, Hospitals Administering HCAHPS for Multiple Sites are subject to the following requirements:

- Complete the Participation Form for Hospitals Administering HCAHPS for Multiple Sites and become approved to administer the HCAHPS Survey
- Follow the Rules of Participation to administer the HCAHPS Survey

  Note: A hospital that administers the HCAHPS Survey for more than one site is considered a survey vendor and must adhere to the Program Requirements stated for survey vendors.

- Comply with all requirements of the HIPAA Security and Privacy Rules in conducting all survey administration and data collection processes
  - https://www.hhs.gov/HIPAA/
- Meet all HCAHPS due dates (including submission of Quality Assurance Plans and survey materials for review) or risk revocation of approval to administer the HCAHPS Survey
- Have appropriate organizational back-up staff for coverage of key staff to administer the HCAHPS Survey
- Receive and perform checks of the patient discharge list and create the sample frame to verify that it includes the entire eligible population and all required data elements
- When updated discharge lists are received, prior to data submission, the hospital administering HCAHPS for Multiple Sites should update all patient administrative information available. In addition, the hospital administering HCAHPS for Multiple Sites must perform quality checks to review and verify changes from the original discharge lists.

  Note: If a hospital client excludes patients from the discharge list, then the hospital must submit a count of patients by each exclusion category to the Hospital Administering HCAHPS for Multiple Sites at a minimum on a monthly basis.

- Sample patients according to the sampling protocols contained in the *Quality Assurance Guidelines V16.0*
- Administer the HCAHPS Survey and oversee the quality of work of staff and subcontractors, if applicable, according to the protocols contained in the *Quality Assurance Guidelines V16.0*
- Obtain a primary and secondary (backup) HCAHPS contact person from each client hospital (strongly recommended)
- Verify that each hospital client has authorized the Hospital Administering HCAHPS for Multiple Sites to submit data on the hospital's behalf
- Request client hospitals grant their survey vendor access to the HCAHPS Warehouse Feedback Reports
- Submit data files to the HQR system (https://hqr.cms.gov/) in accordance with the required survey file layouts by the data submission deadline

- Review HCAHPS Data Submission Reports, for client hospital(s), and confirm successful upload of client hospitals' data files to the HQR system (https://hqr.cms.gov/)
- Review the HCAHPS Submission Results Report (formerly the Review and Correction Report)
- Perform quality checks of all survey administration processes
- Assign appropriate back-up responsibilities within organization for coverage of key staff
- Hospitals Administering HCAHPS for Multiple Sites conducting Telephone Only and Mixed Modes of survey administration should use telephone interviewers who do not know patients either professionally or personally
- Complete and submit an annual Attestation Statement by the due date specified during HCAHPS training and posted on the HCAHPS Web site (https://www.hcahpsonline.org)

Note: If a Hospital Administering HCAHPS for Multiple Sites is non-compliant with program requirements for any of their contracted hospitals, the contracted hospital's HCAHPS results may not be publicly reported, which could affect the hospital's Annual Payment Update (APU) for that fiscal year. In addition, approved Hospitals Administering HCAHPS for Multiple Sites that are non-compliant with HCAHPS protocols may lose their approved HCAHPS Survey administration status.

Survey Vendor Roles and Responsibilities

In the FY 2014 IPPS Final Rule, CMS codified requirements for HCAHPS Survey vendors. These requirements are listed below:

- "CMS approves an application for an entity to administer the HCAHPS Survey as an approved HCAHPS Survey vendor on behalf of one or more hospitals when an applicant has met the Minimum Survey Requirements and Rules of Participation that can be found on the official HCAHPS Online Web site, and agrees to comply with the current survey administration protocols that can be found on the official HCAHPS Online Web site. An entity must be an approved HCAHPS Survey vendor in order to administer and submit HCAHPS data to CMS on behalf of one or more hospitals." *Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations, Section. 412.140*

The FY 2014 IPPS Final Rule also codified HCAHPS Survey vendor compliance with CMS oversight activities:

- "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." *Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations, Section. 412.140*

In addition, HCAHPS Survey vendors are subject to the following requirements:

- Complete the Participation Form for Survey Vendor and become approved to administer the HCAHPS Survey
- Follow the Rules of Participation to administer the HCAHPS Survey
- Comply with all requirements of the HIPAA Security and Privacy Rules in conducting all survey administration and data collection processes
  - https://www.hhs.gov/HIPAA/

- Meet all HCAHPS due dates (including submission of Quality Assurance Plans and survey materials for review) or risk revocation of approval to administer the HCAHPS Survey
- Have appropriate organizational back-up staff for coverage of key staff to administer the HCAHPS Survey
- Receive and perform checks of the patient discharge list and create the sample frame to verify that it includes the entire eligible population and all required data elements
- When updated discharge lists are received, prior to data submission, the survey vendor should update all patient administrative information available. In addition, the survey vendor must perform quality checks to review and verify changes from the original discharge lists.

  Note: If a hospital client excludes patients from the discharge list, then the hospital must submit a count of patients by each exclusion category to the survey vendor at a minimum on a monthly basis.

- Sample patients according to the sampling protocols contained in the *Quality Assurance Guidelines V16.0*
- Administer the HCAHPS Survey and oversee the quality of work of staff and subcontractors, if applicable, according to protocols contained in the *Quality Assurance Guidelines V16.0*
- Obtain a primary and secondary (backup) HCAHPS contact person from each client hospital (strongly recommended)
- Verify that each hospital client has authorized the survey vendor to submit data on the hospital's behalf
- Request that client hospitals grant their survey vendor access to the HCAHPS Warehouse Feedback Reports
- Submit data files to the HQR system (https://hqr.cms.gov/) in accordance with the survey file layouts by the data submission deadline
- Review HCAHPS Data Submission Reports for client hospital(s) and confirm successful upload of client hospitals' data files to the HQR system (https://hqr.cms.gov/)
- Review the HCAHPS Submission Results Report (formerly the Review and Correction Report)
- Perform quality checks of all survey administration processes
- Assign appropriate back-up responsibilities to organizational staff for coverage of key staff
- Maintain active contract(s) with client hospital(s) in order to retain approval status (see Minimum Business Requirements)
- Survey vendors conducting Telephone Only and Mixed Modes of survey administration should use telephone interviewers who do not know patients either professionally or personally
- Complete and submit an annual Attestation Statement by the due date specified during HCAHPS training and posted on the HCAHPS Web site (https://www.hcahpsonline.org)

Note: If a survey vendor is non-compliant with program requirements for any of their contracted hospitals, the contracted hospital's HCAHPS results may not be publicly reported, which could affect the hospital's Annual Payment Update (APU) for that fiscal year. In addition, approved

survey vendors that are non-compliant with HCAHPS protocols may lose their approved HCAHPS Survey administration status.

Hospital/Survey Vendor HCAHPS Rules of Participation

Hospitals/Survey vendors agree to the following Rules of Participation as found in the HCAHPS Participation Forms:

- **Participate in HCAHPS Trainings**
  Hospitals/Survey vendors that intend to administer the survey must participate in the Introduction to HCAHPS Training and subsequent HCAHPS Update Training sessions sponsored by CMS. At a minimum, the hospital's/survey vendor's Project Manager must participate in the HCAHPS training sessions. **Subcontractors and any other organization(s) that are responsible for major functions of HCAHPS Survey administration (e.g., mail/telephone/IVR, XML file preparation) must participate in HCAHPS training.** Hospitals contracting with a survey vendor or another hospital for survey administration do not need to participate in training, but are encouraged to do so.
  - **Introduction to HCAHPS Training**
    Hospitals/Survey vendors that have not participated in prior HCAHPS trainings are required to participate in the Introduction to HCAHPS Training and must complete and submit the HCAHPS Training Attestation Statement Form. New Project Managers must participate in the Introduction to HCAHPS Training. In addition, organizations already approved to administer the HCAHPS Survey may be required to participate in the HCAHPS Introduction Training if requested to do so by the HCAHPS Project Team.
  - **HCAHPS Update Training**
    Hospitals/Survey vendors that continue to be approved to administer the HCAHPS Survey must participate in HCAHPS Update Training via Webinar. Please monitor the HCAHPS Web site for posted updates and announcements.
- **Submit Participation Form**
  After completing the Introduction to HCAHPS Training, new hospitals/survey vendors must complete and submit a Participation Form online within the designated open participation time period. Participation Forms are available on the HCAHPS Web site (https://www.hcahpsonline.org).

  Note: Approval of the hospitals'/survey vendors' participation status to administer the HCAHPS Survey is contingent upon successful completion of teleconference call(s) with the HCAHPS Project Team to discuss relevant survey experience, organizational survey capability and capacity, and quality control procedures; in addition to acceptance of a Quality Assurance Plan (QAP). Approved hospitals/survey vendors who are non-compliant with HCAHPS protocols may lose their approved HCAHPS Survey administration status.

  - **Changes to Participation Form**
    A hospital/survey vendor that elects to change or add an approved mode of survey administration must promptly submit an updated Participation Form requesting approval.

    Note: Survey mode can only be changed at the beginning of a quarter.

- **Change in Participation Status**
  - **Contract with Survey Vendor**
    A self-administering hospital may elect to change its participation status to contract with an approved HCAHPS Survey vendor. This change can only take effect at the beginning of a quarter. Both the hospital and survey vendor must notify the HCAHPS Project Team of the change via email. The hospital must authorize the survey vendor, via the Hospital Quality Reporting (HQR) system, to submit data on the hospital's behalf; see the HQR system Web site (https://hqr.cms.gov/) for details.
  - **Elect to Self-administer**
    A hospital that previously contracted with a survey vendor may elect to change its participation status to self-administer the HCAHPS Survey. This change can only take effect at the beginning of a quarter. In order to be eligible to self-administer the HCAHPS Survey, a hospital must take the following steps:
    1. Participate in the Introduction to HCAHPS Training and all subsequent HCAHPS Update Trainings
    2. Meet the HCAHPS Minimum Survey Requirements for Self-administering Hospitals
    3. Submit a Participation Form for Self-administering Hospitals and be approved to administer the HCAHPS Survey
    4. De-authorize the survey vendor from submitting data in the HQR system (https://hqr.cms.gov/)

Note: A hospital/survey vendor must immediately notify the HCAHPS Project Team of changes in its contact person or key staff and organizational structure (i.e., changes in ownership, name, and address) via email at hcahps@hsag.com.

- **Participate in an HCAHPS Dry Run (Voluntary)**
  A short "dry run" of the survey is strongly recommended for newly approved self-administering hospitals and survey vendors to become familiar with the survey and its implementation protocols prior to the official start of HCAHPS Survey administration. Dry runs are planned for the last month of each quarter (i.e., March, June, September, and January). The dry run will give hospitals/survey vendors the opportunity to gain first-hand experience collecting and transmitting "real" HCAHPS data without the public reporting of HCAHPS results. Using the official survey instrument and the approved modes of administration and data collection protocols, hospitals/survey vendors will collect "real" HCAHPS data and submit the data to the HQR system (https://hqr.cms.gov/). Data submitted for the dry run will not be publicly reported. The hospital/survey vendor must notify the HCAHPS Project Team via email of their intent to submit data as a dry run.
- **Review and Follow the HCAHPS *Quality Assurance Guidelines V16.0* and Policy Updates**
  The *Quality Assurance Guidelines V16.0* manual has been developed to assure the continued standardization of the survey data collection process and the comparability of reported data. Hospitals/Survey vendors must review and follow the HCAHPS *Quality Assurance Guidelines V16.0*. In addition, hospitals/survey vendors must follow all policy

updates, including *HCAHPS Bulletins*, posted on the HCAHPS Web site (https://www.hcahpsonline.org).

- **Attest to the Accuracy of the Organization's Data Collection Process**
  The hospital/survey vendor must review and attest (as determined by CMS) to the accuracy of the organization's data collection process and its conformance with the HCAHPS *Quality Assurance Guidelines V16.0*.

  Note: Hospitals/Survey vendors are responsible for sampling and data submission. Therefore, these processes cannot be subcontracted.

  Any variations from the survey administration protocols (except those that have been pre-approved by CMS through the Exception Request process) will be reviewed by CMS. CMS may determine that data collected in a non-approved manner may not be publicly reported.
- **Develop Hospital/Survey Vendor HCAHPS Quality Assurance Plan (QAP)**
  Hospitals/Survey vendors must develop a QAP for survey administration in accordance with the HCAHPS *Quality Assurance Guidelines V16.0* and update the QAP as part of their participation status. The QAP Outline document (see Appendix S) provides guidelines for developing the QAP. The QAP must be updated annually and as necessary, to reflect changes in key personnel, resources and processes. The QAP must include the following:
  - Organizational background and structure for the project
  - Work plan for survey administration
  - Role of subcontractor(s) and any other organization(s) that are responsible for major HCAHPS Survey administration functions (e.g., mail/telephone/IVR operations, XML file preparation), if applicable
  - Survey and data management system
  - Quality controls for survey administration activities
  - Confidentiality, privacy and security procedures in accordance with HIPAA
  - Annual reporting of the results from quality control activities
  - HCAHPS Survey materials

  *Note: The HCAHPS Project Team's acceptance of a submitted QAP and corresponding survey materials **does not** constitute or imply approval or endorsement of the hospital's/survey vendor's HCAHPS Survey processes. Additionally, any materials submitted with the QAP (e.g., questionnaires, cover letters, tracking forms, etc.) must be templates and **must not** contain any patient protected health information (PHI).*

  Upon request, each hospital/survey vendor must submit their QAP and materials relevant to that year's HCAHPS Survey administration (as determined by CMS), including mailing materials (questionnaires, cover letters and outgoing/return envelopes) and/or telephone/IVR scripts (including screen shots and skip pattern logic, if applicable) to hcahps@hsag.com for review by the HCAHPS Project Team.
- **Become a Hospital Quality Reporting (HQR) System Registered User**
  Hospitals/Survey vendors must submit HCAHPS Survey data electronically via the HQR system (https://hqr.cms.gov/) using the prescribed file specifications. All hospitals/survey vendors participating in HCAHPS must be registered users of the HQR system. In addition,

hospitals contracting with a survey vendor must be registered users of the HQR system and must authorize the survey vendor to submit data on their behalf via the HQR system.

- **Participate in Oversight Activities Conducted by the HCAHPS Project Team**
  Hospitals/Survey vendors, including subcontractors, must be prepared to participate in all on-site or off-site oversight activities, such as on-site visits and/or teleconference calls, as requested by the HCAHPS Project Team, to confirm that correct survey protocols are followed. ***Failure to comply with oversight activities may result in the revocation of approval to administer the HCAHPS Survey.*** All materials relevant to survey administration are subject to review. Non-compliance with HCAHPS program requirements (including, but not limited to, participation and cooperation in oversight activities), may result in the hospital's HCAHPS scores not being publicly reported, which could affect the hospital's APU, and/or other sanctions (see the *Oversight Activities* chapter for more information on non-compliance and sanctions).
  - All data files must be traceable throughout the entire HCAHPS Survey administration process, from receipt of the patient discharge list through data submission. All files must be made available for review during HCAHPS oversight activities such as on-site visits and/or teleconference calls. The process to review these files must be transparent and easily reproducible.
- **Review and Acknowledge Agreement with the Rules of Participation**
  Hospitals/Survey vendors must review and agree to the Rules of Participation in order for their HCAHPS results to be publicly reported on Care Compare (https://www.medicare.gov/care-compare/).

Hospital/Survey Vendor HCAHPS Minimum Survey Requirements to Administer the HCAHPS Survey (Minimum Business Requirements)

An entity must be approved by CMS in order to administer the HCAHPS Survey and submit HCAHPS data to the HCAHPS Data Warehouse. A hospital self-administering the HCAHPS Survey must meet **ALL** of the Self-administering Hospital Minimum Survey Requirements, and a survey vendor or a hospital administering the HCAHPS Survey for multiple sites or their subcontractor(s) must meet **ALL** of the Survey Vendor Minimum Survey Requirements. In addition, subcontractor(s) or other organization(s) performing major HCAHPS Survey administration functions (e.g., mail/telephone/IVR operations, XML file preparation) must also meet **ALL** of the HCAHPS Minimum Survey Requirements which pertain to that role.

In reviewing Participation Forms from potential HCAHPS Survey vendors, the HCAHPS Project Team will take into consideration any prior experience the applicant organization and/or subcontractor(s) may have with administering CMS-sponsored CAHPS Surveys. Applicants must demonstrate their recent survey experience (i.e., provide documentation of meeting survey experience requirements).

The HCAHPS Minimum Business Requirements will continually apply to all HCAHPS approved self-administering hospitals/survey vendors/multi-site hospitals for as long as the organization maintains the HCAHPS approval status. This includes maintaining the adequate number of resources (e.g., staffing, system resources, etc.) in order to fully comply with HCAHPS protocols, deadlines and HCAHPS Project Team requests.

- Approved HCAHPS Survey vendors **and** self-administering hospitals must fully comply with the HCAHPS oversight activities
  - The FY 2014 IPPS Final Rule states: "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." *Federal Register / Vol. 78, No. 160 / Monday, August 19, 2013 / Rules and Regulations, Section. 412.140*
  - In order for the HCAHPS Project Team to perform the required oversight activities, organizations that are approved to administer the HCAHPS Survey must conduct all of their business operations within the United States. This requirement applies to all staff and subcontractors or other organizations (if applicable).
- Approved survey vendors are expected to maintain active contract(s) for HCAHPS Survey administration with client hospital(s). An "active contract" is one in which the HCAHPS Survey vendor is authorized by one or more hospital client(s) to submit HCAHPS data to the HCAHPS Data Warehouse. If an HCAHPS Survey vendor does not have any contracted client hospitals for HCAHPS within two years (a consecutive 24 months) from the date it received approval to administer the HCAHPS Survey, then that survey vendor's "Approved" status for HCAHPS Survey administration will be withdrawn. The HCAHPS "Approved" survey vendor has the option to apply for re-approval prior to the expiration deadline.
  - The first step is to participate in the Introduction to HCAHPS Training. After training is completed, a Participation Form must be submitted for consideration of approval. All Minimum Business Requirements (MBRs) must continue to be met, along with participation in required HCAHPS training sessions in order to be eligible for reconsideration.
  - If the organization is approved to administer the HCAHPS Survey for a second term, and no hospital client(s) are obtained within two years (a consecutive 24 months), then the survey vendor's "Approved" status for HCAHPS Survey administration will be withdrawn. A 24-month wait period will be required before the organization is eligible to apply again. All first time survey vendors have 24 months from the date of conditional approval to obtain a hospital client.
  - If approval status is withdrawn (i.e., not seeking re-approval for second term), a 24-month wait period will be required before the organization is eligible to apply again

Note: If a self-administering hospital or a survey vendor is non-compliant with program requirements, HCAHPS data may not be publicly reported for the hospital (or contracted hospitals), which could affect that hospital's CMS Annual Payment Update (APU) for the fiscal year. For additional information regarding APU requirements, please review the current IPPS Final Rule.

The minimum survey requirements for the organization are as follows:

1. **Relevant Survey Experience**
   Demonstrated **recent** continuous experience in fielding patient-specific surveys in the requested mode (i.e., Mail, and/or Telephone, and/or Mixed Mode, and/or IVR).

Criteria	Requirement	
	Self-administering Hospital	**Survey Vendor/Multi-site**
Patient-Specific Survey Experience	➢ Minimum of two continuous years Mail, and/or Telephone, and/or Mixed Mode, and/or IVR patient-specific survey experience for the most recent two-year time period ➢ Prior experience in conducting surveys in both English and Spanish (preferred)	➢ Minimum of three continuous years Mail, and/or Telephone, and/or Mixed Mode, and/or IVR patient-specific survey experience for the most recent three-year time period ➢ Prior experience in conducting surveys in both English and Spanish (preferred)
Number of Years in Business	➢ Minimum three years	➢ Minimum four years
Sampling Experience ***Note: Hospitals/Survey vendors are responsible for conducting the sampling process and must not subcontract this activity.***	➢ One year prior experience selecting random sample based on specific eligibility criteria within the most recent one-year time period	➢ Two years prior experience selecting random sample based on specific eligibility criteria within the most recent two-year time period ➢ Work with contracted client hospital(s) to obtain patient data for sampling via HIPAA-compliant electronic data transfer processes ➢ Adequately document sampling process

2. Organizational Survey Capacity

Capability and capacity to handle a required volume of mail questionnaires and/or conduct standardized telephone and/or IVR interviewing in specified time frame.

Criteria	Requirement	
	Self–administering Hospital	**Survey Vendor/Multi-site**
Personnel ***Note: Volunteers are not permitted to be involved in any aspect of the HCAHPS Survey administration process.***	➢ Designated HCAHPS Project Manager with minimum one year prior experience conducting patient-specific surveys in the requested mode ➢ Have appropriate organizational back-up staff for coverage of key staff	➢ Designated HCAHPS personnel: • Project Manager with minimum two years prior experience conducting patient-specific surveys in the requested mode • Staff with minimum one year prior experience in sample frame development and sample selection • Programmer (subcontractor designee, if applicable) with minimum one year prior experience processing data and preparing data files • Call Center/Mail Center Supervisor (subcontractor designee, if applicable) with minimum one year prior experience in role ➢ Have appropriate organizational back-up staff for coverage of key staff

Criteria	Requirement	
	Self–administering Hospital	**Survey Vendor/Multi-site**
System Resources ***Note: All system resources are subject to oversight activities, including on-site visits to physical locations. In order for the HCAHPS Project Team to perform the required oversight activities, organizations that are approved to administer the HCAHPS Survey must conduct all of their business operations within the United States. This requirement applies to all staff and subcontractors.***	➢ Physical plant resources available to handle the volume of surveys being administered ➢ A systematic process to: • track fielded surveys throughout the protocol, avoiding respondent burden and losing respondents • assign random, unique, de-identified patient identification number (Patient ID) to track each sampled patient	➢ Physical plant resources available to handle the volume of surveys being administered, including computer and technical equipment ➢ Electronic or alternative survey management system to: • track fielded surveys throughout the protocol, avoiding respondent burden and losing respondents • assign random, unique, de-identified patient identification number (Patient ID) to track each sampled patient
Sample Frame Creation	➢ One year prior experience selecting sample based on specific eligibility criteria ➢ Generate the sample frame data file that contains all discharged patients who meet the eligible population criteria ➢ Draw sample of discharges for the survey, who meet the eligible population criteria	➢ Two years prior experience selecting sample based on specific eligibility criteria ➢ Generate the sample frame data file that contains all discharged patients who meet the eligible population criteria ➢ Draw sample of discharges for the survey, who meet the eligible population criteria
Mail Administration ***Note: Mail survey administration activities must not be conducted from a residence or non-business location.***	➢ Obtain and update addresses ➢ Produce and print survey instruments and materials; a sample of all mailing materials must be submitted for review ➢ Mail out of survey materials ➢ Process survey data (including key-entry or scanning) ➢ Track non-respondents for follow-up mailing	➢ Obtain and update addresses ➢ Produce and print survey instruments and materials; a sample of all mailing materials must be submitted for review ➢ Mail out of survey materials ➢ Process survey data (including key-entry or scanning) ➢ Track non-respondents for follow-up mailing

Criteria	Requirement	
	Self–administering Hospital	**Survey Vendor/Multi-site**
Telephone Administration ***Note: Telephone interviews/monitoring must not be conducted from a residence or non-business location, and cannot be conducted by staff that provide direct patient care.***	➢ Obtain and update all telephone numbers ➢ Collect telephone interview data for the survey; a sample of the telephone script and interviewer screen shots must be submitted for review ➢ Identify non-respondents for follow-up telephone calls ➢ Schedule and conduct callback appointments	➢ Obtain and update all telephone numbers ➢ Collect telephone interview data for the survey, using electronic or alternative interviewing system; a sample of the telephone script and interviewer screen shots must be submitted for review ➢ Identify non-respondents for follow-up telephone calls ➢ Schedule and conduct callback appointments
Mixed Mode Administration ***Note: Mail survey administration activities and telephone interviews/monitoring must not be conducted from a residence or non-business location, and cannot be conducted by staff that provide direct patient care.***	➢ See above referenced Mail Administration requirements ➢ See above referenced Telephone Administration requirements	➢ See above referenced Mail Administration requirements ➢ See above referenced Telephone Administration requirements
Active Interactive Voice Response (IVR) Administration ***Note: Telephone interviews/monitoring must not be conducted from a residence or non-business location, and cannot be conducted by staff that provide direct patient care.***	➢ Obtain and update telephone numbers ➢ Collect touch-tone keypad responses to pre-recorded questions; a sample of the IVR script must be submitted for review ➢ Identify non-respondents for follow-up telephone calls ➢ Ability to conduct telephone interview if respondent opts out of IVR ➢ Schedule and conduct callback appointments	➢ Obtain and update telephone numbers ➢ Collect touch-tone keypad responses to pre-recorded questions; a sample of the IVR script must be submitted for review ➢ Identify non-respondents for follow-up telephone calls ➢ Use electronic telephone or alternative interviewing system to collect telephone interview if respondent opts out of IVR ➢ Schedule and conduct callback appointments

Criteria	Requirement	
	Self–administering Hospital	**Survey Vendor/Multi-site**
Data Submission ***Note: Hospitals/Survey vendors are responsible for conducting data submission and must not subcontract this process.***	➢ One year prior experience transmitting data via secure methods (HIPAA-compliant) ➢ Registered user of the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/) ➢ Prepare final patient-level data files for submission ➢ Access and submit data electronically via the HQR system	➢ Two years prior experience transmitting data via secure methods (HIPAA-compliant) ➢ Registered user of the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/) ➢ Obtain the HQR system survey vendor authorization from contracted hospitals ➢ Prepare final patient-level data files for submission ➢ Access and submit data electronically via the HQR system
Data Security	➢ Take the following actions to secure electronic data: • Use a firewall and/or other mechanisms for preventing unauthorized access to the electronic files • Implement access levels and security passwords so that only authorized users have access to sensitive data • Implement daily data backup procedures that adequately safeguard system data • Test backup files at a minimum on a quarterly basis to make sure the files are easily retrievable and working • Perform frequent saves to media to minimize data losses in the event of power interruption	➢ Take the following actions to secure electronic data: • Use a firewall and/or other mechanisms for preventing unauthorized access to the electronic files • Implement access levels and security passwords so that only authorized users have access to sensitive data • Implement daily data backup procedures that adequately safeguard system data • Test backup files at a minimum on a quarterly basis to make sure the files are easily retrievable and working • Perform frequent saves to media to minimize data losses in the event of power interruption

Criteria	Requirement	
	Self–administering Hospital	**Survey Vendor/Multi-site**
	• Develop a disaster recovery plan for conducting ongoing business operations in the event of a disaster	• Develop a disaster recovery plan for conducting ongoing business operations in the event of a disaster
Data Retention and Storage	➢ Take the following actions to securely store all survey administration related data: • Store HCAHPS-related data files, including patient discharge files and de-identified electronic data files (e.g., HCAHPS Sample Frame, XML files, etc.), for all survey modes for a minimum of three years. Archived electronic data files must be easily retrievable. • Store returned mail questionnaires in a secure and environmentally safe location. Paper copies or optically scanned images of the questionnaires must be retained for a minimum of three years and be easily retrievable, when needed. • Destroy HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files in a secure and environmentally safe location. Obtain a certificate of the destruction of data.	➢ Take the following actions to securely store all survey administration related data: • Store HCAHPS-related data files, including patient discharge files and de-identified electronic data files (e.g., HCAHPS Sample Frame, XML files, etc.), for all survey modes for a minimum of three years. Archived electronic data files must be easily retrievable. • Store returned mail questionnaires in a secure and environmentally safe location. Paper copies or optically scanned images of the questionnaires must be retained for a minimum of three years and be easily retrievable, when needed. • Destroy HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files in a secure and environmentally safe location. Obtain a certificate of the destruction of data.

Criteria	Requirement	
	Self–administering Hospital	**Survey Vendor/Multi-site**
Technical Assistance/ Customer Support	➢ One year prior experience providing telephone customer support ➢ Provide customer support line	➢ Two years prior experience providing telephone customer support ➢ Provide toll-free customer support line
Organizational Confidentiality Requirements	➢ Develop confidentiality agreements which include language related to HIPAA regulations and the protection of patient information, and obtain signatures from all personnel with access to survey information, including staff and all subcontractors involved in survey administration and data collection ➢ Execute Business Associate Agreement(s) in accordance with HIPAA regulations ➢ Confirm that staff and subcontractors are compliant with HIPAA regulations in regard to patient protected health information (PHI) ➢ Establish protocols for secure file transmission. Emailing of PHI via unsecure email is prohibited.	➢ Develop confidentiality agreements which include language related to HIPAA regulations and the protection of patient information, and obtain signatures from all personnel with access to survey information, including staff and all subcontractors involved in survey administration and data collection ➢ Execute Business Associate Agreement(s) in accordance with HIPAA regulations ➢ Confirm that staff and subcontractors are compliant with HIPAA regulations in regard to patient protected health information (PHI) ➢ Establish protocols for secure file transmission. Emailing of PHI via unsecure email is prohibited.

3. Quality Control Procedures

Personnel training and quality control mechanisms employed to collect valid, reliable survey data and achieve at least 300 completed HCAHPS Surveys in a rolling four-quarter period.

Criteria	Requirement	
	Self-administering Hospital	**Survey Vendor/Multi-site**
Demonstrated Quality Control Procedures	➢ Established systems for conducting and documenting quality control activities including: • In-house training for staff and subcontractors involved in survey operations • Printing, mailing and recording receipt of survey information, if applicable • Telephone administration of survey, if applicable • IVR administration of survey, if applicable • Coding and editing or keying in survey data • Preparing final patient-level data files for submission • All other functions and processes that affect the administration of the HCAHPS Survey	➢ Established systems for conducting and documenting quality control activities including: • In-house training for staff and subcontractors involved in survey operations • Printing, mailing and recording receipt of survey information, if applicable • Telephone administration of survey, if applicable • IVR administration of survey, if applicable • Coding and editing or keying in survey data • Preparing final patient-level data files for submission • All other functions and processes that affect the administration of the HCAHPS Survey
Quality Assurance Plan (QAP) Documentation Requirements	➢ Develop a QAP for survey administration in accordance with the HCAHPS *Quality Assurance Guidelines* and update the QAP on an annual basis and at the time of process and/or key personnel changes as part of retaining participation status	➢ Develop a QAP for survey administration in accordance with the HCAHPS *Quality Assurance Guidelines* and update the QAP on an annual basis and at the time of process and/or key personnel changes as part of retaining participation status

Communications and Technical Support

Overview

Hospitals/Survey vendors have access to a number of sources of information regarding HCAHPS. These sources are listed below.

HCAHPS Information and Technical Assistance

For information and technical assistance, contact HCAHPS Information and Technical Support.

- Via email at hcahps@hsag.com
- Via telephone at 1-888-884-4007

When contacting the HCAHPS Project Team regarding a specific hospital, **be sure to provide** the following information in your email or telephone voice mail:

- Hospital six-digit CMS Certification Number (CCN)
- Hospital name

QualityNet Help Desk

For data submission upload issues via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal, and navigating the HQR system, please contact the QualityNet Help Desk.

- Via email at qnetsupport@hcqis.org
- Via telephone at 1-866-288-8912

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

Hospital Value-Based Purchasing (Hospital VBP)

For information pertaining to Hospital Value-Based Purchasing, please visit the CMS Web site.

- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html

For questions related to your hospital's Hospital Value-Based Purchasing Percentage Payment Report, please contact the QualityNet Help Desk.

- Via email at qnetsupport@hcqis.org
- Via telephone at 1-866-288-8912

General Information, Announcements and Updates

To learn more about HCAHPS and to view important new updates and announcements, please visit the HCAHPS Web site (https://www.hcahpsonline.org).

Survey Management

Overview

Hospitals/Survey vendors must establish a survey management process to administer the CAHPS Hospital Survey (HCAHPS). This chapter reviews content pertaining to system resources, location of survey operations, customer support lines, personnel training, monitoring and quality oversight, safeguarding patient confidentiality, data security, and data retention.

System Resources

Hospitals/Survey vendors must have physical plant resources available to handle the volume of surveys being administered, in addition to systematic processes that effectively track sampled patients' progress through the data collection protocol and patients' responses to the survey. All data files must be traceable throughout the entire HCAHPS Survey administration process, from receipt of the patient discharge list through data submission. System resources are subject to oversight activities including on-site visits to physical locations.

At a minimum, hospitals/survey vendors must have the following features/functionality in their survey system (see *Program Requirements* chapter):

Self-administering Hospital	Survey Vendor/Multi-site
➢ Physical plant resources available to handle the volume of surveys being administered ➢ A systematic process to: • track fielded surveys throughout the protocol, avoiding respondent burden and losing respondents • assign a random, unique, de-identified patient identification number (Patient ID) to track each sampled patient	➢ Physical plant resources available to handle the volume of surveys being administered; including computer and technical equipment ➢ Electronic or alternative survey management system to: • track fielded surveys throughout the protocol, avoiding respondent burden and losing respondents • assign a random, unique, de-identified patient identification number (Patient ID) to track each sampled patient

Hospitals/Survey vendors must thoroughly test all system resources prior to survey implementation and on an ongoing basis thereafter.

Location of Survey Operations

➢ Hospitals/Survey vendors and their subcontractor(s), if applicable, must perform work at their formal business address. Business locations must comply with all requirements of the HIPAA Security and Privacy Rules in conducting all survey administration and data collection processes. For more information, please visit: https://www.hhs.gov/HIPAA/.

Note: Mail survey administration activities and telephone interviews/monitoring must not be conducted from a residence or non-business location.

Customer Support Lines

Self-administering hospitals must establish customer support telephone lines, and survey vendors must establish toll-free customer support telephone lines, for callers who have questions about the HCAHPS Survey. Hospitals/Survey vendors conducting the Mail Only or Mixed Mode of survey administration must include contact information for their customer support telephone lines in the initial and follow-up cover letters. Hospitals/Survey vendors conducting Telephone Only or IVR survey administration must have a process in place to address patients' requests to verify the legitimacy of the survey and/or answer questions about the survey.

The HCAHPS Survey Frequently Asked Questions (FAQs) document for customer support personnel and project staff is provided in Appendix O. Customer support personnel must use the FAQs as a guide when answering patients' questions about the survey.

Survey Vendors

Survey vendors who administer the survey via Mail Only and Mixed Modes must provide toll-free customer support telephone lines on behalf of contracted hospitals to answer questions about the HCAHPS Survey. Survey vendors must staff telephone lines during business hours (see guidelines below), and have sufficient capacity to handle incoming calls. Voice mail is acceptable during and after core business hours, but must be regularly monitored and replied to within one business day. The voice mail recording must specify that the caller can leave a message about the HCAHPS Survey or hospital survey. Survey vendors must document questions and responses via a database or tracking log.

In addition to the above requirements, the following guidelines are recommended for customer support lines:

- Staff telephone lines from 9 AM to 9 PM (hospital/survey vendor local time), Monday through Friday
- Maintain sufficient capacity so that 90 percent of incoming calls are answered "live" and the average speed of answer is 30 seconds or less
- Establish a "return call" standard of two business days for caller questions that cannot be answered at the time of the initial call

A hospital may establish a separate customer support telephone line in lieu of the survey vendor; however, the survey vendor is responsible for ensuring the hospital's customer support telephone line adheres to HCAHPS protocols and is operational prior to mailing the questionnaires. In addition, during survey administration, the survey vendor is responsible for monitoring the hospital's customer support telephone line at a minimum, on a quarterly basis. For example, blind calls are placed to each hospital client's customer support telephone line to confirm that the telephone number is operational and to assess hospital compliance with HCAHPS customer support guidelines. The survey vendor must also verify that the hospital is prepared to receive questions prior to the first mailing of the questionnaire. On an ongoing basis, survey vendors must verify that the hospital answers patient questions accurately and keeps a record of customer support inquiries about HCAHPS. Survey vendors must use multiple questions from Appendix O, Section I during the quarterly monitoring/assessment activity.

Self-administering Hospitals

Self-administering hospitals must provide customer support telephone lines to answer questions about the survey. There is flexibility in the hours of operation and in who will staff the line. In particular, the customer support telephone line does not need to be dedicated only to the HCAHPS Survey, but must be staffed by hospital personnel who are able to answer questions about the survey. Self-administering hospitals are encouraged to use a live operator for the customer support telephone line. Voice mail is acceptable during and after core business hours, but must be regularly monitored and voice mail messages must be replied to within one business day. The voice mail recording must specify that the caller can leave a message regarding the HCAHPS Survey or hospital survey. Hospitals must document questions and responses via a database or tracking log.

Providing Customer Support via the Internet (Optional)

In addition to customer support telephone lines, hospitals/survey vendors may also choose to implement systems to support electronic queries from surveyed patients. For example, hospitals/survey vendors may establish an email address for sampled patients to use to submit questions about the survey. Hospitals/Survey vendors should respond to email inquiries within one business day. Hospitals/Survey vendors must document questions and responses via a database or tracking log.

Personnel Training

Training of personnel in the HCAHPS Survey data collection protocols is key to successful survey administration. The following section addresses training provided to:

- Project staff
- Customer support personnel
- Mail data entry personnel
- Telephone interviewers and IVR operators
- Subcontractors

Training of Project Staff

At a minimum, the hospital's/survey vendor's Project Manager and any subcontractor(s) **and any other organization(s)** with responsibility for major survey administration functions must participate in the Introduction to HCAHPS Training and any subsequent HCAHPS Update Training sessions sponsored by CMS. Individuals who are involved and work on any aspect of HCAHPS Survey operations (e.g., account managers, sampling specialists, quality assurance managers, programmers and information technology staff, etc.) must be thoroughly trained by the hospital/survey vendor on HCAHPS Survey specifications and methodology to guarantee standardization of survey administration. Survey vendors should also provide training to their hospital clients on preparation of the patient discharge files.

Hospitals/Survey vendors must establish a process for training new project team members on HCAHPS Survey administration in a timely fashion. It is strongly recommended that staff members are cross-trained in all aspects of the HCAHPS Survey administration process in case of unforeseen staffing turnover or absence. Back-up staff for HCAHPS Survey administration responsibilities must be assigned to staff employed by the hospital/survey vendor.

Note: Volunteers are not permitted to be involved in any aspect of the HCAHPS Survey administration process.

Training of Customer Support Personnel

Hospitals/Survey vendors must train customer support personnel (or contracted hospitals, if applicable) in HCAHPS Survey specifications and methodology to answer questions appropriately. Hospitals/Survey vendors must periodically (at a minimum on a quarterly basis) assess the reliability and consistency of customer support personnel responses. In addition, questions posed by surveyed patients should be reviewed regularly to determine if there is a need to develop additional FAQs.

Training of Mail Data Entry Personnel

Hospitals/Survey vendors will address the following items when training data entry personnel:

- Use of data entry equipment and programs
- Survey specifications and protocols
- Survey instrument, question flow, and skip patterns
- Data key-entry procedures
- Validation programs
- Decision rules/ambiguous responses

Training of Telephone Interviewers and IVR Operators

Hospitals/Survey vendors are provided with standardized telephone and IVR scripts that include scripted introductions and probes for standardization of interviews. Hospitals/Survey vendors will address the following items when training telephone interviewers and IVR operators. Interviewers/Operators must:

- use the standardized telephone and IVR scripts and follow the interviewing guidelines when conducting interviews
- attempt to complete the entire survey
- understand the purpose of the survey so they can encourage patients to participate
- use and understand the FAQ document in order to answer questions in a uniform manner
- be familiar with the operations of the hospital's/survey vendor's telephone/IVR program
- be able to navigate back and forth easily through the survey, without disrupting the flow of the interview
- be familiar with the process for redirecting calls to another interviewer when the patient is personally known

Training of Subcontractors

Hospitals/Survey vendors are responsible for the training and performance of any subcontractor(s) they use. In addition, during survey administration, hospitals/survey vendors are responsible for providing quality oversight and monitoring of their subcontractor's work to confirm that they are in compliance with HCAHPS guidelines.

Subcontractors **and any other organization(s)** that are responsible for major HCAHPS Survey administration functions (e.g., mail/telephone/IVR operations, XML file preparation) must participate in HCAHPS training.

Note: Hospitals/Survey vendors are responsible for sampling and data submission; and therefore, must not subcontract these processes.

Monitoring and Quality Oversight

Hospitals/Survey vendors must establish a system for providing and documenting quality oversight and monitoring of the HCAHPS Survey administration and HCAHPS project staff, including subcontractors. Quality checking activities must be performed by a different staff member than the individual who originally performed the specific project task(s). In addition, hospitals/survey vendors must:

- perform and document quality checks of all key events in survey administration on an ongoing and continuous basis including, but not limited to: sample frame creation; sampling procedures; data receipt; data entry; data submission; backup systems; etc.
- perform and document quality checks of electronic programming code periodically, on an annual basis, at a minimum
- monitor the performance of all staff involved with any aspect of programming, sample frame creation, sampling, processing of response data (from receipt and handling of returned surveys, through data entry, validation, and edit checking) on an ongoing and continuous basis, including conducting on-site verification of processes (strongly recommended on an annual basis, at a minimum)
- ensure that staff and subcontractors are compliant with HIPAA regulations
- monitor the performance of all subcontractor(s), including conducting on-site verification of subcontractor processes (strongly recommended on an annual basis, at a minimum)
- provide performance feedback to all staff and subcontractor(s), through regular assessments, to include special emphasis placed on the detection and correction of identified performance problems

The HCAHPS Project Team will conduct on-site visits to hospitals/survey vendors and to their subcontractors, if applicable, to review hospitals'/survey vendors' operations, monitoring and quality oversight practices. As noted earlier, if a survey vendor is non-compliant with program requirements for any of their contracted hospitals, the hospital's data may not be publicly reported.

Safeguarding Patient Confidentiality

Safeguarding the confidentiality of patients who participate in the HCAHPS Survey is essential. Hospitals/Survey vendors must take the following actions to further protect the confidentiality of patients:

- Prevent unauthorized access to confidential electronic and hard copy information by restricting physical access to confidential data (use locks or password-protected entry systems on rooms, file cabinets and areas where confidential data are stored)
- Develop confidentiality agreements which include language related to HIPAA regulations and the protection of patient information, and obtain signatures from all personnel with access to survey information, including staff and all subcontractors involved in survey administration and data collection. Confidentiality agreements must be reviewed and periodically re-signed at a minimum of every three years.
- Execute Business Associate Agreement(s) in accordance with HIPAA regulations
- Confirm that staff and subcontractors are compliant with HIPAA regulations in regard to patient protected health information (PHI)
- Establish protocols to ensure that the identity of patients who respond to the HCAHPS Survey is not shared with hospital direct care staff. Direct care staff should not be able to identify the individual patients who provided survey responses.

- Establish protocols to limit the use or disclosure of protected health information to the minimum necessary to accomplish the intended purpose
  - Social Security numbers must not be used to identify patients and must not be included in HCAHPS discharge lists
- Establish protocols for secure file transmission. Emailing of PHI via unsecure email is prohibited.
- Establish protocols for identifying security breaches and instituting corrective actions
- Establish protocols for identifying patients who are excluded from the HCAHPS Survey. For a list of exclusions, please refer to the *Sampling Protocol* chapter in this *Quality Assurance Guidelines V16.0* manual. Excluded patients are removed from the eligible patient list by the hospital/survey vendor before the HCAHPS sample is drawn. Patients found to be ineligible after sampling must not be removed or replaced in the sample.
- Store returned mail paper questionnaires and/or electronically scanned questionnaires in a secure and environmentally safe location

*Note: It is strongly recommended that the method used by contracted hospitals to transmit information (e.g., patient discharge files) to the hospital/survey vendor be reviewed by the hospitals' HIPAA/privacy officer to confirm compliance with HIPAA regulations. Any materials (e.g., QAP, questionnaires, cover letters, tracking forms) submitted by the hospital/survey vendor to the HCAHPS Project Team must be blank templates and **must not** contain any patient PHI.*

Data Security

Hospitals/Survey vendors must securely store patient identifying electronic data and responses to the survey. Hospitals/Survey vendors must take the following actions to secure the data:

- Use a firewall and/or other mechanisms for preventing unauthorized access to the electronic files
  - Hospitals/Survey vendors must notify the HCAHPS Project Team within 24 hours upon discovery of a data breach that potentially affects HCAHPS Survey administration within their organization or at a client hospital
- Implement access levels and security passwords so that only authorized users have access to sensitive data
- Implement daily data backup procedures that adequately safeguard system data
- Test backup files at a minimum on a quarterly basis to make sure the files are easily retrievable and working
- Perform frequent saves to media to minimize data losses in the event of power interruption Develop a disaster recovery plan for conducting ongoing business operations in the event of a disaster. The plan must be made available to the HCAHPS Project Team upon request.

Data Retention and Storage

Hospitals/Survey vendors must take the following actions to store files and all survey administration related data in accordance with HIPAA:

- Store HCAHPS-related data files, including patient discharge files and de-identified electronic data files (e.g., HCAHPS Sample Frame, XML files, etc.), for all survey modes for a minimum of three years. Archived electronic data files must be easily retrievable.

- Store returned mail questionnaires in a secure and environmentally safe location. Paper copies or optically scanned images of the questionnaires must be retained for a minimum of three years and be easily retrievable, when needed.
- Destroy HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files in a secure and environmentally safe location. Obtain a certificate of the destruction of data.

Sampling Protocol

Overview

This chapter describes the process and requirements for selecting a random sample of patients to respond to the CAHPS Hospital Survey (HCAHPS). The HCAHPS sampling protocol is designed to ensure that the patients who participate in the survey are representative of all the eligible patients who received care within general acute care hospitals. Several HCAHPS sampling protocol illustrations have been included in this chapter.

Note: The HCAHPS Survey is intended to reflect the care received by patients of all payer types, not just Medicare. Therefore, patients of all payer types are eligible for sampling.

The HCAHPS Survey sampling protocol promotes the following:

- Standardized administration of the HCAHPS Survey by hospitals/survey vendors
- Comparability of resulting data across all participating hospitals

The basic sampling procedure for HCAHPS requires the drawing of a random sample of eligible monthly discharges. Data will be collected from patients in each monthly sample over the 12-month reporting period, and will be aggregated on a quarterly basis to create a rolling 4-quarter data file for each hospital. The most current four quarters of data are used for public reporting. Hospitals may not switch the type of sampling, mode of survey administration, or survey vendor used within a calendar quarter. These types of changes can only be made at the beginning of a calendar quarter.

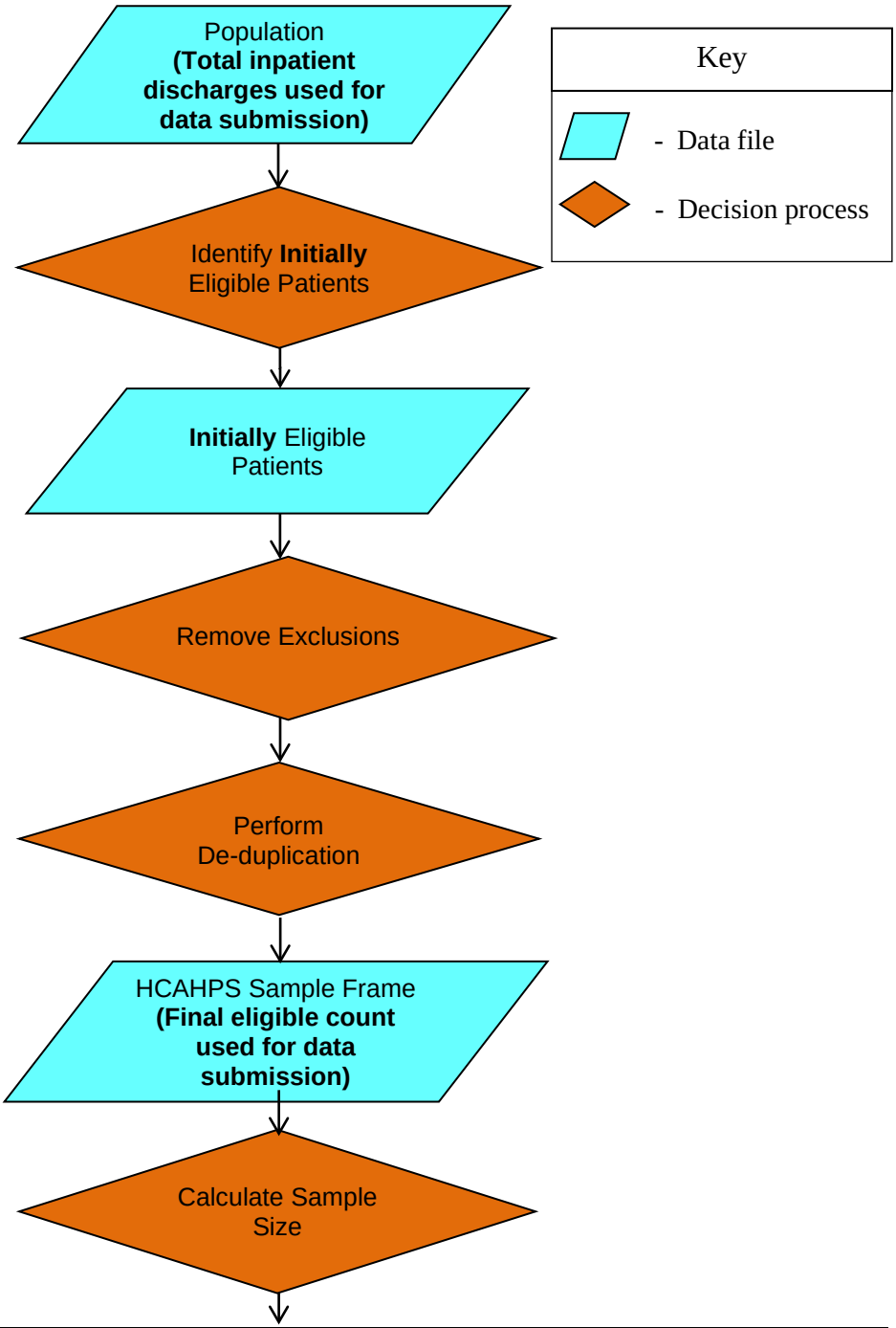
The HCAHPS sampling protocol employs the patient's principal diagnosis at discharge to determine whether he or she falls into one of the three service line categories eligible for HCAHPS: Maternity Care, Medical, or Surgical. While Medicare Severity Diagnosis Related Group (MS-DRG) codes (V.38 effective October 1, 2020 and V.39 MS-DRG codes effective October 1, 2021) are the preferred methods for determining the patient's service line, CMS also allows the following methodologies to be used: V.37 MS-DRG codes; V.36 MS-DRG codes; V.35 MS-DRG codes; V.34 MS-DRG codes; V.33 MS-DRG codes; V.32 MS-DRG codes; V.31 MS-DRG codes; V.30 MS-DRG codes; V.29 MS-DRG codes; V.28 MS-DRG codes; V.27 MS-DRG codes; V.26 MS-DRG codes; V.25 MS-DRG codes; V.24 CMS-DRG codes; a mix of V.39, V.38, V.37, V.36, V.35, V.34, V.33, V.32, V.31, V.30, V.29, V.28, V.27, V.26, V.25, V.24 codes based on payer source; ICD-10 codes; ICD-9 codes; hospital unit; All Patient Refined DRG (APR-DRG) codes; a mix of MS-DRG and APR-DRG codes.

Regardless of the methodology used, the hospital/survey vendor must maintain documentation that demonstrates how the codes are crosswalked to the HCAHPS Service Lines. The method for determining service line must be identified in the XML file or the HCAHPS Data Form, formerly the Online Data Entry Tool. (For more information, see the *Data Specifications and Coding* chapter.)

In order to use a service line methodology other than those identified above, a hospital/survey vendor must first submit an Exception Request Form for approval. (For more information, see the *Exception Request/Discrepancy Report Processes* chapter.)

A flowchart illustrating the steps of the HCAHPS sampling protocol is provided for reference below. A more detailed illustration can be found later in this chapter.

Flowchart of HCAHPS Sampling Protocol



Select a **random sample** of patients to be surveyed and code using one of the following approved sample types:
"1 – Simple Random Sample (SRS)"
"2 – Proportionate Stratified Random Sample (PSRS)"
"3 – Disproportionate Stratified Random Sample (DSRS)"
Note: Selecting all patients in the sample frame is a census, which must be coded "1 – Simple Random Sample."

Eligibility for the HCAHPS Survey

The HCAHPS Survey is broadly intended for patients of all payer types who meet the following criteria:

- Eighteen (18) years or older at the time of admission
- Admission includes at least one overnight stay in the hospital
  - An overnight stay is defined as an inpatient admission in which the patient's admission date is different from the patient's discharge date. The admission need not be 24 hours in length. For example, a patient had an overnight stay if he or she was admitted at 11:00 PM on Day 1, and discharged at 10:00 AM on Day 2. Patients who did not have an overnight stay should not be included in the sample frame (e.g., patients who were admitted for a short period of time solely for observation; patients admitted for same day diagnostic tests as part of outpatient care).

    *Note: Observation patients who do **not** have an inpatient admission are not eligible for the HCAHPS Survey, even if they have an overnight stay.*

- Non-psychiatric MS-DRG/principal diagnosis at discharge

  Note: Patients whose principal diagnosis falls within the Maternity Care, Medical or Surgical service lines and who also have a secondary psychiatric diagnosis are still eligible for the survey.

  *Note: MS-DRG codes in the **ineligible** category include patients with MS-DRG codes for **newborn, psychiatric, substance abuse, rehabilitation, or deceased, and MS-DRG codes with no assigned type**.*

- Alive at the time of discharge

Note: Pediatric patients (under 18 years old at admission) and patients with a primary psychiatric or substance abuse diagnosis are ineligible because the current HCAHPS instrument is not designed to address the unique situation of pediatric patients and their families, or the behavioral health issues pertinent to psychiatric patients.

*Note: Patients identified with "Discharge Status" (UB-04 field location 17) of "30 – Still a Patient" are **not** eligible for the HCAHPS Survey.*

Exclusions from the HCAHPS Survey

There is a two-stage process for determining whether a discharged patient can be included in the HCAHPS Sample Frame. The first stage is to determine whether the discharged patient meets the HCAHPS eligibility criteria, listed above. If the patient meets the eligibility criteria, then a second set of criteria is applied: Exclusions from the HCAHPS Survey.

Patients who meet the eligible population criteria outlined above are to be included in the HCAHPS Sample Frame. However, there are a few categories of otherwise eligible patients who are excluded from the sample frame. These are:

- "No-Publicity" patients – Patients who request that they not be contacted (see below)
- Court/Law enforcement patients (i.e., prisoners); this does not include patients residing in halfway houses
- Patients with a foreign home address (the U.S. territories – Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses; and therefore, are not excluded)
- Patients discharged to hospice care (hospice-home or hospice-medical facility)
- Patients who are excluded because of state regulations
- Patients discharged to nursing homes and skilled nursing facilities

"No-Publicity" patients are defined as those who voluntarily sign a "no-publicity" request while hospitalized or who directly request a survey vendor or hospital not to contact them ("Do Not Call List"). These patients should be excluded from the HCAHPS Survey. However, documentation of patients' "no-publicity" status must be retained for a minimum of three years.

Court/Law enforcement patients (i.e., prisoners) are excluded from HCAHPS because of both the logistical difficulties in administering the survey to them in a timely manner and regulations governing surveys of this population. These individuals can be identified by the "Admission Source" (UB-04 field location 15) of "8 – Court/Law Enforcement" or by "Discharge Status" (UB-04 field location 17) of "21 – Discharged/Transferred to Court/Law Enforcement" or "87 – Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission." This does not include patients residing in halfway houses.

Patients with a ***foreign home address*** are excluded from HCAHPS because of the logistical difficulty and added expense of calling or mailing outside of the United States (the U.S. territories – Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses; and therefore, are not excluded).

Patients ***discharged to hospice care*** are excluded from HCAHPS because of the heightened likelihood that they will expire before the survey process can be completed. Patients with a "Discharge Status" (UB-04 field location 17) of "50 – Hospice-Home" or "51 – Hospice-Certified Medical Facility" would not be included in the sample frame.

Some ***state regulations*** place further restrictions on patients who may be contacted after discharge. It is the responsibility of the hospital/survey vendor to identify any applicable regulations and to exclude those patients as required by law or regulation in the state in which the hospital operates.

Patients ***discharged to nursing homes and skilled nursing facilities*** are excluded from HCAHPS. This applies to patients with a "Discharge Status" (UB-04 field location 17) of:

- "03 – Medicare Certified Skilled Nursing Facility"
- "61 – Medicare Approved Swing Bed Within Hospital"
- "64 – Medicaid Certified Nursing Facility"
- "83 – Medicare Certified Skilled Nursing Facility with a Planned Acute Care Hospital Inpatient Readmission"
- "92 – Medicaid Certified Nursing Facility with a Planned Acute Care Hospital Inpatient Readmission"

Hospitals/Survey vendors must retain documentation that verifies all exclusions and ineligible patients for a minimum of three years. This documentation is subject to review.

*Note: Patients must be included in the HCAHPS Sample Frame unless the hospital/survey vendor has positive evidence that a patient is ineligible or fits within an excluded category. If information is missing on **any** variable that affects survey eligibility when the sample frame is constructed, the patient must be included in the sample frame.*

Patients Discharged to Health Care Facilities

Patients discharged to health care facilities other than nursing homes (e.g., long-term care facilities, assisted living facilities and group homes), who are deemed eligible based on the above criteria, must be included in the HCAHPS Sample Frame. Patients residing in halfway homes, who are deemed eligible, must be included in the HCAHPS Sample Frame. CMS is aware that contacting patients residing in these facilities may be difficult. Nevertheless, hospitals/survey vendors must attempt to contact all patients in the sample in accordance with HCAHPS protocols.

Note: Patients discharged to nursing homes and skilled nursing facilities are excluded from HCAHPS Survey administration. This applies to patients with a "Discharge Status" (UB-04 field location 17) of: "03 – Medicare Certified Skilled Nursing Facility," "61 – Medicare Approved Swing Bed Within Hospital," "64 – Medicaid Certified Nursing Facility," "83 – Medicare Certified Skilled Nursing Facility with a Planned Acute Care Hospital Inpatient Readmission," and "92 – Medicaid Certified Nursing Facility with a Planned Acute Care Hospital Inpatient Readmission."

De-duplication

To reduce respondent burden, the hospital/survey vendor is required on a monthly basis to de-duplicate **eligible** patients based on household and multiple discharges within the same calendar month. De-duplication must be performed using the **sample frame** within each calendar month, utilizing address information (or telephone number for Telephone Only mode) and the patient's medical record number (or other unique identifier). The de-duplication process covers the following two areas:

- De-duplication by Household: Only one adult member per household is included in the sample frame for a given month.
  - For de-duplication purposes, halfway houses and health care facilities are not considered to be a household, and thus must not be de-duplicated. Examples of healthcare facilities include: long-term care facilities, assisted living facilities and group homes.
- De-duplication for Multiple Discharges within a Hospital: While patients are eligible to be included in the HCAHPS Survey in consecutive months, if a patient is discharged more than once within a given calendar month, only one discharge date is included in the sample frame.

The method used for de-duplicating depends on whether sampling is conducted continuously throughout the month, or is conducted only at the end of the month.

- If continuous daily sampling is used, then include only the first discharge date identified in the sample frame. As the sampling frame is created daily, subsequent discharges would not be known at the time the daily sample is drawn. Each daily discharge list must be compared

to the previous discharge lists received in the month in order to exclude additional discharges for a particular patient.

- If weekly sampling is used, each weekly discharge list must be compared to the previous weekly discharge lists for the month. The first discharge encountered would be included in the sample frame and discharges encountered in subsequent weeks would be excluded from the sample frame. In the event a patient is listed with two discharges in the same week (provided the patient had not been included in the sample frame in an earlier week within the same month), then include only the last discharge date during the week in the sample frame. Each weekly discharge list must be compared to the previous discharge lists received in the month in order to exclude additional discharges for a particular patient.
- If end-of-the-month sampling is used, then include only the last discharge date of the month in the sample frame

Note: De-duplication performed several times a month due to the receipt of multiple discharge lists (weekly; two times a month) for a given hospital must look back at the hospital's previous ***sample frame*** *for the month (not the hospital's previous sample).*

Note: Hospitals with multiple locations under a single CCN must apply de-duplication processes across all locations at the same time. If a patient was discharged from different locations within the same month, only one inpatient stay should be included in the sample frame.

Sample Frame Creation

Hospitals/Survey vendors participating in HCAHPS are responsible for generating complete, accurate and valid sample frame data files each month that contain all administrative information on all patients who meet the eligible population criteria. Hospitals/Survey vendors should limit the use or disclosure of protected health information to the minimum necessary to accomplish the intended purpose (i.e., not using information that can trace to an individual's identity, such as Social Security number).

- It is recommended that hospitals contracting with an HCAHPS approved survey vendor submit their entire patient discharge list to their survey vendor, excluding "no-publicity" patients and patients excluded because of state regulations
- If a hospital excludes any patients from the discharge list provided to their survey vendor, they must also submit to their survey vendor a count of total inpatient discharges, ineligible and excluded patients, and a count of patients by each exclusion category by discharge month at a minimum on a monthly basis

Hospitals/Survey vendors use the information derived from the sample frame to administer the survey. **Prior to generating the HCAHPS Sample Frame, hospitals/survey vendors must apply the eligibility criteria, remove exclusions and perform de-duplication.** The following steps must be followed when creating the sample frame:

- Patients whose eligibility status is uncertain must be included in the sample frame
- The sample frame for a particular month must include all eligible hospital discharges between the first and last days of the month (e.g., for January, any qualifying discharges between the 1st and 31st)

- If a hospital is conducting sampling at the end of each month, they must create the sample frame in a timely manner in order to initiate contact for all sampled patients within 42 calendar days of discharge
- The patient address included in the sample frame is the address in the medical record
- Patients with missing or incomplete addresses and/or telephone numbers must not be removed from the sample frame. Instead, every attempt must be made to find the correct address and/or telephone number. If the necessary contact information is not found, the "Final Survey Status" must be coded as "9 – Bad address" or as "10 – Bad/no telephone number." (For more information, see the *Data Specifications and Coding* chapter.)

The hospital/survey vendor must retain the sample frame (i.e., the entire list of eligible HCAHPS patients from which each hospital's sample is pulled) for a minimum of three years.

Note: Patient-identifying information within the sample frame will not be a part of the final data submitted to CMS, nor will any other PHI.

Note: An example of a sample frame file layout and required patient information is included in Appendix P. This is only an example; hospitals/survey vendors are not required to use this layout for their sample frame, but CMS strongly recommends that the hospitals/survey vendors collect all of the data elements from this layout.

Calculating the Sample Size

Hospitals **must** submit at least 300 completed HCAHPS Surveys in a rolling four-quarter period (unless the hospital is too small to obtain 300 completed surveys). **The absence of a sufficient number of HCAHPS eligible discharges is the only acceptable reason for submitting fewer than 300 completed HCAHPS Surveys in a rolling four-quarter period.**

Not all sampled patients who are contacted to complete the survey will actually do so. To calculate the number of monthly discharges needed to reach the required 300 completed surveys per four rolling quarters of data (a 12-month reporting period), it is necessary to take into account the proportion of sampled patients expected to complete the survey (represented by P, below). The number of discharges needed to obtain at least 300 completed surveys is calculated by using the proportion of sampled patients who turn out to be ineligible for the survey (I), and the expected survey response rate among eligible respondents (R). The calculation of the monthly discharges needed to produce at least 300 completes in a reporting period can be summarized in three steps:

*Note: Targeting exactly 300 completed surveys will not consistently result in 300 completed surveys. Thus, to better guarantee reaching the goal of at least 300 completed surveys, we **RECOMMEND** using a **target** of **335** completed surveys for the sample size calculations. In the sample size calculation below, a target of 335 completed surveys is used.*

Step 1: Identify the number of completed surveys needed over the four rolling quarters of data (12-month reporting period).

In order to achieve the 300 completed surveys, a hospital/survey vendor should select a target of at least 335, but may select more if a hospital wants to achieve more than 300 completed surveys.

Define C as the number of completed surveys to target for the sample size calculation.
C = 335

Step 2: Estimate the proportion of patients expected to complete the survey.
Let:

P = proportion of discharged patients expected to complete the survey
I = the expected proportion of discharged patients who are ineligible
R = the expected survey response rate among eligible respondents

The proportion of patients expected to complete the survey (P) is:

$P = (1 - I) \times R$

The following is an example of how to calculate the proportion of patients expected to complete the survey. It is important to note that this is just an example. The expected proportion of discharged patients that are ineligible and the expected response rate can differ by hospital.

Based on results from the National Hospital Discharge Survey, it is estimated that, on average, 17.0 percent of a hospital's discharged patients will be ineligible for the survey. Based on results from previous studies using HCAHPS, it is estimated that, on average, 26.0 percent of eligible and sampled patients will complete the survey.

Note: The parameters I and R used here are estimates. Participating hospitals should monitor their own experience with HCAHPS and adjust the values of I and R as necessary to determine the number of discharges needed over the 12-month reporting period. However, until such experience is gained, it is suggested that I = 0.170 and R = 0.260 are suitable estimates. If a hospital/survey vendor has experienced a lower response rate, the lower rate may be used at the outset to calculate the sample size needed to achieve the minimum required number of completes.

Therefore, the proportion of discharged patients expected to complete the survey is:

$P = (1 - I) \times R = (1 - 0.170) \times 0.260 = 0.216$

Step 3: Calculate the number of discharges needed to produce at least 300 completed surveys over the reporting period:

Example: 12-month reporting period
N12 = Number of discharges to be sampled over the entire 12-month reporting period =

C / P = 335 / 0.216 = 1,551

N1 = Number of discharges to be sampled each month in a 12-month reporting period =

N12 / 12 = 1,551 / 12 = 129

Using our assumptions of a 26.0 percent response rate and a 17.0 percent ineligibility rate, at least 1,551 eligible discharges would need to be sampled over the entire 12-month reporting period. Some smaller hospitals will produce fewer than 1,551 eligible discharges (used in the example above) during the reporting period. In such cases, the hospital must sample all eligible discharges each month and attempt to obtain as many completes as possible.

If a hospital obtains more than 25 and fewer than 100 completed surveys, the hospital's HCAHPS scores will still be publicly reported. However, the lower precision of scores derived from less than 100 completed surveys and less than 50 completed surveys will be noted on Care Compare (https://www.medicare.gov/care-compare/). Public reporting of HCAHPS scores is restricted to hospitals with 25 or more completed surveys.

If a hospital/survey vendor falls short of the monthly goal to reach at least 300 completes for the 12-month reporting period, the hospital/survey vendor should adjust the number of patients they sample in subsequent quarters. For example, to make up for a shortfall in the number of expected completes, hospitals/survey vendors may increase the number of patients sampled over the remaining quarters in the rolling four quarters (12-month reporting period). Within a given quarter, it is strongly recommended that sampling rates be fairly consistent across the months in that quarter.

Note: If in a month, quarter, or public reporting period, a hospital/survey vendor attains at least 300 completed surveys while some surveys are yet to be administered or are in the process of being administered, the hospital/survey vendor must continue to sample and survey using the chosen protocol at the chosen rate. For example, in the case of the Mail Only mode, the second mailing must be sent to patients who did not respond to the first mailing even if the hospital/survey vendor has already attained at least 300 completed surveys for a given month, quarter or reporting period. If the number of completed surveys is greater than 300 for a reporting period, all surveys must be submitted and will be included in the publicly reported results.

If a patient is included in the sample, but is later determined to be ineligible or excludable, the patient's Administrative Data Record is included in the data file submission and is assigned the appropriate disposition code to indicate ineligibility. In the data file submission, only "3 – Ineligible: Not in eligible population" patients are subtracted from the "Eligible Discharges" field in the Header Record. In addition, these patients will be treated as ineligible in the response rate calculations. For further information, see the *Data Specifications and Coding* chapter.

Survey Timing

Surveying of sampled patients must be initiated between 48 hours and six weeks (42 calendar days) after discharge, regardless of the mode of survey administration. Distributing surveys to patients before they are discharged is not allowed. Data collection for sampled patients must be

closed out no later than six weeks (42 calendar days) following the date the first survey is mailed (Mail Only and Mixed Modes), or six weeks (42 calendar days) following the first telephone attempt (Telephone Only and IVR mode). For additional details on survey timing and administration, refer to the *Mail Only Survey Administration, Telephone Only Survey Administration, Mixed Mode Survey Administration,* and *IVR Survey Administration* chapters.

Note: If a patient is discharged to a swing bed (except code "61– SNF Swing Bed Within Hospital"), use the discharge date from the acute care setting, not the discharge date from the swing bed, to begin the 48 hour to six weeks (42 calendar days) window for initial contact.

Sampling Procedure

The basic sampling procedure for HCAHPS entails drawing a random sample of all eligible discharges from a hospital on a monthly basis. Sampling may be conducted either continuously throughout the month or at the end of the month, as long as a random sample is generated from the entire month. If the hospital/survey vendor chooses to sample continuously, each sample must be drawn using the same sampling ratio (for instance, 25 percent of eligible discharges or every fourth eligible discharge) and the same sampling timeframe (for instance, every 24 hours, 48 hours, week, etc.) throughout the month. For details on random sampling methods, see the *Methods of Sampling* section in this chapter.

Once a sample type is used within a quarter, it must be maintained throughout that quarter; "Sample Type" can only be changed at the beginning of a quarter. For more information, see the *Methods of Sampling* section in this chapter.

The required number of completed surveys for the statistical precision of the publicly reported hospital ratings is based on a reliability criterion. In brief, higher reliability means a higher ratio of "signal to noise" in the data. The reliability target for the HCAHPS global items and most composites is 0.8 or higher. Based on this reliability target, hospitals must obtain at least 300 completed HCAHPS Surveys ("completes") over each 12-month reporting period.

The HCAHPS sample must be drawn according to this uninterrupted random sampling protocol and not according to any "quota" system. Hospitals/Survey vendors must sample from every month throughout the entire 12-month reporting period and not stop sampling or curtail ongoing survey administration activities even if 300 completed surveys have been attained.

Note: Small hospitals that are unable to reach at least 300 completed surveys in a 12-month reporting period must sample ALL eligible discharges (i.e., conduct a census) and attempt to obtain as many completes as possible.

Note: Hospitals that share a common CCN (formerly known as the Medicare Provider Number [MPN]) must obtain at least 300 completes per CCN, not per individual hospital. If stratifying the sample by site, see the Methods of Sampling section in this chapter for additional guidance.

Consistent Monthly Sampling

For ease of sampling, CMS recommends that hospitals/survey vendors sample an approximate equal number of discharges each month, unless adjustments are required (at the beginning of a quarter only). Hospitals/Survey vendors have the option to allocate the yearly sample

proportionately to each month according to the expected proportional distribution of total eligible discharges over the four rolling quarters (12-month reporting period). Hospitals/Survey vendors must sample from every month in the reporting period, even if they have already achieved 300 completed surveys. Additional information is provided in the *Data Specifications and Coding* chapter.

Final Survey Sample

The final sample drawn each month must reflect a ***random*** sample of patients from the survey sample frame. If a hospital or survey vendor is conducting two separate surveys in the same month (HCAHPS and another patient survey), the random sample for the HCAHPS Survey must be drawn first.

CMS recognizes that some small hospitals may not be able to obtain at least 300 completed surveys in a 12-month reporting period. In such cases, hospitals must sample ***all*** eligible discharges (that is, conduct a census) and attempt to obtain as many completes as possible.

Note: When a census sample is conducted, the "Type of Sampling" field in the Header Record must be coded "1 – Simple Random Sample."

Methods of Sampling

Sampling for HCAHPS is based on the eligible discharges (HCAHPS Sample Frame) for a calendar **month.** If every eligible discharge for a given month has the same probability of being sampled, then an **equiprobable** approach is being used. Stratified sampling is where eligible discharges are divided into non-overlapping subgroups referred to as **strata**, before sampling.

There are three options for sampling patients for the HCAHPS Survey: Simple Random Sampling (SRS), Proportionate Stratified Random Sampling (PSRS) and Disproportionate Stratified Random Sampling (DSRS).

- **SRS**: **S**imple **R**andom **S**ampling is the most basic sampling type; patients are randomly selected from all eligible discharges for a month. Strata are not used when employing SRS and each patient has equal opportunity of being selected into the sample, making SRS equiprobable.
- **PSRS**: **P**roportionate **S**tratified **R**andom **S**ampling uses strata definitions and random sample selection from all strata at equal rates. Since the sampling rates of the strata are "proportionate," PSRS is also considered equiprobable.
- **DSRS**: **D**isproportionate **S**tratified **R**andom **S**ampling involves sampling within strata at different rates, and thus, DSRS requires information about the strata. By definition, DSRS is not an equiprobable sampling approach as DSRS allows for dissimilar sampling rates across strata.

  Note: Hospitals/Survey vendors must submit an Exception Request Form for approval to use DSRS. See the Exception Request/Discrepancy Report Processes chapter.

The table below summarizes key attributes of the three available sampling methods for HCAHPS.

Sampling Method	Strata Used	Strata Information Submitted to the HCAHPS Data Warehouse*	Equiprobable
SRS	No	No	Yes
PSRS	Yes	No	Yes
DSRS	Yes	Yes	No

**Includes strata names, eligible patients in each strata and strata sample sizes.*

Whether using SRS or stratified random sampling (PSRS or DSRS), caution must be exercised. For example, if strata (PSRS or DSRS) are defined as time periods, the sampling process must account for months that begin or end in the middle of a week.

Simple Random Sampling (SRS)

SRS is the most basic sampling technique. Here, a group of patients (a sample) is randomly selected from a larger group of eligible patients (sample frame). Each patient is chosen entirely by chance, and each eligible patient has an equal chance of being included in the sample. For HCAHPS, a census sample is also considered to be a simple random sample.

SRS Example 1: Daily simple random sampling

- Sampling for **Hospital A** is conducted once every day using a constant sampling rate of 40% of eligible discharges (HCAHPS Sample Frame)
  - Day 1:
    - Total eligible discharges (HCAHPS Sample Frame) for Day 1 (10 patients) are **randomly sorted**, then numbered 1 through 10 (1, 2, 3, 4, 5, 6, 7, 8, 9, 10)
    - Since **Hospital A** is using a 40% sampling rate, the first 4 patients are selected. [**1**, **2**, **3**, **4**, 5, 6, 7, 8, 9, 10]
  - Day 2:
    - Total eligible discharges for Day 2 (8 patients) are **randomly sorted**, then numbered 1 through 8 (1, 2, 3, 4, 5, 6, 7, 8)
    - For Day 2, 40% of 8 eligible discharges is equal to 3.2. Using normal rounding rules, **Hospital A** samples 3 eligible discharges for Day 2 [**1**, **2**, **3**, 4, 5, 6, 7, 8]
  - Day 3:
    - Total eligible discharges for Day 3 (7 patients) are **randomly sorted**, then numbered 1 through 7 (1, 2, 3, 4, 5, 6, 7)
    - Sampling at a 40% rate, **Hospital A** selects 3 eligible discharges (40% of 7 eligible discharges is 2.8) [**1**, **2**, **3**, 4, 5, 6, 7]

SRS Example 2: Daily simple random sampling using "skip patterns"

- Similar to Hospital A, **Hospital B** chooses to sample 40% of its eligible discharges for the month by sampling patients every day. This is executed by randomly sorting each day's eligible discharges and sampling 2 out of every 5 patients.
  - Day 1:
    - Total eligible discharges (HCAHPS Sample Frame) for Day 1 (10 patients) are **randomly sorted**, then numbered 1 through 10 (1, 2, 3, 4, 5, 6, 7, 8, 9, 10)
    - Select the first 2 patients, and then skip the next three. The cycle (select 2 and skip 3) is repeated for the eligible discharges on Day 1. Here, 4 patients would be selected [**1**, **2**, 3, 4, 5, **6**, **7**, 8, 9, 10]
  - Day 2:
    - Total eligible discharges for Day 2 (8 patients) are **randomly sorted**, then numbered 1 through 8 (1, 2, 3, 4, 5, 6, 7, 8)
    - Again, using the same sampling rate of selecting 2 and skipping 3 patients, 4 patients would be selected [**1, 2,** 3, 4, 5, **6, 7,** 8]
  - Day 3:
    - Total eligible discharges for Day 3 (7 patients) are **randomly sorted**, then numbered 1 through 7 (1, 2, 3, 4, 5, 6, 7)
    - For Day 3, 4 patients would be selected [**1, 2**, 3, 4, 5, **6, 7**]
  - In this example, using leftover patients in the next day's count is not needed, as the patients are listed in a random order prior to selecting the sample
  - The sample selection cycle would start all over at the beginning of the next day

SRS Example 3: End of month sampling

- Sampling for **Hospital C** is conducted only once for a given month at the end of the month
  - Suppose Hospital C has 150 eligible discharges for a given month and wishes to use a 50% sampling rate
    - **Randomly sort** all 150 eligible patients prior to sampling
    - Then select 50% of the 150 eligible discharges for a monthly sample size of 75 patients. Since the eligible discharge list is already randomly sorted, the first 75 patients may be selected to form the monthly random sample.

Note: When sampling at the end of the month, please verify that the sample is drawn with enough time to begin survey administration before the 42 calendar days initial contact period expires for patients discharged early in the month.

SRS Example 4: Census sampling

- **Hospital D** is a small hospital and chooses to sample <u>all eligible discharges</u> on a daily basis
  - A census sample is SRS because each patient has an equal chance (100%) of being included in the sample and the patients are not stratified in any manner
  - Suppose Hospital D has 80 eligible discharges for a given month. Since this hospital is using census sampling, each of the 80 eligible patients is included in the hospital's HCAHPS sample.

Note: Sampling processes illustrated in SRS Examples 1, 2 and 4 could be changed to perform simple random sampling on a weekly or bi-weekly basis.

Stratified Random Sampling (Proportionate or Disproportionate)

In stratified random sampling, the entire population is divided into non-overlapping subgroups, or strata, prior to a random sample being drawn. Commonly used definitions for strata include time period (daily, weekly or bi-weekly), hospital unit or hospital campus (for multiple hospital locations sharing a CCN). It is required that all eligible monthly discharges are contained in exactly one of the chosen strata. That is, there must not be any eligible discharges that overlap strata. Each eligible discharge must be a member of one of the defined strata. For HCAHPS, there are two methods for stratified random sampling:

- **PSRS** – Each subgroup, or stratum, will have the same sampling ratio. That is, the percentage of eligible discharges sampled is the same across all strata.
  - PSRS is similar to SRS in that each eligible patient has the same probability of being selected for inclusion in the monthly sample
- **DSRS** – Each subgroup, or stratum, will have dissimilar sampling ratios. With DSRS, the percentage of eligible discharges sampled is not the same across all strata.
  - Unlike SRS and PSRS, using DSRS means that all eligible discharges do not have an equal chance of being selected for inclusion in the monthly sample. To account for this, CMS requires additional information from hospitals/survey vendors who choose to use DSRS as a sampling type.
  - Hospitals/Survey vendors must submit an Exception Request Form and then be approved to use DSRS. See the *Exception Request/Discrepancy Report Processes* chapter.

Note: When using two types of strata definitions (see PSRS Example 3 and DSRS Example 3), it is important to make sure that every eligible discharge for the month is contained within exactly one of the strata.

Proportionate Stratified Random Sampling (PSRS)

In order for sampling to be proportionate, the same sampling ratio (or proportion or percentage) must be applied regardless of the number of eligible discharges in each defined stratum. In addition, the same strata names and definitions should be used each month throughout the quarter.

The following are examples of situations that warrant the use of PSRS:

- The monthly sample is drawn at different scheduled times (e.g., each week) throughout the month. The same percentage of discharges is sampled each week.
- Distinct units within a hospital (e.g., wards, floors, etc.) are sampled separately. The same percentage of discharges is sampled in each unit.
- Multiple hospitals share the same CCN and the random sample is drawn separately from each hospital before all of the hospital's data are combined. (Hospitals that share a CCN must obtain a combined total of at least 300 completes per reporting period.) The same percentage of patients is drawn for each hospital each month.

  Note: Hospitals that share a CCN are not required to use PSRS.

PSRS Example 1: Weeks (Strata are defined as weeks within a month)

- A sample is pulled each week for **Hospital A**, creating five strata: Week 1, Week 2, Week 3, Week 4, and Week 5
  - Even though the number of eligible discharges differs across the five weeks, **Hospital A** takes the same proportion (or percentage) of "sampled" discharges each week
    - A 5th week is used to capture the remaining days in the month
  - Twenty percent of the eligible discharges are randomly pulled for each week. (In order to calculate the sample size, the number of eligible discharges is multiplied by 20% or 0.20.) The table below summarizes this sampling process.

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**

  - PSRS sampling usually results in a different number of sampled patients from each week, but the same proportion (percentage) of eligible discharges each week. Thus, each eligible discharge had an equal chance of being selected for the sample.
  - This Example 1 scenario could also be changed to perform the same sampling process on a daily or twice a month basis. For example, if performing PSRS twice a month, there would only be two strata from which to select eligible patients for inclusion in the monthly sample. The same sampling rate (sample size divided by eligible discharge size) must be used for both time periods in the month.

PSRS Example 2: Hospital Units (Strata are defined as units within a hospital)

- A sample is pulled each month for each of 3 units within **Hospital B**, 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, **Hospital B** uses the same sampling ratio for each unit
  - As seen in the following table, the chosen sampling rate is 30%, meaning that 30% of each unit's eligible monthly discharges will be sampled

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**

- In this example, PSRS sampling results in a different number of sampled patients from each unit, but the proportion (percentage) of the eligible discharges selected from each unit is the same (30%). Thus, each eligible discharge had an equal chance of being chosen, regardless of unit membership.

PSRS Example 3: Combinations of Location and Time Period (Strata are defined as all combinations of hospital location [sharing the same CCN] and week within a month)

- A sample is pulled each week from each of 2 locations for **Hospital C**, creating 10 (2x5) strata as follows: Week 1: East campus, Week 1: West campus; Week 2: East campus, Week 2: West campus; Week 3: East campus, Week 3: West campus; Week 4: East campus, Week 4: West campus; Week 5: East campus, Week 5: West campus
  - Even though the number of eligible discharges differs across the 2 hospital locations and 5 weeks within the month, **Hospital C** takes the same proportion (or percentage) of eligible discharges for each of the 10 defined strata
  - Fifty percent of the eligible discharges are randomly pulled from each hospital location per week. (In order to calculate the sample size, the number of eligible discharges is multiplied by 50% or 0.50.) The strata are summarized in the following table.

Stratum	Week	Location	Eligible Discharges	Sampling Rate	Sampled Patients
1	1	East	100	0.50	100 * 0.50 = **50**
2	1	West	60	0.50	60 * 0.50 = **30**
3	2	East	110	0.50	110 * 0.50 = **55**
4	2	West	72	0.50	72 * 0.50 = **36**
5	3	East	130	0.50	130 * 0.50 = **65**
6	3	West	54	0.50	54 * 0.50 = **27**
7	4	East	96	0.50	96 * 0.50 = **48**
8	4	West	64	0.50	64 * 0.50 = **32**
9	5	East	106	0.50	106 * 0.50 = **53**
10	5	West	70	0.50	70 * 0.50 = **35**

  - The number of sampled patients differs noticeably in the two hospital campuses and among the five weeks. However, since **Hospital C** employed the same sampling ratio (50%) for each campus and each week, each eligible discharge had an equal chance of being selected for sampling, regardless of location or week.
  - Care must be exercised when combining two types of strata (Location and Time Period). If a hospital or survey vendor encounters questions while implementing this sampling scenario, please contact HCAHPS Technical Assistance.
  - A similar sampling scenario would be to use hospital unit and time as strata definitions, rather than hospital location and time, as in this Example 3

Disproportionate Stratified Random Sampling (DSRS)

DSRS occurs when dissimilar sampling ratios are used in drawing samples from different strata. If the hospital/survey vendor elects to use DSRS, there are several additional requirements that must be met:

- Hospitals/Survey vendors that elect to use DSRS must complete and submit an Exception Request Form. The process for identifying the strata and the number of discharges that will be sampled must be clearly stated in the request. After submitting an Exception Request Form, CMS decides whether to approve the use of DSRS by hospitals/survey vendors. See the *Exception Request/Discrepancy Report Processes* chapter.

- If a hospital or survey vendor uses DSRS, additional data must be submitted. These data include: the total number of inpatient discharges within a stratum; the total number of patients within a stratum who were eligible for surveying in the month; the total number of patients within a stratum who were sampled in the month; and, the name of each stratum from which a sample was drawn.
  - Hospitals/Survey vendors must submit an Exception Request Form. The same strata names should be used in each month throughout the quarter.
- Hospitals/Survey vendors using DSRS are required to sample a minimum of ten eligible discharges in each stratum in each month. **Hospitals that are uncertain about their ability to meet this requirement should re-evaluate their strata definitions or choose not to use DSRS.**

When DSRS is used, CMS creates and employs inverse probability strata weights (using total eligible discharges and completed surveys by strata) so that responding patients are representative of all eligible patients with respect to the strata used in DSRS.

DSRS Example 1: Hospital Units (Strata are defined as units within a hospital)

- A sample is pulled for each of three units within **Hospital A** in each month of a quarter, 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 (10) is randomly selected from each unit
  - As the following table shows, 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**

- In this Example 1, DSRS sampling results in the same number of sampled patients from each unit, but the proportion (percentage) of the eligible discharges selected from each unit is different. Thus, each eligible discharge did not have an equal chance of being chosen.

DSRS Example 2: Weeks (Strata are defined as weekly time periods)

- A sample is pulled for **Hospital B** in each week of the month
  - In particular, **Hospital B** uses sampling rates equal to 10%, 50%, 50%, 10%, and 50% for Week 1, Week 2, Week 3, Week 4, and Week 5, respectively
    - A fifth week is used to capture the remaining days in the month

- The following table summarizes Hospital B's sampling

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**

DSRS Example 3: All Combinations of Hospital Unit and Time Period (Strata are defined as all combinations of hospital unit and week within a month)

- A random sample is pulled once per week (Week 1, Week 2, Week 3, Week 4, and Week 5) from each of three hospital units (Unit 1, Unit 2 and Unit 3) within **Hospital C**
  - Since there are 5 weeks within the time period (month) and 3 units within **Hospital C**, this sampling scenario uses 15 strata (5 x 3)
  - **Hospital C** chooses to sample 25% of eligible discharges from Unit 1, 50% from Unit 2, and 100% from Unit 3 across all 5 weeks. The following table summarizes the strata.

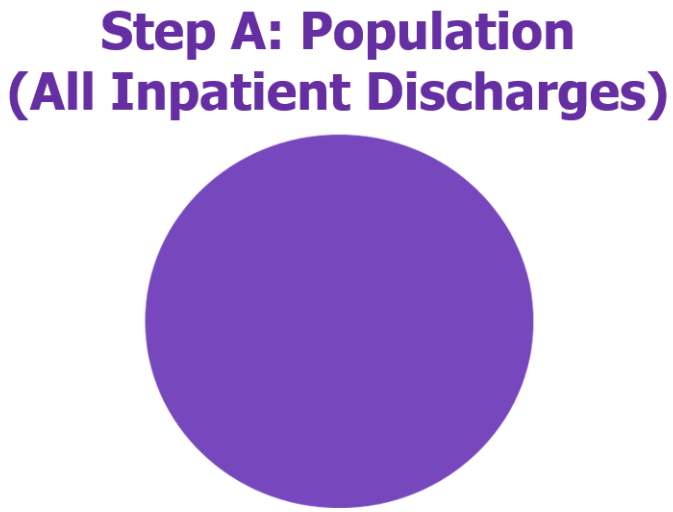
Stratum	Week	Unit	Eligible Discharges	Sampling Rate	Sampled Patients
1	1	1	100	0.25	100 * 0.25 = **25**
2	1	2	60	0.50	60 * 0.50 = **30**
3	1	3	18	1.00	18 * 1.00 = **18**
4	2	1	80	0.25	80 * 0.25 = **20**
5	2	2	50	0.50	50 * 0.50 = **25**
6	2	3	12	1.00	12 * 1.00 = **12**
7	3	1	88	0.25	88 * 0.25 = **22**
8	3	2	60	0.50	60 * 0.50 = **30**
9	3	3	14	1.00	14 * 1.00 = **14**
10	4	1	96	0.25	96 * 0.25 = **24**
11	4	2	70	0.50	70 * 0.50 = **35**
12	4	3	16	1.00	16 * 1.00 = **16**
13	5	1	56	0.25	56 * 0.25 = **14**
14	5	2	20	0.50	20 * 0.50 = **10**
15	5	3	12	1.00	12 * 1.00 = **12**

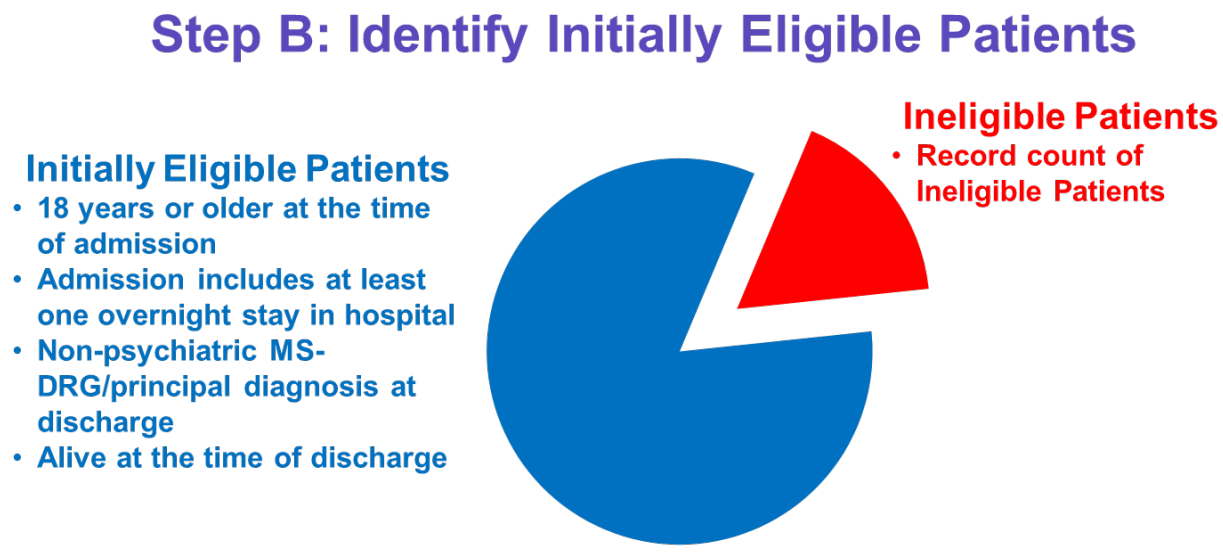
- Care must be exercised when combining two types of strata (Unit and Time Period). If a hospital or survey vendor encounters questions while implementing this sampling scenario, please contact HCAHPS Technical Assistance.
- A similar sampling scenario would be to use hospital location and time as strata definitions, rather than hospital unit and time, as in this example

Note: Other sampling scenarios may exist and the hospital/survey vendor should contact HCAHPS Information and Technical Support with questions via email at hcahps@hsag.com *or call 1-888-884-4007.*

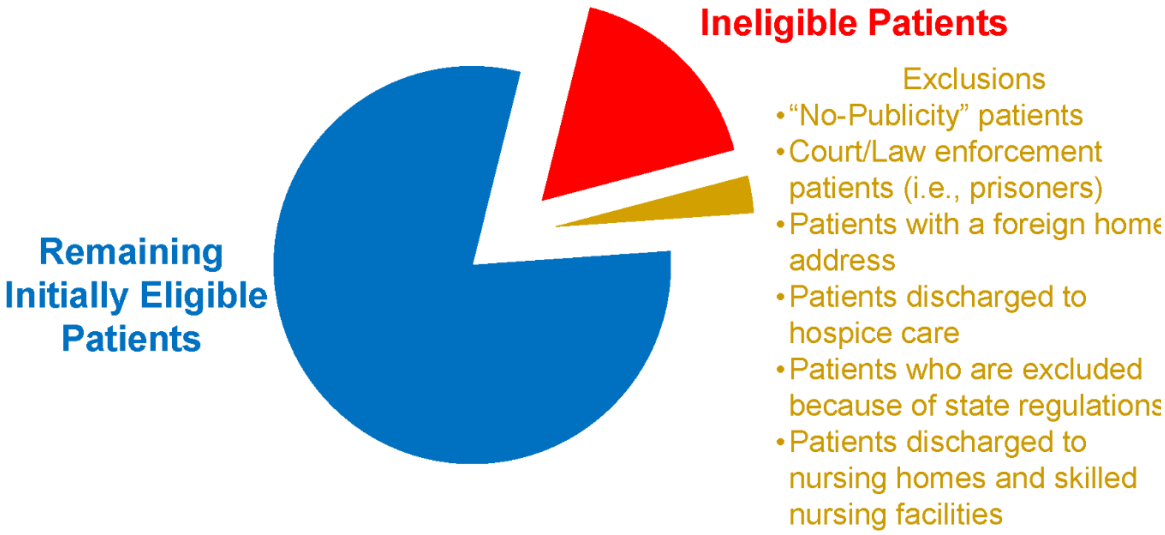
HCAHPS Sampling Protocol Illustration

To summarize, the following illustration is provided.

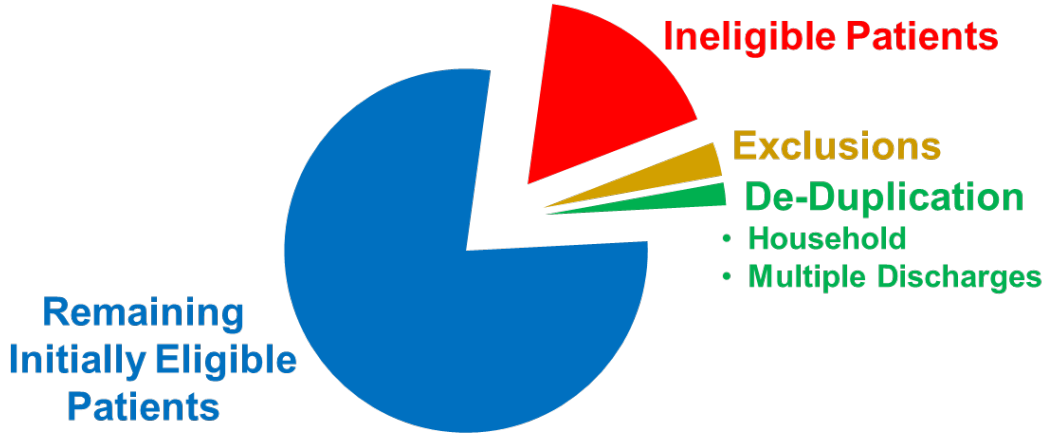


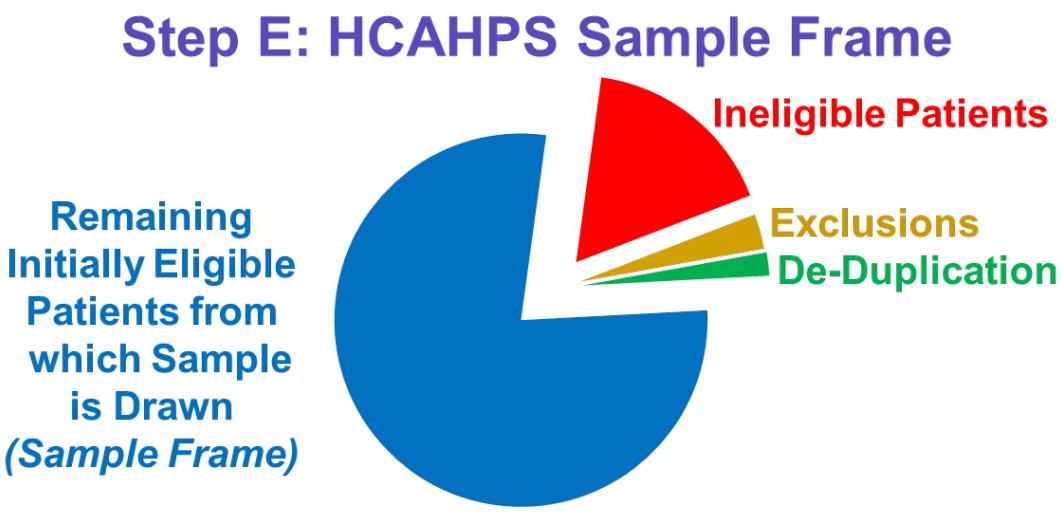


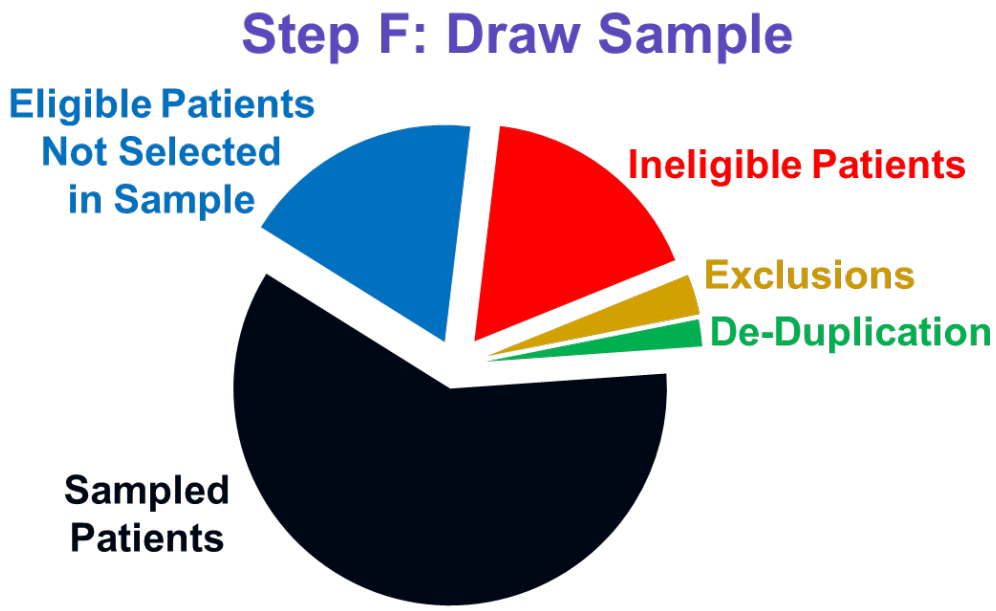
Step C: Remove Exclusions



Step D: Perform De-Duplication




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
Eligible Patients Not Selected in Sample
Ineligible Patients
Exclusions
De-Duplication
Sampled Patients

MS-DRG Codes and Service Line Categories

Each patient who is included in the HCAHPS Survey administration must be assigned to one of three service line categories: (1) Maternity Care; (2) Medical; or (3) Surgical. The preferred method of assignment to the service line categories is based on the patient's MS-DRG code (V.38 effective October 1, 2020 and V.39 MS-DRG code effective October 1, 2021) at discharge. Alternatively, CMS currently allows other methods of determining service line, which include the following: V.37 MS-DRG codes; V.36 MS-DRG codes; V.35 MS-DRG codes; V.34 MS-DRG codes; V.33 MS-DRG codes; V.32 MS-DRG codes; V.31 MS-DRG codes; V.30 MS-DRG codes; V.29 MS-DRG codes; V.28 MS-DRG codes; V.27 MS-DRG codes; V.26 MS-DRG codes; V.25 MS-DRG codes; V.24 CMS-DRG codes; a mix of V.39, V.38, V.37, V.36, V.35, V.34, V.33, V.32, V.31, V.30, V.29, V.28, V.27, V.26, V.25, V.24 MS-DRG codes based on payer source; ICD-10 codes/ICD-9 codes; hospital unit; APR-DRG codes; a mix of MS-DRG and APR-DRG codes. **Regardless of the methodology used, the hospital/survey vendor must maintain documentation that demonstrates how the codes are crosswalked to the HCAHPS Service Lines.** The HCAHPS Survey data are patient-mix adjusted by service line, though not publicly reported by service line.

A missing MS-DRG code does not exclude a patient from being drawn into the sample frame. Until the MS-DRG code is available, an interim service line designation of "Missing" should be assigned to such patients. The patient's service line should be updated as soon as the MS-DRG code becomes available. While awaiting the determination of service line (and the patient is otherwise eligible for HCAHPS), the patient should be presumed eligible for HCAHPS sampling and survey administration.

If a patient is determined to be ineligible after the sample is drawn but prior to administration of the survey, do not survey that patient, and do not remove or replace that patient in the sample. The patient is assigned "Final Survey Status" code "3 – Ineligible: Not in eligible population." If a patient is surveyed and then found to be ineligible, the patient is assigned "Final Survey Status" code "3 – Ineligible: Not in eligible population." For additional information regarding final survey status, see the *Data Specifications and Coding* chapter.

Hospitals that do not use one of the allowed methods listed above to determine service line must submit an Exception Request Form (online) requesting approval to use other means of determining patient service line categories. Survey vendors must submit the Exception Request Form (online) on behalf of their client hospitals. For further information on the process of applying for an exception, see the *Exception Request/Discrepancy Report Processes* chapter.

The following table provides the list of V.38 MS-DRG codes implemented with discharges occurring on or after October 1, 2020 in the IPPS Final Rule (CMS-1735-F). This table can be used to classify patients into one of the three major categories (Maternity Care, Medical or Surgical). The information in this table is updated to reflect changes to MS-DRG codes as published in the Federal Register Notice approximately two times per year. The V.39 MS-DRG codes to be implemented on or after October 1, 2021 will be available on the HCAHPS Web site (https://www.hcahpsonline.org). Please visit the HCAHPS Web site for the most current information.

Note: It is strongly recommended that hospitals/survey vendors assign the HCAHPS Service Line based on the hospital information (e.g., patient MS-DRG code at discharge).

- *Survey vendors: If client hospitals assign the HCAHPS Service Line, then the survey vendor must validate that the service line is assigned appropriately and is in accordance with the service line determination methodology identified in the "Determination of Service Line" field*

Table of V.38 MS-DRG Codes and Service Line Categories[10]

HCAHPS Sampling Protocol Service Line – MS-DRG Crosswalk for HCAHPS		
MS-DRG	**Service Line**	**Eligible for HCAHPS**
768, 783-788, 796-798, 805-807 *Note: While the Federal Register classifies these codes as medical or surgical, for HCAHPS they are to be coded as Maternity Care.*	1 = Maternity Care	Yes
14, 16-18, 52-103, 121-125, 146-159, 175-208, 280-282, 286-316, 368-395, 432-446, 533-566, 592-607, 637-645, 682-684, 686-690, 693-700, 722-730, 754-761, 776, 779, 808-816, 831-849, 862-872, 913-923, 933-935, 947-951, 963-965, 974-977	2 = Medical	Yes
1-8, 10-13, 19-42, 113-117, 135-145, 163-168, 215-229, 231-236, 239-274, 319-320, 326-358, 405-425, 453-483, 485-489, 492-522, 570-585, 614-630, 650-675, 707-718, 734-750, 769-770, 799-804, 817-830, 853-858, 901-909, 927-929, 939-941, 955-959, 969-970, 981-983, 987-989	3 = Surgical	Yes
283-285, 789-795, 876, 880-887, 894-897, 945-946, 998-999	Ineligible	No
A missing MS-DRG code does not exclude a patient from being drawn into the sample frame.	M = Missing	Yes

Note: Ineligible MS-DRGs include patients with MS-DRGs for ***newborn, psychiatric, substance abuse, rehabilitation, or deceased, and MS-DRGs with no assigned type****.*

[10] **This table of MS-DRG codes is based on Table 5 of the FY 2021 Federal Register Notice, Vol. 85, No. 182 / Friday, September 18, 2020.**

Hospitals/Survey vendors are responsible for reviewing the list of MS-DRG codes at a minimum on an annual basis to check for updates. The information in this table is updated to reflect changes to MS-DRG codes as published in the Federal Register Notice approximately two times per year. Please visit the HCAHPS Web site (https://www.hcahpsonline.org) for the most current information.

If a patient with an ineligible MS-DRG code from the above table is drawn into the sample, code the Final Survey Status, as "3 – Ineligible: Not in eligible population."

If a patient has an invalid MS-DRG code that is not listed in the above table, then the survey vendor must confirm the accuracy of the MS-DRG code with the client hospital. If the client hospital does not provide an updated valid MS-DRG code, then the survey vendor must ask for a description or additional information about the MS-DRG code in question. If the patient still has an invalid MS-DRG code at time of sample frame creation and the patient is otherwise eligible for HCAHPS, then include the patient in the sample frame.

Verify that the hospital is not using any of the ineligible MS-DRG codes as a "filler" code (e.g., 999) prior to obtaining the final billing MS-DRG code.

If the patient's service line is unknown at time of sample frame creation and the patient is otherwise eligible for HCAHPS, then include the patient in the sample frame.

Mail Only Survey Administration

New for 2021

Beginning with July 1, 2021 discharges, there will be one version of the HCAHPS cover letters (previously the Optional Modified version with revisions).

- HCAHPS Initial and Follow-up Cover Letters (see Appendices A through G), including new required and optional elements

In addition, survey and cover letter language, in all official HCAHPS Survey translations, is located in Appendices A through G.

Overview

This chapter describes guidelines for the Mail Only mode of the CAHPS Hospital Survey (HCAHPS) administration.

Data collection for sampled discharged patients must be initiated between 48 hours and six weeks (42 calendar days) after discharge. Hospitals/Survey vendors must wait 48 hours to make the first attempt to contact discharged patients. This will allow enough time to pass for the patient to return home and feel settled after his or her hospital stay. Patients must **not** be given the survey while they are still in the hospital.

Hospitals/Survey vendors will send sampled patients a first questionnaire with a cover letter. A second questionnaire with a follow-up cover letter **must** be sent to all sampled patients who did not respond to the first questionnaire, approximately 21 calendar days after the first questionnaire mailing.

Note: If after the first mailing the hospital/survey vendor learns that a sampled patient is ineligible for HCAHPS, the hospital/survey vendor must not send the patient the second questionnaire. ***After the sample has been drawn, any patients who are found to be ineligible must not be removed or replaced in the sample. Instead, these patients are assigned a "Final Survey Status" code of ineligible (2, 3, 4, or 5; as applicable). An Administrative Data Record must be submitted for these patients.***

Data collection must be closed out for a sampled patient by six weeks (42 calendar days) following the mailing of the first questionnaire. Patients who receive the HCAHPS Survey must not be offered incentives of any kind. Patients who do not respond to the survey are assigned a "Final Survey Status" code of non-response.

Hospitals/Survey vendors must make every reasonable effort to achieve optimal survey response rates and to pursue contacts with potential respondents until the data collection protocol is completed.

No proxy respondents are permitted in the administration of the HCAHPS Survey, not even for patients who are critically ill, elderly, physically, or mentally impaired. As stated above, a proxy respondent must not answer the survey questions for the patient; however, an individual may assist

the patient with reading the survey, writing responses or with translation of the survey, but only the patient may provide answers to the survey.

The basic tasks and timing for conducting the HCAHPS Survey using the Mail Only mode of survey administration are summarized below.

Mail Only Survey Administration
Send first questionnaire with initial cover letter to sampled patient(s) between 48 hours and six 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 six weeks (42 calendar days) of the first questionnaire mailing.
Submit final data files to CMS via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal, by the data submission deadline. No files will be accepted after the submission deadline date.

To reiterate, the initial mail-out of the survey must occur between 48 hours and six weeks (42 calendar days) after discharge. Data collection must then be completed no later than six weeks (42 calendar days) after the initial mail-out. To illustrate the timing of survey mail-out, three examples are provided of patients who were discharged from a hospital on July 1.

Example Patient 1:

- The first survey is mailed out on July 4 (three days after discharge)
- If the patient has not returned the survey by July 25 (21 days after the initial mailing on July 4), a second survey is mailed out
  - An optional reply-by date on the **follow-up cover letter** with the second survey mailing will be August 8 (35 days from initial mailing)
- Data collection must be closed out on August 15 for this patient, which is six weeks (42 calendar days) from the July 4 initial mail-out date:
  - If the survey is returned on August 15, which is the last day of the survey administration time period for this patient, then the survey is included in the final survey data file and assigned a "Final Survey Status" code of either "1 – Completed survey" or "6 – Non-response: Break-off" based on the calculation of percent complete as described in the *Data Specifications and Coding* chapter
    - Lag Time (See the *Data Specifications and Coding* chapter) for this patient is calculated as 45 days
  - If the survey is returned after August 15 (August 16, for example), which is beyond the six weeks (42 calendar days) survey administration time period for this patient, then the survey data are not included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and a "Final Survey Status" code of "8 – Non-response: Non-response after maximum attempts" is assigned
    - Lag Time for this patient is calculated and entered as the number of days between the patient's discharge from the hospital and the date that data collection activities ended for this patient. Lag time for this patient is calculated as 46 days.

Example Patient 2:

- The first survey is mailed out on August 12 (42 calendar days after discharge)
- If the patient has not returned the survey by September 2 (21 days after the initial mailing on August 12), a second survey is mailed out
  - The reply-by date **follow-up cover letter** with the second survey mailing will be September 16 (35 days from initial mailing)
- Data collection must be closed out on September 23 for this patient, which is six weeks (42 calendar days) from the August 12 initial mail-out date:
  - If the survey is received on September 23, which is the last day of the survey administration time period for this patient, then the survey data are included in the final survey data file and assigned a "Final Survey Status" code of either "1 – Completed survey" or "6 – Non-response: Break-off" based on the calculation of percent complete as described in the *Data Specifications and Coding* chapter
    - Lag Time for this patient is calculated as 84 days
  - If the survey is received after September 23, (September 24, for example) which is beyond the six week (42 calendar days) survey administration time period for this patient, then the survey data are not included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and a "Final Survey Status" code of "8 – Non-response: Non-response after maximum attempts" is assigned
    - Lag Time for this patient is calculated and entered as the number of days between the patient's discharge from the hospital and the date that data collection activities ended for this patient. Lag time for this patient is calculated as 85 days.

Example Patient 3:

- The first survey is mailed out on August 12 (42 calendar days after discharge)
- If the patient has not returned the survey by September 2 (21 days after the initial mailing on August 12), a second survey is mailed out
  - The reply-by date **follow-up cover letter** with the second survey mailing will be September 16 (35 days from initial mailing)
- If the patient has not returned a survey by September 23, then data collection must be closed out on September 23 for this patient, which is six weeks (42 calendar days) from the August 12 initial mail-out date:
  - If the survey is received on September 23, which is the last day of the survey administration time period for this patient, and there is evidence received on September 23 that the patient is deceased (e.g., the words "deceased" written on the survey, etc.) then the survey data are not included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and the "Final Survey Status" code of "2 – Ineligible: Deceased" is assigned
    - Lag Time for this patient is calculated and entered as 84 days

Note: The timing of the survey administration protocol begins with the first mailing and does not restart if another "first mailing" is sent to the patient due to an address correction/update. Therefore, data collection must still be closed out by six weeks (42 calendar days) following the original first mailing.

Production of Questionnaire and Related Materials

The Mail Only mode of survey administration may be conducted in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, or German. Hospitals/Survey vendors are provided with the HCAHPS questionnaires in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, and German (Appendices A through G), and initial and follow-up cover letters in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, and German (Appendices A through G). Hospitals/Survey vendors are not permitted to make or use any other translations of the HCAHPS cover letters or questionnaires. **We strongly encourage hospitals/survey vendors to administer the HCAHPS Survey in both English and Spanish, including offering the official HCAHPS Survey translations (Chinese, Russian, Vietnamese, Portuguese, and German) for hospitals with significant patient populations speaking in these languages.** We encourage hospitals that serve patient populations that speak languages other than those noted to request CMS to create an official translation of the HCAHPS Survey in those languages.

For HCAHPS Survey administration, the OMB Paperwork Reduction Act language must appear in the mailing, either on the cover letter or on the front or back of the questionnaire. (See Appendices A through G for the exact language in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, and German.) In addition, the OMB control number (OMB #0938-0981) and expiration date must appear on the front page of the questionnaire.

To reinforce the requirement that no one other than the sampled patient completes the survey, language must be included in the questionnaire, and optionally in the cover letter(s), clearly stating that only the sampled patient may fill out the survey.

Each hospital/survey vendor will submit a sample of their HCAHPS mailing materials (questionnaires, cover letters, and outgoing/return envelopes) with all applicable HCAHPS *Quality Assurance Guidelines V16.0* updates for review by the HCAHPS Project Team. Please see the *Oversight Activities* chapter for more detail.

Required for the Mail Questionnaire

The HCAHPS Survey (Questions 1-29) must remain together. The HCAHPS Survey questions cannot be eliminated from the questionnaire.

Hospitals/Survey vendors must adhere to the following specifications for questionnaire formatting and the production of mail materials:

Questions and Answer Categories

- Question and answer category wording must not be changed
- No changes are permitted to the order of the HCAHPS Survey (Questions 1-29)
- No changes are permitted to the order of the answer categories for the HCAHPS questions
- Question and answer categories must remain together in the same column and on the same page
- Response choices must be listed individually for each question, not presented in a matrix format. For example, when a series of questions is asked that have the same answer categories (Never, Sometimes, Usually, or Always), the answer categories must be repeated with every question. A matrix format which simply lists the answer categories across the top of the page and the questions down the side of the page is not allowed,

because it has been shown that this format tends to produce inaccurate and incomplete responses.

- Response options must be listed vertically (see examples in Appendix A). Response options that are listed horizontally or in a combined vertical and horizontal format are not allowed.

Formatting

- Wording that is underlined in the questionnaire provided in the HCAHPS *Quality Assurance Guidelines* must be emphasized in the same manner in the hospital's/survey vendor's questionnaire
- Arrow (i.e., ➔) placement in the questionnaire instructions and answer categories that specifies skip patterns must not be changed
- Section headings (e.g., YOUR CARE FROM NURSES, etc.) must be included on the questionnaire and must be capitalized
- Survey materials must be in a readable font (i.e., Arial or Times New Roman) with a font size of 10-point at a minimum

Other Requirements

- All survey instructions written at the top of the questionnaire must be printed verbatim
- The text indicating the purpose of the unique identifier *("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.")* must be printed either immediately after the survey instructions on the questionnaire (preferred) or on the cover letter, and may appear on both
- Randomly generated, unique identifiers must be placed on the first or last page of the questionnaire, at a minimum. Hospitals/Survey vendors may add internal codes on the questionnaire for tracking purposes; however, the internal codes must not contain any patient identifiers such as the patient's discharge date (including the month and year), doctor or unit. The patient's name must not be printed on the questionnaire.
- The copyright statement must be included on the questionnaire, preferably on the last page, in a readable font size at a minimum of 10-point (See Appendices A through G for the exact text)
- The OMB control number (OMB #0938-0981) and expiration date must appear on the front page of the questionnaire
- The OMB language must appear verbatim on either the front or back page of the questionnaire (preferred) or on the cover letter, and may appear on both, in a readable font size at a minimum of 10-point (See Appendices A through G for the exact text in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, and German); however, the OMB language cannot be printed on a separate piece of paper
- The hospital's/survey vendor's return address must be printed on the questionnaire to make sure that the questionnaire is returned to the correct address in the event that the enclosed return envelope is misplaced by the patient
    - If the hospital's/survey vendor's name is included in the return address, then the hospital's/survey vendor's business name must be used, not an alias or tag line

Optional for the Mail Questionnaire

Hospitals/Survey vendors have some flexibility in formatting the HCAHPS questionnaire by following the guidelines described below.

- Small coding numbers, preferably in superscript, may be included next to the response choices on the questionnaire
- It is acceptable to have a place on the survey for patients to voluntarily fill in their name/ telephone number as long as the name/telephone number items are placed after the HCAHPS questions. A transition statement must be placed before this item.
- Hospital logos may be included on the questionnaire; however, other images and tag lines are not permitted
- It is optional to place the title "HCAHPS Survey" on the questionnaire
- The phrase "Use only blue or black ink" may be printed on the questionnaire
- The name of the hospital may be printed on the questionnaire before Question 1 and in the introduction to Question 18
  - "Please answer the questions in this survey about your stay at [HOSPITAL NAME]. Do not include any other hospital stays in your answers."
- Page numbers may be included on the questionnaire
  - This is encouraged as a guide to assist patients in responding to all pages of the questionnaire
- Color may be incorporated in the questionnaire
- The phrase "There are only a few remaining items left" before the "About You" questions may be eliminated
- Language such as one of the following may be added in the footer of the survey:
  - Continue on next page
  - Continue on reverse side
  - Turn over to continue
  - ➔ to continue
  - Continue on back
  - Turn over

Hospitals/Survey vendors should consider incorporating the following recommendations in formatting the HCAHPS questionnaire to increase the likelihood of receiving a returned survey:

- Two-column format that is used in Appendices A through G
- Wide margins (at least 3/4 inch) so that the survey has sufficient white space to enhance its readability

Use of Supplemental Questions

Hospitals/Survey vendors may add a reasonable number of hospital-specific supplemental questions to the HCAHPS Survey, following the guidelines described below:

- Hospital-specific supplemental question(s) may be added to the HCAHPS Survey but only after all of the HCAHPS Survey questions (Questions 1-29). This approach ensures that the survey is conducted consistently across participating hospitals.
- Supplemental questions must be integrated into the HCAHPS Survey and not be a separate insert
- The mandatory transition statement must be placed in the survey immediately before the supplemental questions to indicate a transition from the HCAHPS questions to the hospital-

specific supplemental question or questions (see Appendices A through G for the exact text in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, and German)

- Hospitals may include additional transition statements following the required transition statement. Examples of allowable additional transition statements are as follows:
  - *"Now [NAME OF HOSPITAL] would like to gather some additional detail on topics previously examined. These items use a somewhat different way of asking for your response since they are getting at a slightly different way of thinking about the topics."*
  - *"The following questions focus on additional care you may have received from [NAME OF HOSPITAL]."*

  Note: Transition statements must be submitted for review by the HCAHPS Project Team.

- In addition, if a client hospital requests that a survey vendor include supplemental questions as part of the HCAHPS Survey asking the patient to provide their name, telephone number or other contact information, the survey vendor is required to include explanatory text. This text must be placed before the requested information and state the purpose for the patient to optionally provide the requested information. It is NOT sufficient to only state that this information is optional. The following are examples of permissible explanatory text:
  - *"If you wish to be contacted by the hospital, please provide your name and telephone number. This information is not required."*
  - *"By providing your name and telephone number, you may be contacted by the hospital. This information is not required."*

Hospitals/Survey vendors must avoid hospital-specific supplemental questions that:

- pose a burden to the patient (e.g., number, length, and complexity of supplemental questions, etc.)
- may affect responses to the HCAHPS Survey
- may cause the patient to terminate the survey (e.g., items that ask about sensitive medical, health or personal topics, etc.)
- jeopardize patient confidentiality (e.g., items that ask for the patient's Social Security number, etc.)
- ask the patient to explain why he or she chose a specific response; for example, it is not acceptable to ask patients why they indicated that they would not recommend the hospital to friends and family

The number of supplemental questions added is left to the discretion of the hospital/survey vendor. The hospital/survey vendor must submit the maximum number of supplemental survey items in the Administrative Data section for each survey (see Appendix R).

- Each potential supplemental item counts as one question, whether or not the item is phrased as a sentence or as a question
- Each open-ended or free response question counts as one supplemental item

Cover Letters

Hospitals/Survey vendors may adapt the sample HCAHPS Cover Letters provided (see Appendices A through G) or compose their own cover letters. Hospitals/Survey vendors must

follow the guidelines described below when altering the cover letter templates provided in this manual.

Note: Text is formatted in [UPPERCASE LETTERING] to designate a placeholder. Please populate placeholders using standard capitalization rules.

Required for the Cover Letter

- Cover letters must be in a readable font (i.e., Arial or Times New Roman) with a font size of 12-point at a minimum
- Cover letters must be printed on the hospital's (preferred) or survey vendor's letterhead and must include the signature of the hospital administrator or hospital/survey vendor project director
  - An electronic signature is permissible
- The following items must be included in the body of the cover letter:
  - Name and address of the sampled patient. "To Whom It May Concern" is not an acceptable salutation.
  - The hospital name and discharge date (it is optional to include the day of the week, e.g., Monday, with the 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.
  - The sentence stating the sponsor of the survey and length of time to complete questions 1-29: "Questions 1-29 in the survey are sponsored by the United States Department of Health and Human Services and should take about 7 minutes to complete."
  - The sentence stating that participation in the survey is voluntary and responses are kept private: "Your participation is voluntary, and your answers will be kept private."
  - The sentences stating the purpose of the survey and where to find hospital ratings: "Your responses will help improve the quality of hospital care and help other people make more informed choices about their care. You can see current survey results and find hospital ratings on the Care Compare Web site (www.medicare.gov/care-compare)."
  - A customer support telephone number for hospitals self-administering the survey and a toll-free customer support telephone number for survey vendors. In some instances, hospitals contracting with survey vendors may want their own telephone number on the survey in addition to, or in lieu of, the survey vendor's number. In cases where the hospital has a customer support telephone number in lieu of the survey vendor, it is the responsibility of the survey vendor to monitor the hospital's customer support telephone number, at a minimum on a quarterly basis, to confirm that the hospital's customer support telephone number is operational. The survey vendor must also verify that the hospital is prepared to receive questions prior to the first mailing of the questionnaire; the hospital answers patient questions accurately; and the hospital keeps a record of customer support inquiries about HCAHPS.
- The OMB language (Appendices A through G) must appear verbatim on either the questionnaire (preferred) or cover letter, and may appear on both, in a readable font at a minimum of 10-point
- Cover letters must **not**:
  - be attached to the survey; doing so could compromise confidentiality

- attempt to bias, influence or encourage patients to answer HCAHPS questions in a particular way
- imply that the hospital, its personnel or its agents will be rewarded or gain benefits if patients answer HCAHPS questions in a particular way
- ask or imply that patients should choose certain responses; indicate that the hospital is hoping for a given response, such as a "10," "Definitely yes," or an "Always"
- indicate that the hospital's goal is for all patients to rate them as a "10," "Definitely yes" or an "Always"
- offer incentives of any kind for participation in the survey
- include any content that attempts to advertise or market the hospital's mission or services
- offer patients the opportunity to complete the survey over the telephone
- include any promotional or marketing text

Optional for the Cover Letter

- Use of the Spanish, Chinese, Russian, Vietnamese, Portuguese, or German cover letters is allowed if the hospital/survey vendor is sending a Spanish, Chinese, Russian, Vietnamese, Portuguese, or German questionnaire to the patient
- Information may be added to the cover letters (in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, or German) that indicates that the patient may request a mail survey in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, or German
- Any instructions that appear on the survey may be repeated in the cover letter
- The wording indicating the purpose of the unique identifier ("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.") must be printed immediately after the survey instructions on the questionnaire (preferred) or on the cover letter, and may appear on both
- Hospital's/Survey vendor's return address may be included on the cover letter to make sure the questionnaire is returned to the correct address in the event that the enclosed return envelope is misplaced by the patient
- If the hospital's/survey vendor's name is included in the return address, then the hospital's/survey vendor's business name must be used, not an alias or tag line
- A reply-by date may be added to the **follow-up cover letter**. It is recommended that the reply-by date be calculated as 35 days from the initial mailing to make sure the survey is returned before the data collection closes.
  - There are two options for adding the reply-by date to the **follow-up cover letter** in a readable font size at a minimum of 12-point. (See Appendices A through G for the exact text and placement.)

Required for the Envelopes

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

Optional for the Envelopes

- The outgoing envelope may be printed with the banner, "Important - Open Immediately." No other banners may be used on the outgoing or return envelope.
  - Other messages, marketing or promotional text such as, "Survey Enclosed," "Important Information from the Centers for Medicare & Medicaid Services Enclosed," or "We always strive to provide excellent service" on either side (front or back) is **not** permitted
- The outgoing envelope may be printed with the hospital or survey vendor logo, or both
- Hospitals/Survey vendors may use window envelopes as a quality control measure to ensure that each patient's survey package is mailed to the address of record for that patient

Note: Any variations to the survey materials, other than the optional items listed above, will require an approved Exception Request prior to survey administration (see the Exception Request/Discrepancy Report Processes chapter).

Mailing of Materials

Hospitals/Survey vendors must mail materials following the guidelines described below:

- Attempts must be made to contact every eligible patient drawn into the sample, whether or not they have a complete mailing address. Hospitals/Survey vendors must use commercial software or other means to update addresses provided by the hospital for sampled patients. (Mailings returned as undeliverable and for which no updated address is available must be coded "9 – Non-response: Bad address.") Hospitals/Survey vendors must retain a record of attempts made to acquire missing address data. All materials relevant to survey administration are subject to review.
  - Hospitals/Survey vendors have flexibility in not sending mail surveys to patients without mailing addresses, such as the homeless. However, hospitals/survey vendors must first make every reasonable attempt to obtain a patient's address including re-contacting the hospital client to inquire about an address update for patients with no mailing address. Attempts to obtain the patient's address must be documented.

  Note: It is strongly recommended that hospitals/survey vendors check the accuracy of sampled patients' contact information prior to survey fielding.

- The HCAHPS Survey cannot be administered without both a cover letter and self-addressed, stamped business return envelope
- All mailings must be sent to each patient by name, and to the patient's most current address listed in the hospital record or retrieved by other means
- For patients who request to be sent an additional questionnaire (either after the first or second mailing) hospitals/survey vendors must follow the guidelines below:
  - It is acceptable to mail a replacement survey at the patient's request within the 42 calendar day survey administration period; however, the survey administration timeline does not restart
  - After 42 calendar days from the first mailing, a replacement HCAHPS Survey must NOT be mailed-out, as the data collection timeframe of 42 calendar days after the first mailing has expired

Hospitals/Survey vendors are **not** allowed to:

- show or provide the HCAHPS Survey or cover letters to patients prior to the administration of the survey, including while the patient is still in the hospital
- mail any pre-notification letters or postcards after discharge to inform patients about the HCAHPS Survey

Note: In instances where returned mail surveys have all missing responses (i.e., without any questions answered – blank questionnaires), send a second survey to the patient if the data collection time period has not expired. If the second mailing is returned with all missing responses, then code the "Final Survey Status" as "7 – Non-response: Refusal." If the second mailing is not returned, then code the "Final Survey Status" as "8 – Non-response: Non-response after maximum attempts."

Note: When the first survey is not returned, the second survey is mailed and subsequently the second mailed survey is returned with all missing responses, then code the "Final Survey Status" as "7 – Non-response: Refusal."

It is strongly recommended that all mailings be sent with first class postage or indicia to ensure delivery in a timely manner and to maximize response rates, as first class mail is more likely to be opened.

Data Receipt and Retention

Hospitals/Survey vendors may use key-entry or scanning to record returned survey data in their data collection systems. Returned questionnaires must be tracked by date of receipt as well as key-entered or scanned in a timely manner. If a patient returns two survey questionnaires, the hospital/survey vendor must use only the first HCAHPS Survey received.

Hospitals/Survey vendors must maintain a crosswalk of their interim disposition codes to the HCAHPS Final Survey Status codes and include the crosswalk in the hospital's/survey vendor's QAP.

Hospitals/Survey vendors must record and submit lag time for **all** HCAHPS "Final Survey Status" codes. Additionally, hospitals/survey vendors must include the "Number Survey Attempts – Mail" field in the Administrative Data Record. This field is required when "Survey Mode" in the Header Record is "1 – Mail Only." Hospitals/Survey vendors must document the "Number Survey Attempts – Mail" for the mail wave in which the "Final Survey Status" is determined. For example, if a survey is returned from the first mailing then the "Number of Survey Attempts – Mail" would be coded "1 – First wave mailing." When a survey is returned from the second mailing, then the "Number Survey Attempts – Mail" would be coded "2 – Second wave mailing." Please see the *Data Specifications and Coding* chapter for more information regarding the calculation of lag time and coding the "Number Survey Attempts – Mail" field.

Hospitals/Survey vendors must follow the data entry decision rules and data storage requirements described below.

Key-entry

Hospitals'/Survey vendors' key-entry processes must incorporate the following features:

- *Unique record verification system*: The survey management system performs a check to verify that the patient response data have not already been entered in the survey management system
- *Valid range checks*: The data entry system identifies responses/entries that are invalid or out-of-range
- *Validation*: Hospitals/Survey vendors must have a plan and process in place to verify the accuracy of key-entered data. Hospitals/Survey vendors must confirm that key-entered data accurately capture the responses on the original survey. A different staff member (preferably the data entry supervisor) must reconcile any discrepancies. It is strongly suggested that hospitals using the HCAHPS Data Form, formerly the Online Data Entry Tool, download Excel spreadsheets containing entered data and compare entered data to the original returned surveys. This validation process must be performed by someone other than the person doing data entry via the HCAHPS Data Form.

Scanning

Hospitals'/Survey vendors' scanning software must accommodate the following:

- *Unique record verification system*: The survey management system performs a check to confirm that the patient's survey responses have not already been entered in the survey management system
- *Valid range checks*: The software identifies invalid or out-of-range responses
- *Validation*: Hospitals/Survey vendors must have a plan and process in place to confirm the accuracy of scanned data. Hospitals/Survey vendors must make certain that scanned data accurately capture the responses on the original survey. A staff member must reconcile any responses not recognized by the scanning software.

Decision Rules

Whether employing scanning or key-entry of mail questionnaires, hospitals/survey vendors must use the following decision rules to resolve common ambiguous situations. Hospitals/Survey vendors must follow these guidelines to ensure standardization of data entry across hospitals.

- If a mark falls between two response options but is obviously closer to one than the other, then select the choice to which the mark is closest
- If a mark falls equidistant between two response options, then code the value for the item as "M – Missing/Don't Know"
- If a mark is missing, code the value for the item as "M – Missing/Don't Know." Hospitals/Survey vendors must not impute a response.
- When more than one response option is marked, code the value as "M – Missing/Don't Know" (except for survey Question 28, *"What is your race? Please choose one or more."*)

  *Note: In instances where there are multiple marks, **but** the patient's intent is clear, hospitals/survey vendors should code the survey with the patient's **clearly identified** intended response.*

Data Storage

Hospitals/Survey vendors must store returned paper questionnaires or scanned images of paper questionnaires in a secure and environmentally controlled location for a minimum of three years. Paper questionnaires or scanned images must be easily retrievable. Hospitals/Survey vendors must

destroy HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files in a secure and environmentally safe location. Obtain a certificate of the destruction of data.

Quality Control Guidelines

Hospitals/Survey vendors are responsible for the quality of work performed by any staff members and subcontractor(s), such as printers or fulfillment houses. Hospitals/Survey vendors must conduct **on-site** verification of printing and mailing processes (strongly recommended on an annual basis, at a minimum), regardless of whether they are using organizational staff or subcontractor(s) to perform this work.

Note: Mail survey administration activities must not be conducted from a residence or non-business location.

To avoid mail administration errors and to make certain that questionnaires are delivered as required, hospitals/survey vendors must:

- perform interval checking of at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of all printed mailing pieces for:
  - fading, smearing and misalignment of printed materials
  - appropriate survey contents, accurate address information and proper postage on the survey sample packet
  - assurance that all printed materials in a mailing envelope have the same unique identifier
  - inclusion of all eligible sampled patients in the sample mailing for that month
- include seeded mailings in mail-outs at a minimum on a quarterly basis
  - Seeded mailings are sent to designated hospital/survey vendor HCAHPS project staff (other than the staff producing the materials) to check for timeliness of delivery, accuracy of addresses, content of the mailing, and the quality of the printed materials
  - Seeded mailings must be integrated into the hospital's batched survey mailings, not sent as a stand-alone mailing to HCAHPS project staff
- perform address updates for missing or incorrect information
  - Attempts must be made to update address information to confirm accuracy and correct formatting
  - In addition to working with client hospitals to obtain the most current patient contact information, hospitals/survey vendors must employ other methods, such as the National Change of Address (NCOA) and the United States Postal Service (USPS) Coding Accuracy Support System (CASS) Certified Zip+4 software. Other means are also available to update addresses for accurate mailings, such as:
    - Commercial software
    - Internet search engines

*Note: If automated processes are being used to perform interval checks, then checks of the system or equipment must be performed on an ongoing and continuous basis throughout the survey administration period. Hospitals/Survey vendors **must** retain a record of all quality control activities and document these activities in the hospital's/survey vendor's QAP. All materials relevant to survey administration are subject to review.*

Telephone Only Survey Administration

New for 2021

Beginning with July 1, 2021 discharges, there will be one version of the HCAHPS Telephone Script (previously the Optional Modified version with revisions).

- HCAHPS Telephone Script (see Appendices H through K), including new required and optional elements

Overview

This chapter describes guidelines for the Telephone Only mode of the CAHPS Hospital Survey (HCAHPS) administration.

Data collection for sampled discharged patients must be initiated between 48 hours and six weeks (42 calendar days) after discharge. Hospitals/Survey vendors must wait 48 hours to make the first attempt to contact discharged patients. This will allow enough time to pass for the patient to return home and feel settled after his or her hospital stay. The HCAHPS Survey must **not** be administered while the patient is still in the hospital. A total of five telephone attempts must be made to contact non-respondents.

Note: If the hospital/survey vendor learns that a sampled patient is ineligible for HCAHPS, the hospital/survey vendor must not make further attempts to contact that patient. ***After the sample has been drawn, any patients who are found to be ineligible must not be removed or replaced in the sample. Instead, these patients are assigned the "Final Survey Status" code of ineligible (2, 3, 4, or 5; as applicable). An Administrative Data Record must be submitted for these patients.***

Data collection must be closed out for a sampled patient by six weeks (42 calendar days) following the first call attempt. If it is known that the patient may be available in the latter part of the 42 calendar day data collection time period (e.g., patient is on vacation the first 2 or 3 weeks of the 42 calendar day data collection time period and there would be an opportunity to reach the patient closer to the end of the data collection time period), then hospitals/survey vendors must use the entire data collection time period to schedule telephone calls. Telephone call attempts are to be made between the hours of 9 AM and 9 PM respondent time. Patients who receive the HCAHPS Survey must not be offered incentives of any kind. Patients who do not respond to the survey are assigned a "Final Survey Status" code of non-response.

Hospitals/Survey vendors must make every reasonable effort to achieve optimal survey response rates and to pursue contact with potential respondents until the data collection protocol is completed.

No proxy respondents are permitted in the administration of the HCAHPS Survey, not even for patients who are critically ill, elderly, physically or mentally impaired, or do not speak the language in which the survey is being administered (i.e., English, Spanish, Chinese, or Russian). As stated above, a proxy respondent must not answer the survey questions for the patient. However, an individual may assist the patient by repeating questions or with translation of the survey, but only the patient may provide answers to the survey.

The basic tasks and timing for conducting the HCAHPS Survey using the Telephone Only mode of survey administration are summarized below.

Telephone Only Survey Administration
Initiate systematic telephone contact with sampled patient(s) between 48 hours and six weeks (42 calendar days) after discharge.
Complete telephone sequence so that a total of five telephone calls are attempted at different times of the day, on different days of the week and in different weeks within the six weeks (42 calendar days) after initiation of the survey (initial contact). The five telephone call attempts must span more than one week (eight or more days) to account for patients who are temporarily unavailable. If it is known that the patient may be available in the latter part of the 42 calendar day data collection time period (e.g., patient is on vacation the first 2 or 3 weeks of the 42 calendar day data collection time period and there would be an opportunity to reach the patient closer to the end of the data collection time period), then hospitals/survey vendors must use the entire data collection time period to schedule telephone calls.
Submit final data files to CMS via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal, by the data submission deadline. No files will be accepted after the submission deadline date.

To reiterate, the first telephone attempt must occur between 48 hours and six weeks (42 calendar days) after discharge. Data collection must then be completed no later than six weeks (42 calendar days) after the initial telephone attempt. To illustrate the timing of the telephone attempts, three examples are provided of patients who were discharged from a hospital on July 1.

Example Patient 1:

- The first telephone attempt is made on July 4 (three days after discharge)
- Data collection must be closed out by August 15 for this patient, which is six weeks (42 calendar days) from the July 4 first telephone attempt date:
  - If a telephone interview is completed on August 15, which is the last day of the survey administration time period for this patient, then the survey data are included in the final survey data file and assigned a "Final Survey Status" code of either "1 – Completed survey" or "6 – Non-response: Break-off" based on the calculation of percent complete as described in the Data Specifications and Coding chapter
    - Lag Time (See the *Data Specifications and Coding* chapter) for this patient is calculated as 45 days
  - If the survey is mistakenly completed after August 15 (August 16, for example), which is beyond the six weeks (42 calendar days) survey administration time period for this patient, then the survey data are not included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and a "Final Survey Status" code of "8 – Non-response: Non-response after maximum attempts" is assigned
    - Lag Time for this patient is calculated and entered as 46 days

Example Patient 2:

- The first telephone attempt is made on August 12 (42 calendar days after discharge)
- Data collection must be closed out by September 23 for this patient, which is six weeks (42 calendar days) from the August 12 first telephone attempt date
  - If a telephone interview is completed on September 23, which is the last day of the survey administration time period for this patient, then the survey data are included in the final survey data file and assigned a "Final Survey Status" code of either "1 – Completed survey" or "6 – Non-response: Break-off" based on the calculation of percent complete as described in the *Data Specifications and Coding* chapter
    - Lag Time for this patient is calculated as 84 days

Example Patient 3:

- The first telephone attempt is made on August 12 (42 calendar days after discharge)
- Data collection must be closed out on September 23 for this patient, which is six weeks (42 calendar days) from the August 12 first telephone attempt date:
  - If the patient is reached on the fifth attempt on September 21 and the patient refuses to participate in the HCAHPS Survey, then the survey data are not included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and the "Final Survey Status" code of "7- Non-response: Refusal" is assigned
    - Lag Time for this patient is calculated and entered as 82 days

Hospitals/Survey vendors must make every reasonable effort to achieve optimal telephone response rates by thoroughly familiarizing interviewers with the study purpose; carefully supervising interviewers; retraining those interviewers having difficulty enlisting cooperation; and re-contacting reluctant respondents with different interviewers at different times until the final data collection protocol is completed.

Telephone Interviewing Systems

Telephone Script

Hospitals/Survey vendors are provided standardized telephone scripts in English, Spanish, Chinese, and Russian (Appendices H through K) for HCAHPS Survey administration. These telephone scripts must be read verbatim without adding any other scripting or tag questions, such as "How are you?" Hospitals/Survey vendors are not permitted to make or use any other language translations of the HCAHPS Telephone Scripts. **We strongly encourage hospitals/survey vendors to administer the HCAHPS Survey in both English and Spanish, including offering the official HCAHPS Survey translations (Chinese or Russian) for hospitals with significant patient populations speaking in these languages.**

Each hospital/survey vendor must submit a copy of their HCAHPS Telephone Script and interviewer screen shots (including skip pattern logic) for review by the HCAHPS Project Team. Please see the *Oversight Activities* chapter for more detail.

Required for the Telephone Script

The HCAHPS Survey (Questions 1-29) must remain together. The HCAHPS Survey questions cannot be eliminated from the script.

Programming of the telephone scripts must follow the guidelines described below:

- Question and answer category wording must not be changed
- No changes are permitted to the order of the HCAHPS Survey (Questions 1-29)
- No changes are permitted to the order of the answer categories for the HCAHPS questions
- All underlined content must be emphasized
  - No other script content is to be emphasized; in particular, response options must be read at the same even pace without any additional emphasis on any particular response category
- Only one language (English, Spanish, Chinese, or Russian) may appear on the electronic interviewing system screen
- The hospital/survey vendor is responsible for programming the scripts and specifications into their electronic telephone interviewing system software or an alternative system
  - The transitional phrases found throughout the telephone script are part of the structured script and must be read. An example of a transitional phrase that must be read can be found before Question 10 (Q10_Intro): "The next questions are about your experiences in this hospital."
  - Do not program a specific response category as the default option
  - Survey vendors that subcontract call center services must instruct interviewers, if asked who is calling, to state the survey vendor name in the CATI script introduction for the data collection contractor: "…calling from [DATA COLLECTION CONTRACTOR] on behalf of [HOSPITAL NAME]…"

*Note: Hospitals/Survey vendors **must** include the copyright statement on any published materials containing the HCAHPS Telephone Script, preferably at the end of the telephone script (see Appendices H through K).*

Hospitals/Survey vendors must have a process in place to address patients' requests to verify the survey legitimacy or to answer questions about the survey. See Appendix O "Frequently Asked Questions for Customer Support."

Use of Supplemental Questions

Hospitals/Survey vendors may add a reasonable number of hospital-specific supplemental questions to the HCAHPS Survey, following the guidelines described below:

- Hospital-specific supplemental question(s) may be added to the HCAHPS Survey but only after all the HCAHPS Survey questions (Questions 1-29). This approach ensures that the survey is conducted consistently across participating hospitals.
- The mandatory transition statement must be placed in the survey immediately before the supplemental questions to indicate a transition from the HCAHPS questions to the hospital-specific supplemental question or questions (see Appendices H through K for the exact text in English, Spanish, Chinese and Russian)
- Hospitals may include additional transition statements following the required transition statement. Examples of allowable additional transition statements are as follows:

- *"Now [NAME OF HOSPITAL] would like to gather some additional detail on topics previously examined. These items use a somewhat different way of asking for your response since they are getting at a slightly different way of thinking about the topics."*
- *"The following questions focus on additional care you may have received from [NAME OF HOSPITAL]."*

Note: Transition statements must be submitted for review by the HCAHPS Project Team.

- In addition, if a client hospital requests that a survey vendor include supplemental questions as part of the HCAHPS Survey asking the patient to provide their address or other contact information, the survey vendor is required to include explanatory text. This text must be placed 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 contact information. This information is not required."*
  - *"By providing your contact information, you may be contacted by the hospital. This information is not required."*

Hospitals/Survey vendors must avoid hospital-specific supplemental questions that:

- pose a burden to the patient (e.g., number, length, and complexity of supplemental questions, etc.)
- may affect responses to the HCAHPS Survey
- may cause the patient to terminate the survey (e.g., items that ask about sensitive medical, health or personal topics, etc.)
- jeopardize patient confidentiality (e.g., items that ask for the patient's Social Security number, etc.)
- ask the patient to explain why he or she chose a specific response; for example, it is not acceptable to ask patients why they indicated that they would not recommend the hospital to friends and family

The number of supplemental questions added is left to the discretion of the hospital/survey vendor. The hospital/survey vendor must submit the maximum number of supplemental survey items in the Administrative Data Record for each survey (see Appendix R).

- Each potential supplemental item counts as one question, whether or not the item is phrased as a sentence or as a question
- Each open-ended or free response question counts as one supplemental item

Interviewing Systems

Two methods exist for telephone interviewing:

1. An electronic telephone interviewing system **is required for survey vendors**; it is optional for hospitals that are self-administering the survey. An electronic telephone interviewing system uses standardized scripts and design specifications. The hospital/survey vendor is responsible for programming the scripts and specifications into their electronic telephone interviewing software. Regardless of patient response, the interviewer must record all responses in the telephone interview.

- 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
- Survey vendors may program the caller ID to display "on behalf of [HOSPITAL NAME]," with the permission and compliance of the hospital's HIPAA/Privacy Officer. Survey vendors **must not** program the caller ID to display only "[HOSPITAL NAME]."

2. Manual data collection is permitted only for hospitals that are self-administrating the survey. Manual data collection involves an interviewer who conducts the interview using the standardized script over the telephone and records answers on paper.

Monitoring/Recording Telephone Calls

Survey vendors must be aware of and follow applicable state regulations when monitoring and/or recording telephone calls, including those that permit monitoring/recording of telephone calls only after the interviewer states, "This call may be monitored (and/or recorded) for quality improvement purposes." This statement is found at the end of the INTRO section of the HCAHPS Telephone Script located in Appendices H through K.

Telephone Attempts

Hospitals/Survey vendors must attempt to reach each and every patient in the sample. It is strongly recommended that hospitals/survey vendors use both the primary (Patient Telephone Number 1) and secondary (Patient Telephone Number 2) numbers provided by the hospital. If the first telephone number is found to be bad/non-working, then the second telephone number should be used. It is up to the hospitals'/survey vendors' discretion to determine the number of attempts made to each telephone number; however, no more than a total of five call attempts can be made to a sampled patient.

Telephone call attempts are to be made between the hours of 9 AM and 9 PM respondent time. Repeated attempts must be made until the patient is contacted, found ineligible or five attempts have been made. After five attempts to contact the patient have been made, no further attempts are to be made. A telephone attempt is defined as one of the following:

- The telephone rings six times with no answer
- The interviewer reaches a wrong number
- An answering machine/voice mail is reached. In this case, the interviewer must not leave a message.
- The interviewer reaches a household member and is told that the patient is not available to come to the telephone or has a new telephone number. The interviewer must not leave a message.
- The interviewer reaches the patient and is asked to call back at a more convenient time

- The callback must be scheduled at the patient's convenience. When requested, hospitals/survey vendors must schedule a telephone callback that accommodates a patient's request for a specific day and time (i.e., between the hours of 9 AM and 9 PM respondent time within the 42 calendar day data collection period).

- The interviewer reaches a 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
- The interviewer reaches a "screening" number (e.g., privacy screen, privacy manager, phone intercept, or blocked call)
  - Hospitals/Survey vendors count this as one telephone attempt and continue to make additional attempts (up to five) to reach the patient before dispositioning the call as "8 – Non-response: Non-response after maximum attempts"

Sampled patients are to be called up to five times unless the sampled patient completes the survey, is found to be ineligible or explicitly refuses to complete the survey (or if someone refuses on behalf of the patient).

- If the patient is unavailable for any reason, the interviewer must not conduct the interview with a proxy
- If the hospital/survey vendor learns that a patient is ineligible for HCAHPS, that patient must not receive any further telephone attempts

Hospitals/Survey vendors must adhere to the following guidelines in their attempts to contact patients:

- Telephone attempts are made at various times of the day, on different days of the week and in different weeks to maximize the probability that the hospital/survey vendor will contact the patient

  Note: More than one telephone attempt may be made in a week (seven calendar days). However, the five telephone attempts cannot be made in only one week (seven calendar days). The five call attempts must span more than one week (eight or more days), and it is strongly recommended that call attempts also include weekends.

- Patients who call back after an initial contact can be scheduled for interviews or forwarded to an available HCAHPS interviewer
- Interviewers must not leave messages on answering machines or with household members, since this could violate a patient's privacy. Hospitals/Survey vendors must instead attempt to re-contact the patient to complete the HCAHPS Survey.
- When a patient requests to complete at a later date a telephone survey already in progress, a callback should be scheduled. At the time of the callback, the interview should resume with the next question where the patient left off from the previous call.
- If on the fifth attempt, the patient requests to schedule an appointment to complete the survey, it is permissible to schedule that appointment and call the patient back provided that the appointment is within the 42 calendar day data collection time period. If on the callback at the scheduled time, no connection is made with the patient, then no further contact may be attempted. This additional (sixth) call attempt would be coded as "5 – Fifth Telephone attempt" for data submission.

Hospitals/Survey vendors must take the following steps to contact **difficult to reach patients**:

- If the patient's telephone number is incorrect, make every effort to find the correct telephone number. If the person answering the telephone knows how to reach the patient, the new information must be used.
- It is strongly recommended that the secondary telephone number be contacted if there is more than one telephone number available for the patient
- If the patient is away temporarily, he or she must be contacted upon return, provided that it is within the data collection time period. If it is known that the patient may be available in the latter part of the 42 calendar day data collection time period (e.g., patient is on vacation the first 2 or 3 weeks of the 42 calendar day data collection time period and there would be an opportunity to reach the patient closer to the end of the data collection time period), then hospitals/survey vendors must use the entire data collection time period to schedule telephone calls.
- If the patient does not speak the language in which the survey is being administered, the interviewer must thank the patient for his or her time and terminate the interview
- If the patient is temporarily ill or readmitted to the hospital, the interviewer must re-contact the patient before the end of the data collection period to see if there has been a recovery and the patient can now complete the survey
- If the patient is unavailable for any reason, the interviewer must not conduct the interview with a proxy
- If the call is inadvertently dropped and the interview is interrupted, the patient should be re-contacted immediately to complete the remainder of the survey. This re-contact does not constitute an additional call attempt.

Obtaining and Updating Telephone Numbers

Hospitals/Survey vendors normally obtain telephone numbers from the hospital's patient discharge records. It is strongly recommended that two telephone numbers are collected and used for each patient, if available. Hospitals/Survey vendors must use commercial software or other means to update telephone numbers provided by the hospital for **all** sampled patients. Requisite attempts must be made to contact every eligible patient drawn into the sample, whether or not there is a complete and correct telephone number for the patient when the sample is created. Hospitals/Survey vendors must retain a record of attempts to acquire missing telephone numbers. All materials relevant to survey administration are subject to review.

In addition to working with client hospitals to obtain the most current patient contact information, hospitals/survey vendors must employ various methods for updating telephone numbers:

- Running update program software against the sample file just before or after uploading data to survey management systems
- Utilizing commercial software, Internet directories and/or directory assistance

Note: It is strongly recommended that hospitals/survey vendors check the accuracy of sampled patients' contact information prior to survey fielding.

Data Receipt and Retention

Hospitals/Survey vendors must record the date of the telephone interview and must link survey responses from the telephone interview to their survey management system, regardless of the interviewing system employed. Hospitals/Survey vendors must maintain a crosswalk of their interim disposition codes to the HCAHPS "Final Survey Status" codes and include the crosswalk in the hospital's/survey vendor's QAP.

Hospitals/Survey vendors must record and submit lag time for **all** HCAHPS "Final Survey Status" codes. Additionally, hospitals/survey vendors must include the "Number Survey Attempts – Telephone" field in the Administrative Data Record. This field is required when "Survey Mode" in the Header Record is "2 – Telephone Only." Hospitals/Survey vendors must document the "Number Survey Attempts – Telephone" for the telephone attempt in which the "Final Survey Status" is determined. For example, if the interview was conducted and finished with the patient on the fourth telephone attempt then the "Number Survey Attempts – Telephone" would be coded as "4 – Fourth Telephone attempt." Please see the *Data Specifications and Coding* chapter for more information regarding the calculation of lag time and coding the "Number Survey Attempts – Telephone" field.

Electronic Telephone Interviewing System

The electronic telephone interviewing system employed by hospitals/survey vendors must be electronically linked to their survey management system to enable responses obtained from the electronic telephone interviewing system to be automatically added to the survey management system.

Manual Data Collection

Only hospitals self-administering the survey are permitted to use manual data collection methods. Hospitals using manual data entry (paper questionnaires) to collect survey data over the telephone must follow the guidelines below for linking survey responses to the survey management system. Either key-entry or scanning may be used.

- Key-entry
  - *Unique record verification system*: The survey management system performs a check to verify that the patient response data have not already been entered in the survey management system
  - *Valid range checks*: The data entry system identifies responses/entries that are invalid or out-of-range
  - *Validation*: The hospital must perform checks to confirm that key-entered data accurately capture the responses of the telephone interview. A different staff member (preferably the data entry supervisor) must reconcile any discrepancies. It is strongly suggested that hospitals using the HCAHPS Data Form, formerly the Online Data Entry Tool, download Excel spreadsheets containing entered data and compare entered data to the original survey completed by the telephone interviewer. This validation process must be performed by someone other than the person doing data entry via the HCAHPS Data Form.
- Scanning

- *Unique record verification system*: The survey management system performs a check to confirm that the survey responses have not already been entered in the survey management system
- *Valid range checks*: The software identifies invalid or out-of-range responses
- *Validation*: The hospital must perform checks to verify that scanned data accurately capture the responses on the original survey completed by the telephone interviewer. A staff member must reconcile any responses not recognized by the scanning software.

Data Storage

The following data storage guidelines must be followed for HCAHPS telephone surveys:

- Data collected through an electronic telephone interviewing system must be retained in a secure manner for a minimum of three years and must be easily retrievable
- Data collected manually by telephone with paper questionnaires and then key-entered must be de-identified and stored in a secure and environmentally controlled location for a minimum of three years and must be easily retrievable
- Optically scanned questionnaire images of telephone interviews collected with paper questionnaires also must be de-identified and retained in a secure and environmentally controlled location for a minimum of three years and must be easily retrievable
- Hospitals/Survey vendors must destroy HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files in a secure and environmentally safe location. Obtain a certificate of the destruction of data.

Quality Control Guidelines

Hospitals/Survey vendors are responsible for the quality of work performed by any staff members and subcontractor(s). Hospitals/Survey vendors must employ the following guidelines for proper interviewer training, monitoring and oversight regardless of whether they are using organizational staff or subcontractor(s) to perform this work.

Interviewer Training

Consistent monitoring of interviewers' work is essential to achieve standardized and accurate results. Properly trained and supervised interviewers ensure that standardized, non-directive interviews are conducted. Interviewers conducting the telephone survey must be trained prior to interviewing. (See Appendix N for more information on interviewing guidelines.)

- Training must direct interviewers to read questions exactly as worded in the script, use non-directive probes and maintain a neutral and professional relationship with the respondent
  - During the course of the survey, the use of neutral acknowledgment words such as the following is permitted:
    - Thank you
    - Alright
    - Okay
    - I understand, or I see
    - Yes, Ma'am
    - Yes, Sir
- Interviewers must be trained to read the script from the telephone screens (reciting the survey from memory can lead to unnecessary errors and missed updates to the scripts)

- Interviewers must be trained to read response options exactly as worded and at an even pace without emphasis on any particular response category
- Interviewers must be trained to record responses to survey questions only after the patient has responded to the questions; that is, interviewers must not pre-code response choices
- In organizations where interviewers assign interim or final call disposition codes, they must be trained in the definition of each disposition code
- Interviewers must be trained in a process for redirecting calls to another interviewer when the patient is personally known to the initial interviewer
- Interviewers must be trained to adjust the pace of the HCAHPS Survey interview to be conducive to the needs of the respondent

If a hospital/survey vendor uses a subcontractor to conduct telephone interviewing, then the hospital/survey vendor is responsible for attending/participating in the subcontractor's telephone interviewer training to confirm compliance with HCAHPS protocols and guidelines. Hospitals/Survey vendors must conduct on-site verification of subcontractor's interviewing processes (strongly recommended on an annual basis, at a minimum).

Telephone Monitoring and Oversight

Each hospital/survey vendor employing the Telephone Only mode of survey administration must institute a telephone monitoring and evaluation program. The telephone monitoring and evaluation program must include, but is not limited to, the following oversight activities:

- Hospitals/Survey vendors must monitor at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of all HCAHPS interviews, dispositions and call attempts in their entirety (across all translations in which the survey is administered) through silent monitoring of interviewers using the electronic telephone interviewing system software or an alternative system. Silent monitoring must be performed at the hospitals'/survey vendors' or their subcontractors' business locations. All staff conducting HCAHPS interviews must be included in the monitoring. Hospitals'/Survey vendors' supervisory staff monitoring the telephone interviewers should use the electronic telephone interviewing system to listen to the audio of the call and simultaneously observe that the correct responses are entered by the interviewer. Additionally, it is required that hospitals/survey vendors provide "floor rounding" in their call-center(s) to visually observe and ensure the professionalism of the telephone interviewers.

  Note: Telephone interviews/monitoring must not be conducted from a residence or non-business location.

- For hospitals using manual data collection, supervisors must observe at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of all HCAHPS interviews and call attempts in their entirety when silent monitoring is not an option
- Hospitals/Survey vendors using a subcontractor must monitor at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of the subcontractor's HCAHPS telephone interviews and call attempts in their entirety, provide feedback to the subcontractor's interviewers about their performance and confirm that the

subcontractor's interviewers correct any areas that need improvement. Feedback must be provided to interviewers as soon as possible following a monitoring session.

Note: HCAHPS protocols currently require that approved HCAHPS Survey vendors who subcontract the task of HCAHPS telephone interviewing monitor at least 10 percent of all HCAHPS calls/attempts/completed surveys (on an ongoing and continuous basis throughout the survey administration period). The HCAHPS Project Team also expects that a survey vendor's subcontractor will conduct internal monitoring of their telephone interviewers as a matter of good business practice that incorporates quality checks. While it is preferred that each organization continue to monitor 10 percent of HCAHPS interviews (for an overall total of 20 percent), it is permissible for the survey vendor and its subcontractor to conduct a combined total of at least 10 percent monitoring, as long as each organization conducts a portion of the monitoring. Therefore, the survey vendor and its subcontractor can determine the ratio of monitoring that each organization conducts, as long as the combined total meets or exceeds 10 percent. Please note that HCAHPS interviews monitored concurrently by the survey vendor and its subcontractor do not contribute separately to each organization's monitoring time.

- Staff who are found to be consistently unable to follow the script verbatim, employ proper probes, remain objective and courteous, be clearly understood, or operate the electronic telephone interviewing system competently, must be identified and retrained or, if necessary, replaced
- In organizations where interviewers assign interim or final disposition codes, the assignment of codes must be reviewed by a supervisor
- Organizations must monitor interviewer survey response coding by, at a minimum, reviewing the frequency of missing responses in the surveys administered by interviewers

*Note: Hospitals/Survey vendors **must** retain a record of all quality control activities and document these activities in the hospital's/survey vendor's QAP. All materials relevant to survey administration are subject to review.*

Mixed Mode Survey Administration

New for 2021

Beginning with July 1, 2021 discharges, there will be one version of the HCAHPS cover letters and telephone script (previously the Optional Modified version with revisions).

- HCAHPS Initial Cover Letter (see Appendices A through D), including new required and optional elements
- HCAHPS Telephone Script (see Appendices H through K), including new required and optional elements

In addition, survey and cover letter language, in all official HCAHPS Survey translations, is located in Appendices A through D.

Overview

This chapter describes guidelines for the Mixed Mode of the CAHPS Hospital Survey (HCAHPS) administration, which is a combination of an initial mailing of the questionnaire with telephone follow-up.

Data collection for sampled discharged patients must be initiated between 48 hours and six weeks (42 calendar days) after discharge. Hospitals/Survey vendors must wait 48 hours to make the first attempt to contact discharged patients. This will allow enough time to pass for the patient to return home and feel settled after his or her hospital stay. Patients must **not** be given the survey while they are still in the hospital.

Hospitals/Survey vendors must send sampled patients a questionnaire with a cover letter, then approximately 21 calendar days after mailing the questionnaire conduct a maximum of five telephone attempts to non-respondents.

*Note: Reversing the protocol (telephone attempts followed by mail attempt) is **not** allowed.*

Note: If the hospital/survey vendor learns that a sampled patient is ineligible for HCAHPS, no further attempts should be made to contact that patient. ***After the sample has been drawn, any patients who are found to be ineligible must not be removed or replaced in the sample. Instead, these patients are assigned the "Final Survey Status" code of ineligible (2, 3, 4, or 5, as applicable). An Administrative Data Record must be submitted for these patients.***

Data collection must be closed out for a sampled patient by six weeks (42 calendar days) following the mailing of the questionnaire. If the patient did not return a mail survey and it is known that the patient may be available in the latter part of the 21 calendar day telephone component of the data collection time period and there would be an opportunity to reach the patient closer to the end of the telephone component of the data collection time period, then hospitals/survey vendors must use the entire 21 calendar day telephone component data collection time period to schedule telephone calls. Telephone call attempts are to be made between the hours of 9 AM and 9 PM, respondent time. Patients who receive the HCAHPS Survey must not be offered incentives of any

kind. Patients who do not respond to the survey are assigned a "Final Survey Status" code of non-response.

Hospitals/Survey vendors must make every reasonable effort to achieve optimal survey response rates and to pursue contact with potential respondents until the data collection protocol is completed.

No proxy respondents are permitted in the administration of the HCAHPS Survey, not even for patients who are critically ill, elderly, physically or mentally impaired, or do not speak the language in which the survey is being administered (i.e., English, Spanish, Chinese, or Russian). As stated above, a proxy must not answer the survey questions for the respondent; however, an individual may assist the patient with reading the survey, writing responses, or with translation of the survey, but only the patient may provide answers to the survey.

The basic tasks and timing for conducting the HCAHPS Survey, using the Mixed Mode of survey administration, are summarized below.

Mixed Mode Survey Administration
Send mail questionnaire with cover letter to sampled patient(s) between 48 hours and six weeks (42 calendar days) after discharge.
Initiate systematic telephone contact for all non-respondents approximately 21 calendar days after mailing the questionnaire.
Over the next 21 calendar days, five telephone calls must be attempted at different times of the day, on different days of the week and in different weeks. The five telephone call attempts must span more than one week (eight or more days) to account for patients who are temporarily unavailable. If it is known that the patient may be available in the latter part of the 21 calendar day telephone component data collection time period (e.g., the patient is on vacation the first 2 weeks of the 21 calendar day telephone component of the data collection time period and there would be an opportunity to reach the patient closer to the end of the data collection time period) then hospitals/survey vendors must use the entire data collection time period to schedule telephone calls.
Submit final data files to CMS via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal, by the data submission deadline. No files will be accepted after the submission deadline date.

To reiterate, the mail-out of the survey must occur between 48 hours and six weeks (42 calendar days) after discharge. Data collection then must be completed no later than six weeks (42 calendar days) after the mailing of the questionnaire. To illustrate the timing of survey mail-out and telephone follow-up, three examples are provided of patients who were discharged from a hospital on July 1.

Example Patient 1:

- The survey is mailed out on July 4 (three days after discharge)
- If the patient has not returned the survey by July 25 (21 days after the initial mailing on July 4), telephone contact must be initiated
- Data collection must be closed out on August 15 for this patient, which is six weeks (42 calendar days) from the July 4 initial mail-out date:
  - If a telephone interview is completed on August 15, which is the last day of the survey administration time period for this patient, then the survey data are included in the final survey data file and assigned a "Final Survey Status" code of either "1 – Completed survey" or "6 – Non-response: Break-off" based on the calculation of percent complete as described in the *Data Specifications and Coding* chapter
    - Lag Time (See the *Data Specifications and Coding* chapter) for this patient is calculated as 45 days
  - If the survey is mistakenly completed after August 15 (August 16, for example), which is beyond the six weeks (42 calendar days) survey administration time period for this patient, then the survey data are not included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and a "Final Survey Status" code of "8 – Non-response: Non-response after maximum attempts" is assigned
    - Lag Time for this patient is calculated and entered as 46 days

Example Patient 2:

- The survey is mailed out on August 12 (42 calendar days after discharge)
- If the patient has not returned the survey by September 2 (21 days after the initial mailing on August 12), telephone contact must be initiated
- If the patient has not returned a survey by September 23, then data collection must be closed out by September 23 for this patient, which is six weeks (42 calendar days) from the August 12 initial mail-out date:
  - If a telephone interview is completed on September 23, which is the last day of the survey administration time period for this patient, then the survey data are included in the final survey data file and assigned a "Final Survey Status" code of either "1 – Completed survey" or "6 – Non-response: Break-off" based on the calculation of percent complete as described in the *Data Specifications and Coding* chapter
    - Lag Time for this patient is calculated as 84 days

Example Patient 3:

- The survey is mailed out on August 12 (42 calendar days after discharge)
- If the patient has not returned the survey by September 2 (21 days after the initial mailing on August 12), telephone contact must be initiated
- If the patient has not returned a survey by September 23, then data collection must be closed out on September 23 for this patient, which is six weeks (42 calendar days) from the August 12 first telephone attempt date:
  - If the patient is reached on the fifth attempt on September 21 and the patient refuses to participate in the HCAHPS Survey, then the survey data are not included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and the "Final Survey Status" code of "7 – Non-response: Refusal" is assigned
    - Lag Time for this patient is calculated and entered as 82 days

Mail Protocol

This section describes guidelines for the mail phase of the Mixed Mode of survey administration.

Production of Questionnaire and Related Materials

The mail phase of the Mixed Mode of survey administration can be conducted in English, Spanish, Chinese, or Russian. Hospitals/Survey vendors are provided with the HCAHPS questionnaires in English, Spanish, Chinese, and Russian, and cover letters in English, Spanish, Chinese, and Russian (Appendices A through D). Hospitals/Survey vendors are not permitted to make or use any other translations of the HCAHPS cover letter or questionnaire. **We strongly encourage hospitals/survey vendors to administer the HCAHPS Survey in both English and Spanish, including offering the official HCAHPS Survey translations (Chinese or Russian) for hospitals with significant patient populations speaking in these languages**.

For HCAHPS Survey administration, the OMB Paperwork Reduction Act language must appear in the mailing, either on the cover letter or on the front or back of the questionnaire, in a readable font size at a minimum of 10-point. (See Appendices A through D for the exact language in English, Spanish, Chinese, and Russian.) In addition, the OMB control number (OMB #0938-0981) and expiration date must appear on the front page of the questionnaire.

To reinforce the requirement that no one other than the sampled patient completes the survey, wording must be included in the questionnaire, and optionally in the cover letter, clearly stating that only the sampled patient may fill out the survey.

Each hospital/survey vendor must submit a sample of their HCAHPS mailing materials (questionnaire, cover letter and outgoing/return envelopes) with all applicable HCAHPS *Quality Assurance Guidelines V16.0* updates for review by the HCAHPS Project Team. Please see the *Oversight Activities* chapter for more detail.

Required for the Mail Questionnaire

The HCAHPS Survey (Questions 1-29) must remain together. The HCAHPS Survey questions cannot be eliminated from the questionnaire.

Hospitals/Survey vendors must adhere to the following specifications for questionnaire formatting and the production of mailing materials.

Questions and Answer Categories

- Question and answer category wording must not be changed
- No changes are permitted to the order of the HCAHPS Survey (Questions 1-29)
- No changes are permitted to the order of answer categories for the HCAHPS questions
- Question and answer categories must remain together in the same column and on the same page
- Response choices must be listed individually for each question, not presented in a matrix format. For example, when a series of questions is asked that have the same answer categories (Never, Sometimes, Usually, or Always) the answer categories must be repeated with every question. A matrix format which simply lists the answer categories across the top of the page and the questions down the side of the page is not allowed, because it has been shown that this format tends to produce inaccurate and incomplete responses.
- Response options must be formatted and listed vertically (see examples in Appendix A). Response options that are listed horizontally or in a combined vertical and horizontal format are not allowed.

Formatting

- Wording that is underlined in the questionnaire provided in the HCAHPS *Quality Assurance Guidelines* must be emphasized in the same manner in the hospital's/survey vendor's questionnaire
- Arrow (i.e., ➔) placement in the questionnaire instructions and answer categories that specifies skip patterns must not be changed
- Section headings (e.g., YOUR CARE FROM NURSES, etc.) must be included on the questionnaire and must be capitalized
- Survey materials must be in a readable font (i.e., Arial or Times New Roman) with a font size of 10-point at a minimum

Other Requirements

- All survey instructions written at the top of the questionnaire must be printed verbatim
- The text indicating the purpose of the unique identifier *("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.")* must be printed immediately after the survey instructions on the questionnaire (preferred) or on the cover letter, and may appear on both
- Randomly generated, unique identifiers must be placed on the first or last page of the questionnaire, at a minimum. Hospitals/Survey vendors may add internal codes as identifiers on the survey for tracking purposes; however, the internal codes must not contain any patient identifiers such as the patient's discharge date (including the month and year), doctor or unit. The patient's name must not be printed on the questionnaire.
- The copyright statement must be included on the questionnaire, preferably on the last page, in a readable font size at a minimum of 10-point (See Appendices A through D for the exact text)
- The OMB control number (OMB #0938-0981) and expiration date must appear on the front page of the questionnaire
- The OMB language must appear verbatim on either the front or back page of the questionnaire (preferred) or on the cover letter, and may appear on both in a readable font size at a minimum of 10-point (See Appendices A through D for the exact text in English,

Spanish, Chinese, and Russian); however, the OMB language cannot be printed on a separate piece of paper

- The hospital's/survey vendor's return address must be printed on the questionnaire in order to make sure that the questionnaire is returned to the correct address in the event that the enclosed return envelope is misplaced by the patient
  - If the hospital's/survey vendor's name is included in the return address, then the hospital's/survey vendor's business name must be used, not an alias or tag line

Optional for the Mail Questionnaire

Hospitals/Survey vendors have some flexibility in formatting the HCAHPS questionnaire by following the guidelines described below:

- Small coding numbers, preferably in superscript, may be included next to the response choices on the questionnaire
- It is acceptable to have a place on the survey for patients to voluntarily fill in their name/telephone number as long as the name/telephone number items are placed after the HCAHPS questions and the request includes a transition statement
- Hospital logos may be included on the questionnaire; however, other images and tag lines are not permitted
- It is optional to place the title "HCAHPS Survey" on the questionnaire
- The phrase "Use only blue or black ink" may be printed on the questionnaire
- The name of the hospital may be printed on the questionnaire before Question 1 and in the introduction to Question 18
  - "Please answer the questions in this survey about your stay at [HOSPITAL NAME]. Do not include any other hospital stays in your answers."
- Page numbers may be included on the questionnaire
  - This is encouraged as a guide to assist patients in responding to all pages of the questionnaire
- Color may be incorporated in the questionnaire
- The phrase "There are only a few remaining items left" before the "About You" questions may be eliminated
- Language such as one of the following may be added in the footer of the survey:
  - Continue on next page
  - Continue on reverse side
  - Turn over to continue
  - ➔ to continue
  - Continue on back
  - Turn over

Hospitals/Survey vendors should consider incorporating the following recommendations in formatting the HCAHPS questionnaire to increase the likelihood of receiving a returned survey:

- Two-column format that is used in Appendices A through D
- Wide margins (at least 3/4 inch) so that the survey has sufficient white space to enhance its readability

Use of Supplemental Questions

Hospitals/Survey vendors may add a reasonable number of hospital-specific supplemental questions to the HCAHPS Survey following the guidelines described below:

- Hospital-specific supplemental question(s) may be added to the HCAHPS Survey but only after all of the HCAHPS Survey questions (Questions 1-29). This approach ensures that the survey is conducted consistently across participating hospitals.
- Supplemental questions must be integrated into the HCAHPS Survey and not be a separate insert
- The mandatory transition statement must be placed in the survey immediately before the supplemental questions to indicate a transition from the HCAHPS questions to the hospital-specific supplemental question or questions (see Appendices A through D for the exact text in English, Spanish, Chinese and Russian)
- Hospitals may include additional transition statements following the required transition statement. Examples of allowable additional transition statements are as follows:
  - *"Now [NAME OF HOSPITAL] would like to gather some additional detail on topics previously examined. These items use a somewhat different way of asking for your response since they are getting at a slightly different way of thinking about the topics."*
  - *"The following questions focus on additional care you may have received from [NAME OF HOSPITAL]."*

  Note: Transition statements must be submitted for review by the HCAHPS Project Team.

- In addition, if a client hospital requests that a survey vendor include supplemental questions as part of the HCAHPS Survey asking the patient to provide their name, telephone number or other contact information, the survey vendor is required to include explanatory text. This text must be placed before the requested information and state the purpose for the patient to optionally provide the requested information. It is NOT sufficient to only state that this information is optional. The following are examples of permissible explanatory text:
  - *"If you wish to be contacted by the hospital, please provide your name and telephone number. This information is not required."*
  - *"By providing your name and telephone number, you may be contacted by the hospital. This information is not required."*

Hospitals/Survey vendors must avoid hospital-specific supplemental questions that:

- pose a burden to the patient (e.g., number, length, and complexity of supplemental questions, etc.)
- may affect responses to the HCAHPS Survey
- may cause the patient to terminate the survey (e.g., items that ask about sensitive medical, health or personal topics, etc.)
- jeopardize patient confidentiality (e.g., items that ask for the patient's Social Security number, etc.)
- ask the patient to explain why he or she chose a specific response; for example, it is not acceptable to ask patients why they indicated that they would not recommend the hospital to friends and family

The number of supplemental questions added is left to the discretion of the hospital/survey vendor. The hospital/survey vendor must submit the maximum number of supplemental survey items in the Administrative Data section for each survey (see Appendix R).

- Each potential supplemental item counts as one question, whether or not the item is phrased as a sentence or as a question
- Each open-ended or free response question counts as one supplemental item

Initial Cover Letter

Hospitals/Survey vendors may adapt the sample HCAHPS Initial Cover Letter provided (see Appendices A through D) or compose their own cover letter. Hospitals/Survey vendors must follow the guidelines described below when altering the cover letter template provided in this manual.

Note*: Text is formatted in [UPPERCASE LETTERING] to designate a placeholder. Please populate placeholders using standard capitalization rules.*

Required for the Initial Cover Letter

- Cover letter must be in a readable font (i.e., Arial or Times New Roman) with a font size of 12-point at a minimum
- Cover letter must be printed on the hospital's (preferred) or survey vendor's letterhead and must include the signature of the hospital administrator or hospital/survey vendor project director
  - An electronic signature is permissible
- The following items must be included in the body of the cover letter:
  - Name and address of the sampled patient. "To Whom It May Concern" is not an acceptable salutation.
  - The hospital name and discharge date (it is optional to include the day of the week, e.g., Monday, with the 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.
  - The sentence stating the sponsor of the survey and length of time to complete questions 1-29: "Questions 1-29 in the survey are sponsored by the United States Department of Health and Human Services and should take about 7 minutes to complete."
  - The sentence stating that participation in the survey is voluntary and responses are kept private: "Your participation is voluntary, and your answers will be kept private."
  - The sentences stating the purpose of the survey and where to find hospital ratings: "Your responses will help improve the quality of hospital care and help other people make more informed choices about their care. You can see current survey results and find hospital ratings on the Care Compare Web site (www.medicare.gov/care-compare)."
  - A customer support telephone number for hospitals self-administering the survey and a toll-free customer support telephone number for survey vendors. In some instances, hospitals contracting with survey vendors may want their own telephone number on the survey in addition to, or in lieu of, the survey vendor's number. In cases where the hospital has a customer support telephone number in lieu of the survey vendor, it is the responsibility of the survey vendor to monitor the hospital's customer support

telephone number, at a minimum on a quarterly basis, to confirm that the hospital's customer support telephone number is operational. The survey vendor must also verify that the hospital is prepared to receive questions prior to the first mailing of the questionnaire; the hospital answers patient questions accurately; and the hospital keeps a record of customer support inquiries about HCAHPS.

- The OMB language (Appendices A through G) must appear verbatim on either the questionnaire (preferred) or cover letter, and may appear on both, in a readable font at a minimum of 10-point
- Cover letter must **not**:
  - be attached to the survey; doing so could compromise confidentiality
  - attempt to bias, influence or encourage patients to answer HCAHPS questions in a particular way
  - imply that the hospital, its personnel or its agents will be rewarded or gain benefits if patients answer HCAHPS questions in a particular way
  - ask or imply that patients should choose certain responses; indicate that the hospital is hoping for a given response, such as a "10," "Definitely yes," or an "Always"
  - indicate that the hospital's goal is for all patients to rate them as a "10," "Definitely yes" or an "Always"
  - offer incentives of any kind for participation in the survey
  - include any content that attempts to advertise or market the hospital's mission or services
  - offer patients the opportunity to complete the survey over the telephone
  - include any promotional or marketing text

Optional for the Initial Cover Letter

- Use of the Spanish, Chinese, Russian, Vietnamese, Portuguese, or German cover letters is allowed if the hospital/survey vendor is sending a Spanish, Chinese, Russian, Vietnamese, Portuguese, or German questionnaire to the patient
- Information may be added to the cover letters (in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, or German) that indicates that the patient may request a mail survey in English, Spanish, Chinese, Russian, Vietnamese, Portuguese, or German
- Any instructions that appear on the survey may be repeated in the cover letter
- The wording indicating the purpose of the unique identifier ("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.") must be printed immediately after the survey instructions on the questionnaire (preferred) or on the cover letter, and may appear on both.
- Hospital's/Survey vendor's return address may be included on the cover letter to make sure the questionnaire is returned to the correct address in the event that the enclosed return envelope is misplaced by the patient
- If the hospital's/survey vendor's name is included in the return address, then the hospital's/survey vendor's business name must be used, not an alias or tag line

Required for the Envelopes

- The outgoing envelope **must** be printed with the hospital's/survey vendor's address as the return address

- A self-addressed, stamped business return envelope must be enclosed in the survey envelope along with the cover letter and questionnaire
- All envelopes must be in a readable font (i.e., Arial or Times New Roman) with a font size of 10-point at a minimum

Optional for the Envelopes

- The outgoing envelope may be printed with the banner, "Important - Open Immediately." No other banners may be used on the outgoing or return envelopes.
    - Other messages, marketing or promotional text such as, "Survey Enclosed," "Important Information from the Centers for Medicare & Medicaid Services Enclosed," or "We always strive to provide excellent service" on either side (front or back) is **not** permitted
- The outgoing envelope may be printed with the hospital or survey vendor logo, or both
- Hospitals/Survey vendors may use window envelopes as a quality control measure to ensure that each patient's survey package is mailed to the address of record for that patient

Note: Any variations to the survey materials, other than the optional items listed above, will require an approved Exception Request prior to survey administration (see the Exception Request/Discrepancy Report Processes chapter).

Mailing of Materials

Hospitals/Survey vendors must mail materials following the guidelines described below:

- Attempts must be made to contact every eligible patient drawn into the sample, whether or not they have a complete mailing address. Hospitals/Survey vendors must use commercial software or other means to update addresses provided by the hospital for sampled patients. (Mailings returned as undeliverable and for which no updated address is available must be coded as "9 – Non-response: Bad address.") Hospitals/Survey vendors must retain a record of attempts made to acquire missing address data. All materials relevant to survey administration are subject to review.
    - Hospitals/Survey vendors have flexibility in not sending mail surveys to patients without mailing addresses, such as the homeless. However, hospitals/survey vendors must first make every reasonable attempt to obtain a patient's address including re-contacting the hospital client to inquire about an address update for patients with no mailing address. Attempts to obtain the patient's address must be documented.

    Note: It is strongly recommended that hospitals/survey vendors check the accuracy of sampled patients' contact information prior to survey fielding.

- The HCAHPS Survey cannot be administered without both a cover letter and self-addressed, stamped business return envelope
- All mailings are sent to each patient by name and to the patient's most current address listed in the hospital record or retrieved by other means
- For patients who request to be sent an additional questionnaire, hospitals/survey vendors must follow the guidelines below:

- It is acceptable to mail a replacement survey at the patient's request within the first 21 calendar days of the 42 calendar day survey administration period; however, the survey administration timeline does not restart
- After 21 calendar days from the mailing, a replacement HCAHPS Survey must NOT be mailed-out, as the telephone portion of the Mixed Mode protocol must be initiated

Hospitals/Survey vendors are **not** allowed to:

- show or provide the HCAHPS Survey or cover letters to patients prior to the administration of the survey, including while the patient is still in the hospital
- mail any pre-notification letters or postcards after discharge to inform patients about the HCAHPS Survey

Note: In instances where returned mail surveys have all missing responses (i.e., without any questions answered – blank questionnaire), initiate telephone contact within 21 days of mailing the questionnaire.

It is strongly recommended that the mailing be sent with first class postage or indicia to ensure delivery in a timely manner and to maximize response rates, as first class mail is more likely to be opened.

Data Receipt and Retention of Mailed Questionnaires

Hospitals/Survey vendors utilizing the Mixed Mode of survey administration must keep track of the mode in which each survey was completed (i.e., Mail or Telephone). If a patient returned the HCAHPS mail questionnaire with enough of the questions applicable to all patients answered for the survey to be considered a completed survey (based on the calculation of percent complete; for more information see the *Data Specifications and Coding* chapter), then the hospital/survey vendor must: 1) retain documentation in their survey management system that the patient completed the survey in the *mail* phase of the Mixed Mode of survey administration; and, 2) assign the appropriate "Survey Completion Mode" in the administrative record for this patient (see the *Data Specifications and Coding* chapter on "Survey Completion Mode" for more information).

Hospitals/Survey vendors may use key-entry or scanning to record returned survey data in their data collection systems. Returned questionnaires must be tracked by date of receipt and key-entered or scanned in a timely manner. If a patient completes the HCAHPS Survey via the telephone and a questionnaire is subsequently returned by the same patient, the hospital/survey vendor must use the telephone HCAHPS Survey responses since they were completed first.

Hospitals/Survey vendors must maintain a crosswalk of their interim disposition codes to the HCAHPS "Final Survey Status" codes and include the crosswalk in the hospital's/survey vendor's QAP.

Hospitals/Survey vendors must follow the data entry decision rules and data storage requirements described below.

Key-entry

Hospitals'/Survey vendors' key-entry processes must incorporate the following features:

- *Unique record verification system*: The survey management system performs a check to verify that the patient response data have not already been entered in the survey management system
- *Valid range checks*: The data entry system identifies responses/entries that are invalid or out-of-range
- *Validation*: Hospitals/Survey vendors must have a plan and process in place to verify the accuracy of the key-entered data. Hospitals/Survey vendors must confirm that key-entered data accurately capture the responses on the original survey. A different staff member (preferably the data entry supervisor) must reconcile any discrepancies. It is strongly suggested that hospitals using the HCAHPS Data Form, formerly the Online Data Entry Tool, download Excel spreadsheets containing entered data and compare entered data to the original returned surveys. This validation process must be performed by someone other than the person doing data entry via the HCAHPS Data Form.

Scanning

Hospitals'/Survey vendors' scanning software should accommodate the following:

- *Unique record verification system*: The survey management system performs a check to confirm that the patient's survey responses have not already been entered in the survey management system
- *Valid range checks*: The software identifies invalid or out-of-range responses
- *Validation*: Hospitals/Survey vendors must have a plan and process in place to confirm the accuracy of scanned data. Hospitals/Survey vendors must make certain that scanned data accurately capture the responses on the original survey. A staff member must reconcile any responses not recognized by the scanning software.

Decision Rules for Mail Data

Whether employing scanning or key-entry of mail questionnaires, hospitals/survey vendors must use the following decision rules to resolve common ambiguous situations. Hospitals/Survey vendors must follow these guidelines to ensure standardization of data entry across hospitals.

- If a mark falls between two response options but is obviously closer to one than the other, then select the choice to which the mark is closest
- If a mark falls equidistant between two response options, then code the value for the item as "M – Missing/Don't Know"
- If a mark is missing, code the value for the item as "M – Missing/Don't Know." Hospitals/Survey vendors must not impute a response.
- When more than one response option is marked, code the value as "M – Missing/Don't Know" (except for survey Question 28 *"What is your race? Please choose one or more."*)

  Note: In instances where there are multiple marks, ***but*** *the patient's intent is clear, hospitals/survey vendors should code the survey with the patient's* ***clearly identified*** *intended response.*

Storage of Mail Data

Hospitals/Survey vendors must store returned paper questionnaires or scanned images of paper questionnaires in a secure and environmentally controlled location for a minimum of three years. Paper questionnaires or scanned images must be easily retrievable. Hospitals/Survey vendors must destroy HCAHPS-related data files, including paper copies or scanned images of the

questionnaires and electronic data files in a secure and environmentally safe location. Obtain a certificate of the destruction of data.

Quality Control Guidelines for Mail Data

Hospitals/Survey vendors are responsible for the quality of work performed by any staff members and subcontractor(s), such as printers or fulfillment houses. Hospitals/Survey vendors must conduct **on-site** verification of printing and mailing processes (strongly recommended on an annual basis, at a minimum), regardless of whether they are using organizational staff or subcontractor(s) to perform this work.

Note: Mail survey administration activities must not be conducted from a residence or non-business location.

To avoid mail administration errors and to make certain the questionnaires are delivered as required, hospitals/survey vendors must:

- perform interval checking of at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of all printed mailing pieces for:
  - fading, smearing and misalignment of printed materials
  - appropriate survey contents, accurate address information and proper postage on the survey sample packet
  - assurance that all printed materials in a mailing envelope have the same unique identifier
  - inclusion of all eligible sampled patients in the sample mailing for that month
- include seeded mailings in mail-outs at a minimum on a quarterly basis
  - Seeded mailings are sent to designated hospital/survey vendor HCAHPS project staff (other than the staff producing the materials) to check for timeliness of delivery, accuracy of addresses, content of the mailing, and quality of the printed materials
  - Seeded mailings must be integrated into the hospital's batched survey mailings, not sent as a stand-alone mailing to HCAHPS project staff
- perform address updates for missing or incorrect information
  - Attempts must be made to update address information to confirm accuracy and correct formatting
  - In addition to working with client hospitals to obtain the most current patient contact information, hospitals/survey vendors must employ other methods, such as the NCOA and the USPS CASS Certified Zip+4 software. Other means are also available to update addresses for accurate mailings, such as:
    - Commercial software
    - Internet search engines

*Note: If automated processes are being used to perform interval checks, then checks of the system or equipment must be performed regularly. Hospitals/Survey vendors **must** retain a record of all quality control activities and document these activities in the hospital's/survey vendor's QAP. All materials relevant to survey administration are subject to review.*

Telephone Protocol

If the mail questionnaire has not been returned within 21 calendar days following its mail-out to sampled patients, hospitals/survey vendors must follow the HCAHPS telephone survey protocol. This section describes guidelines for the telephone phase of the Mixed Mode of survey administration. Hospitals/Survey vendors must conduct a maximum of five telephone attempts to non-respondents from the questionnaire mailing.

Hospitals/Survey vendors should make every reasonable effort to achieve optimal telephone response rates, such as thoroughly familiarizing interviewers with the study purpose, carefully supervising interviewers, retraining those interviewers having difficulty enlisting cooperation, and re-contacting reluctant respondents with different interviewers at different times, until the data collection protocol is completed.

Telephone Interviewing Systems

This section describes guidelines for the telephone phase of the Mixed Mode of survey administration.

Telephone Script

Hospitals/Survey vendors are provided standardized telephone scripts in English, Spanish, Chinese, and Russian (Appendices H through K) for HCAHPS Survey administration. These telephone scripts must be read verbatim without adding any other scripting or tag questions, such as "How are you?" Hospitals/Survey vendors are not permitted to make or use any other language translations of the HCAHPS Telephone Scripts. **We strongly encourage hospitals/survey vendors to administer the HCAHPS Survey in both English and Spanish, including offering the official HCAHPS Survey translations (Chinese or Russian) for hospitals with significant patient populations speaking in these languages**.

Each hospital/survey vendor must submit a copy of their HCAHPS Telephone Script and interviewer screen shots (including skip pattern logic) for review by the HCAHPS Project Team. Please see the *Oversight Activities* chapter for more detail.

Required for the Telephone Script

The HCAHPS Survey (Questions 1-29) must remain together. The HCAHPS Survey questions cannot be eliminated from the questionnaire.

Programming of the telephone scripts must follow the guidelines described below:

- Question and answer category wording must not be changed
- No changes are permitted to the order of the HCAHPS Survey (Questions 1-29)
- No changes are permitted to the order of the answer categories for the HCAHPS questions
- All underlined content must be emphasized
  - No other script content is to be emphasized; in particular, response options must be read at the same even pace without any additional emphasis on any particular response category
- Only one language (English, Spanish, Chinese, or Russian) may appear on the electronic interviewing system screen
- The hospital/survey vendor is responsible for programming the scripts and specifications into their electronic telephone interviewing system software or an alternative system

- The transitional phrases found throughout the telephone script are part of the structured script and must be read. An example of a transitional phrase that should be read can be found before Question 10 (Q10_Intro): "The next questions are about your experiences in this hospital."
- Do not program a specific response category as the default option
- Survey vendors that subcontract call center services must instruct interviewers to state the survey vendor name in the CATI script introduction for the data collection contractor: "…calling from [DATA COLLECTION CONTRACTOR] on behalf of [HOSPITAL NAME]…"

*Note: Hospitals/Survey vendors **must** include the copyright statement on any published materials containing the HCAHPS Telephone Script, preferably at the end of the telephone script (see Appendices H through K).*

Hospitals/Survey vendors must have a process in place to address patients' requests to verify the survey legitimacy or to answer questions about the survey. See Appendix O "Frequently Asked Questions for Customer Support."

Use of Supplemental Questions

Hospitals/Survey vendors may add a reasonable number of hospital-specific supplemental questions to the HCAHPS Survey following the guidelines described below:

- Hospital-specific supplemental question(s) may be added to the HCAHPS Survey but only after <u>all</u> of the HCAHPS Survey questions (Questions 1-29). This approach ensures that the survey is conducted consistently across participating hospitals.
- The mandatory transition statement must be placed in the survey immediately before the supplemental questions to indicate a transition from the HCAHPS questions to the hospital-specific supplemental question or questions (see Appendices H through K for the exact text in English, Spanish, Chinese and Russian)
- Hospitals may include additional transition statements following the required transition statement. Examples of allowable additional transition statements are as follows:
  - *"Now [NAME OF HOSPITAL] would like to gather some additional detail on topics previously examined. These items use a somewhat different way of asking for your response since they are getting at a slightly different way of thinking about the topics."*
  - *"The following questions focus on additional care you may have received from [NAME OF HOSPITAL]."*

  Note: Transition statements must be submitted for review by the HCAHPS Project Team.

- In addition, if a client hospital requests that a survey vendor include supplemental questions as part of the HCAHPS Survey asking the patient to provide their address or other contact information, the survey vendor is required to include explanatory text. This text must be placed 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 contact information. This information is not required."*

- *"By providing your contact information, you may be contacted by the hospital. This information is not required."*

Hospitals/Survey vendors must avoid the following types of hospital-specific supplemental questions that:

- pose a burden to the patient (e.g., number, length and complexity of supplemental questions, etc.)
- may affect responses to the HCAHPS Survey
- may cause the patient to terminate the survey (e.g., items that ask about sensitive medical, health or personal topics, etc.)
- jeopardize patient confidentiality (e.g., items that ask for the patient's Social Security number, etc.)
- ask the patient to explain why he or she chose a specific response; for example, it is not acceptable to ask patients why they indicated that they would not recommend the hospital to friends and family

The number of supplemental questions added is left to the discretion of the hospital/survey vendor. The hospital/survey vendor must submit the maximum number of supplemental survey items in the Administrative Data Record for each survey (see Appendix R).

- Each potential supplemental item counts as one question, whether or not the item is phrased as a sentence or as a question
- Each open-ended or free response question counts as one supplemental item

Interviewing Systems

Two methods exist for telephone interviewing:

1. An electronic telephone interviewing system **is required for survey vendors**; it is optional for hospitals that are self-administering the survey. An electronic telephone interviewing system uses standardized scripts and design specifications. The hospital/survey vendor is responsible for programming the scripts and specifications into their electronic telephone interviewing software. Regardless of patient response, the interviewer must record all responses in the telephone interview.
    - 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
    - Survey vendors may program the caller ID to display "on behalf of [HOSPITAL NAME]," with the permission and compliance of the hospital's HIPAA/Privacy Officer. Survey vendors **must not** program the caller ID to display only "[HOSPITAL NAME]."
2. Manual data collection is permitted only for hospitals that are self-administering the survey. Manual data collection involves an interviewer who conducts the interview using the standardized script over the telephone and records answers on paper.

Monitoring/Recording Telephone Calls

Survey vendors must be aware of and follow applicable state regulations when monitoring and/or recording telephone calls, including those that permit monitoring/recording of telephone calls only after the interviewer states, "*This call may be monitored (and/or recorded) for quality improvement purposes*." This statement is found at the end of the INTRO section of the HCAHPS Telephone Script located in Appendices H through K.

Telephone Attempts

Hospitals/Survey vendors must attempt to reach each and every non-respondent to the mail survey. It is strongly recommended that hospitals/survey vendors use both the primary (Patient Telephone Number 1) and secondary (Patient Telephone Number 2) numbers provided by the hospital. If the first telephone number is found to be bad/non-working, then the second telephone number should be used. It is up to the hospitals'/survey vendors' discretion to determine the number of attempts made to each telephone number; however, no more than a total of five call attempts can be made to a sampled patient.

Telephone call attempts are to be made between the hours of 9 AM and 9 PM respondent time. Repeated attempts must be made until the patient is contacted, found ineligible or five attempts have been made. After five attempts to contact the patient have been made, no further attempts are to be made. A telephone attempt is defined as one of the following:

- The telephone rings six times with no answer
- The interviewer reaches a wrong number
- An answering machine/voice mail is reached. In this case, the interviewer must not leave a message.
- The interviewer reaches a household member and is told that the patient is not available to come to the telephone or has a new telephone number. The interviewer must not leave a message.
- The interviewer reaches the patient and is asked to call back at a more convenient time
  - The callback must be scheduled at the patient's convenience. When requested, hospitals/survey vendors must schedule a telephone callback that accommodates a patient's request for a specific day and time (i.e., between the hours of 9 AM and 9 PM respondent time within the 42 calendar day data collection period).
- The interviewer reaches a 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
- The interviewer reaches a "screening" number (e.g., privacy screen, privacy manager, phone intercept or blocked call)
  - Hospitals/Survey vendors count this as one telephone attempt and continue to make additional attempts (up to five) to reach the patient before dispositioning the call as "8 – Non-response: Non-response after maximum attempts"

Sampled patients are to be called up to five times unless the sampled patient completes the survey, is found to be ineligible or explicitly refuses to complete the survey (or if someone refuses on behalf of the patient).

- If the patient is unavailable for any reason, the interviewer must not conduct the interview with a proxy

- If the hospital/survey vendor learns that a patient is ineligible for HCAHPS, that patient must not receive any further telephone attempts

Hospitals/Survey vendors must adhere to the following guidelines in their attempts to contact patients:

- Telephone attempts are made at various times of the day, on different days of the week and in different weeks to maximize the probability that the hospital/survey vendor will contact the patient

  Note: More than one telephone attempt may be made in a week (seven calendar days). However, the five telephone attempts cannot be made in only one week (seven calendar days). The five call attempts must span more than one week (eight or more days), and it is strongly recommended that call attempts also include weekends.

- Patients who call back after an initial contact can be scheduled for an interview or forwarded to an available interviewer
- Interviewers must not leave messages on answering machines or with household members, since this could violate a patient's privacy. Hospitals/Survey vendors must instead attempt to re-contact the patient to complete the HCAHPS Survey.
- When a patient requests to complete at a later date a telephone survey already in progress, a callback should be scheduled. At the time of the callback, the interview should resume with the next question where the patient left off from the previous call.
- If on the fifth attempt, the patient requests to schedule an appointment to complete the survey, it is permissible to schedule that appointment and call the patient back provided that the appointment is within the 42 calendar day data collection time period. If on the callback at the scheduled time, no connection is made with the patient, then no further contact may be attempted. This additional (sixth) call attempt would be coded as "5 – Fifth Telephone attempt" for data submission.

Hospitals/Survey vendors take the following steps to contact **difficult-to-reach patients**:

- If the patient's telephone number is incorrect, make every effort to find the correct telephone number. If the person answering the telephone knows how to reach the patient, the new information must be used.
- It is strongly recommended that the secondary telephone number be contacted if there is more than one telephone number available for the patient
- If the patient is away temporarily, he or she must be contacted upon return, provided that it is within the data collection time period. If it is known that the patient may be available in the latter part of the 21 calendar day telephone component of the data collection time period (e.g., patient is on vacation the first 2 weeks of the 21 calendar day telephone component of the data collection time period and there would be an opportunity to reach the patient closer to the end of the data collection time period), then hospitals/survey vendors must use the entire data collection time period to schedule telephone calls.
- If the patient does not speak the language in which the survey is being administered, the interviewer must thank the patient for his or her time and terminate the interview
- If the patient is temporarily ill or re-admitted to the hospital, the interviewer must re-contact the patient before the end of the data collection period to see if there has been a recovery and the patient can now complete the survey

- If the patient is unavailable for any reason, the interviewer must not conduct the interview with a proxy
- If the call is inadvertently dropped and the interview is interrupted, the patient should be re-contacted immediately to complete the remainder of the survey. This re-contact does not constitute an additional call attempt.

Obtaining and Updating Telephone Numbers

Hospitals/Survey vendors normally obtain telephone numbers from the hospital's patient discharge records. It is strongly recommended that two telephone numbers are collected and used for each patient, if available. Hospitals/Survey vendors must use commercial software or other means to update telephone numbers provided by the hospital for **all** sampled patients. Requisite attempts must be made to contact every non-respondent to the mail survey, whether or not there is a complete and correct telephone number for the patient when the sample is created. Hospitals/Survey vendors must retain a record of attempts to acquire missing telephone numbers. All materials relevant to survey administration are subject to review.

In addition to working with client hospitals to obtain the most current patient contact information, hospitals/survey vendors must employ various methods for updating telephone numbers:

- Running update program software against the sample file just before or after uploading data to survey management systems
- Utilizing commercial software, Internet directories and/or directory assistance

Note: It is strongly recommended that hospitals/survey vendors check the accuracy of sampled patients' contact information prior to survey fielding.

Receipt and Retention of Telephone Data

Hospitals/Survey vendors utilizing the Mixed Mode of survey administration must keep track of the mode in which the survey was completed (i.e., Mail or Telephone). If a patient completed the HCAHPS Survey by *telephone* with enough of the questions applicable to all patients answered for the survey to be considered a completed survey (based on the calculation of percent complete; for more information see the *Data Specifications and Coding* chapter), then the hospital/survey vendor must:

- retain documentation in their survey management system that the patient completed the survey in the *telephone* phase of the Mixed Mode of survey administration
- assign the appropriate "Survey Completion Mode" in the administrative record for this patient (see the *Data Specifications and Coding* chapter on "Survey Completion Mode" for more information)
- document the telephone attempt "Number Survey Attempts – Telephone" in which the "Final Survey Status" is determined. For example, if the interview was conducted and finished with the patient on the fourth telephone attempt then the hospital/survey vendor must document the "Number Survey Attempts – Telephone" as "4 – Fourth Telephone attempt." Please see the *Data Specifications and Coding* chapter for more information on coding the "Number Survey Attempts – Telephone" field.

Hospitals/Survey vendors must record the date of the telephone interview and must link survey responses from the telephone interview to their survey management system, regardless of the interviewing system employed. Hospitals/Survey vendors must maintain a crosswalk of their

interim disposition codes to the HCAHPS "Final Survey Status" codes and include the crosswalk in the hospital's/survey vendor's QAP.

Hospitals/Survey vendors must record and submit lag time for **all** HCAHPS "Final Survey Status" codes. Additionally, hospitals/survey vendors must include the "Number Survey Attempts – Telephone" field in the Administrative Data Record. This field is required when "Survey Mode" in the Header Record is "3 – Mixed Mode" and "Survey Completion Mode" is "2 – Mixed Mode-phone." If the survey is completed/dispositioned during the telephone phase of the Mixed Mode, the "Number Survey Attempts – Telephone" captures the telephone attempt in which the final disposition of the survey is determined. More information regarding the calculation of lag time and coding the "Number Survey Attempts – Telephone" field is presented in the *Data Specifications and Coding* chapter.

Hospitals/Survey vendors must follow the interviewing guidelines in Appendix N and data storage requirements described below.

Electronic Telephone Interviewing System

The electronic telephone interviewing systems employed by hospitals/survey vendors must be electronically linked to their survey management system to enable responses obtained from the electronic telephone interviewing system to be automatically added to the survey management system.

Manual Data Collection

Only hospitals self-administering the survey are permitted to use manual data collection methods. Hospitals using manual data entry (paper questionnaires) to collect survey data over the telephone must follow the guidelines below for linking survey responses to the survey management system. Either key-entry or scanning may be used.

- Key-entry
  - *Unique record verification system*: The survey management system performs a check to verify that the patient response data have not already been entered in the survey management system
  - *Valid range checks*: The data entry system identifies responses/entries that are invalid or out-of-range
  - *Validation*: The hospital must perform checks to confirm that key-entered data accurately capture the responses of the telephone interview. A different staff member (preferably the data entry supervisor) must reconcile any discrepancies. It is strongly suggested that hospitals using the HCAHPS Data Form, formerly the Online Data Entry Tool, download Excel spreadsheets containing entered data and compare entered data to the original survey completed by the telephone interviewer. This validation process must be done by someone other than the person doing data entry via the HCAHPS Data Form.
- Scanning
  - *Unique record verification system:* The survey management system performs a check to confirm that the patient's survey responses have not already been entered in the survey management system
  - *Valid range checks:* The software identifies invalid or out-of-range responses

- *Validation:* The hospital must perform checks to confirm that scanned data accurately capture the responses on the original survey completed by the telephone interviewer. A staff member must reconcile any responses not recognized by the scanning software.

Storage of Telephone Data

The following data storage guidelines must be followed for HCAHPS telephone surveys:

- Data collected through an electronic telephone interviewing system must be retained in a secure manner for a minimum of three years and must be easily retrievable
- Data collected manually by telephone with paper questionnaires and then key-entered must be de-identified and stored in a secure and environmentally controlled location for a minimum of three years and must be easily retrievable
- Optically scanned questionnaire images of telephone interviews collected with paper questionnaires also must be de-identified and retained in a secure and environmentally controlled location for a minimum of three years and must be easily retrievable
- Hospitals/Survey vendors must destroy HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files in a secure and environmentally safe location. Obtain a certificate of the destruction of data.

Quality Control Guidelines for Telephone Data Collection

Hospitals/Survey vendors are responsible for the quality of work performed by any staff members and subcontractor(s). Hospitals/Survey vendors must employ the following guidelines for proper interviewer training, monitoring and oversight regardless of whether they are using organizational staff or subcontractor(s) to perform this work.

Interviewer Training

Consistent monitoring of interviewers' work is essential to achieve standardized and accurate results. Properly trained and supervised interviewers ensure that standardized, non-directive interviews are conducted. Interviewers conducting the telephone survey must be trained prior to interviewing. (See Appendix N for more information on interviewing guidelines.)

- Training must direct interviewers to read questions exactly as worded in the script, use non-directive probes and maintain a neutral and professional relationship with the respondent
  - During the course of the survey, the use of neutral acknowledgment words such as the following is permitted:
    - Thank you
    - Alright
    - Okay
    - I understand, or I see
    - Yes, Ma'am
    - Yes, Sir
- Interviewers must be trained to read the script from the telephone screens (reciting the survey from memory can lead to unnecessary errors and missed updates to the scripts)
- Interviewers must be trained to read response options exactly as worded and at an even pace without emphasis on any particular response category
- Interviewers must be trained to record responses to survey questions only after the patient has responded to the questions; that is, interviewers must not pre-code response choices

- In organizations where interviewers assign interim or final call disposition codes, they must be trained in the definition of each disposition code
- Interviewers must be trained in a process for redirecting calls to another interviewer when the patient is personally known to the initial interviewer
- Interviewers must be trained to adjust the pace of the HCAHPS Survey interview to be conducive to the needs of the respondent

If the hospital/survey vendor uses a subcontractor to conduct telephone interviewing, then the hospital/survey vendor is responsible for attending/participating in the subcontractor's telephone interviewer training to confirm compliance with HCAHPS protocols and guidelines. Hospitals/Survey vendors must conduct on-site verification of subcontractor's interviewing processes (strongly recommended on an annual basis, at a minimum).

Telephone Monitoring and Oversight

Each hospital/survey vendor employing the Mixed Mode of survey administration must institute a telephone monitoring and evaluation program, during the telephone phase of the protocol. The telephone monitoring and evaluation program must include, but is not limited to, the following oversight activities:

- Hospitals/Survey vendors must monitor at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of all HCAHPS interviews, dispositions and call attempts in their entirety (across all translations in which the survey is administered) through silent monitoring of interviewers using the electronic telephone interviewing system software or an alternative system. Silent monitoring must be performed at the hospital's/survey vendors' or their subcontractors' business locations. All staff conducting HCAHPS interviews must be included in the monitoring. Hospitals'/Survey vendors' supervisory staff monitoring the telephone interviewers should use the electronic telephone interviewing system to listen to the audio of the call and simultaneously observe that the correct responses are entered by the interviewer. Additionally, it is required that hospitals/survey vendors provide "floor rounding" in their call-center(s) to visually observe and ensure the professionalism of the telephone interviewers.

  Note: Telephone interviews/monitoring must not be conducted from a residence or non-business location.

- For hospitals using manual data collection, supervisors must observe at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of all interviews and call attempts in their entirety where silent monitoring is not an option
- Hospitals/Survey vendors using a subcontractor must monitor at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of the subcontractor's HCAHPS telephone interviews and call attempts in their entirety, provide feedback to the subcontractor's interviewers about their performance and confirm that the subcontractor's interviewers correct any areas that need improvement. Feedback must be provided to interviewers as soon as possible following a monitoring session.

  Note: HCAHPS protocols currently require that approved HCAHPS Survey vendors who subcontract the task of HCAHPS telephone interviewing monitor at least 10 percent of all HCAHPS calls/attempts/completed surveys (on an ongoing and continuous basis

throughout the survey administration period). The HCAHPS Project Team also expects that a survey vendor's subcontractor will conduct internal monitoring of their telephone interviewers as a matter of good business practice that incorporates quality checks. While it is preferred that each organization continue to monitor 10 percent of HCAHPS interviews (for an overall total of 20 percent), it is permissible for the survey vendor and its subcontractor to conduct a combined total of at least 10 percent monitoring, as long as each organization conducts a portion of the monitoring. Therefore, the survey vendor and its subcontractor can determine the ratio of monitoring that each organization conducts, as long as the combined total meets or exceeds 10 percent. Please note that HCAHPS interviews monitored concurrently by the survey vendor and its subcontractor do not contribute separately to each organization's monitoring time.

- Staff who are found to be consistently unable to follow the script verbatim, employ proper probes, remain objective and courteous, be clearly understood, or operate the electronic telephone interviewing system competently must be identified and retrained or, if necessary, replaced
- In organizations where interviewers assign interim or final disposition codes, the assignment of codes must be reviewed by a supervisor
- Organizations must monitor interviewer survey response coding by, at a minimum, reviewing the frequency of missing responses in the surveys administered by interviewers

*Note: Hospitals/Survey vendors **must** retain a record of all quality control activities and document these activities in the hospital's/survey vendor's QAP. All materials relevant to survey administration are subject to review.*

Active Interactive Voice Response (IVR) Survey Administration

New for 2021

Beginning with July 1, 2021 discharges, there will be one version of the HCAHPS Active IVR Script (previously the Optional Modified version with revisions).

- HCAHPS Active IVR Script (see Appendices M and L), including new required and optional elements

Overview

This chapter describes guidelines for the Active Interactive Voice Response (IVR) mode of the CAHPS Hospital Survey (HCAHPS) administration.

Data collection for sampled discharged patients must be initiated between 48 hours and six weeks (42 calendar days) after discharge. Hospitals/Survey vendors must wait 48 hours to make the first attempt to contact discharged patients. This will allow enough time to pass for the patient to return home and feel settled after his or her hospital stay. The HCAHPS Survey must not be administered while the patient is still in the hospital. A total of five IVR attempts must be made to contact non-respondents.

Note: If the hospital/survey vendor learns that a patient is ineligible for HCAHPS, the hospital/survey vendor must not make further attempts to contact that patient. ***After the sample has been drawn, any patients who are found to be ineligible must not be removed or replaced in the sample. Instead, these patients are assigned a "Final Survey Status" code of ineligible (2, 3, 4, or 5; as applicable). An administrative record must be submitted for these patients.***

Data collection must be closed out for a sampled patient by six weeks (42 calendar days) following the first IVR attempt. If it is known that the patient may be available in the latter part of the 42 calendar day data collection time period (e.g., patient is on vacation the first 2 or 3 weeks of the 42 calendar day data collection time period and there would be an opportunity to reach the patient closer to the end of the data collection time period), then hospitals/survey vendors must use the entire data collection time period to schedule telephone calls. IVR attempts are to be made between the hours of 9 AM and 9 PM, respondent time. A live operator must be available to introduce the patient to the purpose of the call, get his or her permission for IVR survey administration and orient the patient to the IVR system. Patients who receive the HCAHPS Survey must not be offered incentives of any kind. Patients who do not respond to the survey are assigned a "Final Survey Status" code of non-response.

Hospitals/Survey vendors must record and submit lag time for **all** HCAHPS "Final Survey Status" codes. Additionally, hospitals/survey vendors must include "Number Survey Attempts – Telephone" in the Administrative Data Record. This field is required when "Survey Mode" in the Header Record is "4 – IVR." This field captures the telephone attempt in which the final disposition of the survey is determined. More information regarding the calculation of lag time and the coding of the survey attempts field is presented in the *Data Specifications and Coding* chapter.

Hospitals/Survey vendors must make every reasonable effort to achieve optimal survey response rates and to pursue contacts with potential respondents until the data collection protocol is completed.

No proxy respondents are permitted in the administration of the HCAHPS Survey, not even for patients who are critically ill, elderly, physically or mentally impaired, or do not speak the language in which the survey is being administered (i.e., English or Spanish). As stated above, a proxy respondent must not answer the survey questions for the patient; however, an individual may assist the patient by repeating the questions or with translation of the survey, but only the patient may provide answers to the survey.

The basic tasks and timing for conducting the HCAHPS Survey using the IVR mode of survey administration are summarized below.

IVR Survey Administration
Initiate systematic IVR contact to sampled patient(s) between 48 hours and six weeks (42 calendar days) after discharge.
Complete IVR sequence so that a total of five IVR calls are attempted at different times of day, on different days of the week and in different weeks within six weeks (42 calendar days) after initiation of the survey (initial contact). The five IVR call attempts must span more than one week (eight or more days) to account for patients who are temporarily unavailable. If it is known that the patient may be available in the latter part of the 42 calendar day data collection time period (e.g., patient is on vacation the first 2 or 3 weeks of the 42 calendar day data collection time period and there would be an opportunity to reach the patient closer to the end of the data collection time period), then hospitals/survey vendors must use the entire data collection time period to schedule telephone calls.
Submit final data files to CMS via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal, by the data submission deadline. No files will be accepted after the submission deadline date.

To reiterate, the first IVR attempt must occur between 48 hours and six weeks (42 calendar days) after discharge. Data collection must then be completed no later than six weeks (42 calendar days) after the initial IVR attempt. To illustrate the timing of IVR survey attempts, three examples are provided of patients who were discharged from a hospital on July 1.

Example Patient 1:

- The first IVR attempt is made on July 4 (three days after discharge)
- Data collection must be closed out by August 15 for this patient, which is six weeks (42 calendar days) from the July 4 first IVR attempt date:
  - If an IVR telephone interview is completed on August 15, which is the last day of survey administration for this patient, then the survey data are included in the final survey data file and assigned a "Final Survey Status" code of either "1 – Completed survey" or "6 – Non-response: Break-off" based on the calculation of percent complete as described in the *Data Specifications and Coding* chapter
    - Lag Time (See the *Data Specifications and Coding* chapter) for this patient is calculated as 45 days
  - If the survey is **mistakenly** completed **after** August 15 (August 16, for example), which is beyond the six week (42 calendar days) survey administration time period for this patient, then the survey data are **not** included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and a "Final Survey Status" code of "8 – Non-response: Non-response after maximum attempts" is assigned
    - Lag Time for this patient is calculated and entered as 46 days

Example Patient 2:

- The first IVR attempt is made on August 12 (42 calendar days after discharge)
- Data collection must be closed out by September 23 for this patient, which is six weeks (42 calendar days) from the August 12 date:
  - If an IVR telephone interview is completed on September 23, which is the last day of survey administration for this patient, then the survey data are included in the final survey data file and assigned a "Final Survey Status" code of either "1 – Completed survey" or "6 – Non-response: Break-off" based on the calculation of percent complete as described in the *Data Specifications and Coding* chapter
    - Lag Time for this patient is calculated as 84 days

Example Patient 3:

- The first IVR attempt is made on August 12 (42 calendar days after discharge)
- Data collection must be closed out on September 23 for this patient, which is six weeks (42 calendar days) from the August 12 first IVR attempt date:
  - If the patient is reached on the fifth attempt on September 21 and the patient refuses to participate in the HCAHPS Survey, then the survey data are not included in the final survey data file **(however, an Administrative Data Record is submitted for this patient)** and the "Final Survey Status" code of "7 – Non-response: Refusal" is assigned
    - Lag Time for this patient is calculated and entered as 82 days

Hospitals/Survey vendors must make every reasonable effort to achieve optimal survey response rates by thoroughly familiarizing IVR operators with the study purpose; carefully supervising operators; retraining those operators having difficulty enlisting cooperation; and re-contacting reluctant respondents with different operators at different times until the data collection protocol is completed.

IVR Interviewing Systems

IVR Script

Hospitals/Survey vendors are provided a standardized IVR script in both English and Spanish (Appendices L and M) for HCAHPS Survey administration. These IVR scripts must be read verbatim without adding any other scripting or tag questions, such as "How are you?" **We strongly encourage hospitals/survey vendors to administer the HCAHPS Survey in both English and Spanish.** Hospitals/Survey vendors are not permitted to make or use any other language translations of the HCAHPS IVR script.

Each hospital/survey vendor must submit a copy of their HCAHPS IVR script/program (including skip pattern logic) for review by the HCAHPS Project Team. Please see the *Oversight Activities* chapter for more detail.

Required for the IVR Script

The HCAHPS Survey (Questions 1-29) must remain together. The HCAHPS Survey questions cannot be eliminated from the questionnaire.

Programming of the IVR script must follow the guidelines described below:

- Question and answer category wording must not be changed
- No changes are permitted to the order of the HCAHPS Survey (Questions 1-29)
- No changes are permitted to the order of the answer categories for the HCAHPS questions
- All underlined content must be emphasized
  - No other script content is to be emphasized; in particular, response options must be read at the same even pace without any additional emphasis on any particular response category
- The hospital/survey vendor is responsible for programming the scripts and specifications into their electronic IVR interviewing system software, or an alternative system
  - The transitional phrases found throughout the IVR script are part of the structured script and must be read. An example of a transitional phrase that must be read can be found before Question 10 (Q10_Intro): "The next questions are about your experiences in this hospital."
  - Do not program a specific response category as the default option

*Note: Hospitals/Survey vendors **must** include the copyright statement on any published materials containing the HCAHPS IVR script, preferably at the end of the IVR script (see Appendices L and M).*

Hospitals/Survey vendors must have a process in place to address patients' requests to verify the survey legitimacy or to answer questions about the survey. See Appendix O "Frequently Asked Questions for Customer Support."

Use of Supplemental Questions

Hospitals/Survey vendors may add a reasonable number of hospital-specific supplemental questions to the HCAHPS Survey, following the guidelines described below:

- Hospital-specific supplemental question(s) may be added to the HCAHPS Survey but only after all of the HCAHPS Survey questions (Questions 1-29). This approach ensures that the survey is conducted consistently across participating hospitals.

- The mandatory transition statement must be placed in the survey immediately before the supplemental questions to indicate a transition from the HCAHPS questions to the hospital-specific supplemental question or questions (see Appendices L and M for the exact text in English and Spanish)
- Hospitals may include additional transition statements following the required transition statement. Examples of allowable additional transition statements are as follows:
  - "*Now [NAME OF HOSPITAL] would like to gather some additional detail on topics previously examined. These items use a somewhat different way of asking for your response since they are getting at a slightly different way of thinking about the topics."*
  - *"The following questions focus on additional care you may have received from [NAME OF HOSPITAL]."*

Note: Transition statements must be submitted for review by the HCAHPS Project Team.

- In addition, if a client hospital requests that a survey vendor include supplemental questions as part of the HCAHPS Survey asking the patient to provide their address or other contact information, the survey vendor is required to include explanatory text. This text must be placed 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 contact information. This information is not required."*
  - *"By providing your contact information, you may be contacted by the hospital. This information is not required."*

Hospitals/Survey vendors must avoid hospital-specific supplemental questions that:

- pose a burden to the patient (e.g., number, length and complexity of supplemental questions, etc.)
- may affect responses to the HCAHPS Survey
- may cause the patient to terminate the survey (e.g., items that ask about sensitive medical, health or personal topics, etc.)
- jeopardize patient confidentiality (e.g., items that ask for the patient's Social Security number, etc.)
- ask the patient to explain why he or she chose a specific response; for example, it is not acceptable to ask patients why they would not recommend the hospital to friends or family members

The number of supplemental questions added is left to the discretion of the hospital/survey vendor. The hospital/survey vendor must submit the maximum number of supplemental survey items in the Administrative Data section for each survey (see Appendix R).

- Each potential supplemental item counts as one question, whether or not the item is phrased as a sentence or as a question
- Each open-ended or free response question counts as one supplemental item

IVR Interviewing System

IVR survey interviewing should be conducted using an electronic telephone interviewing system. Hospitals/Survey vendors should program the standardized HCAHPS IVR script and survey specifications into the IVR system. IVR technology must be capable of recording and storing patient answers provided through touch-tone keypad response. Any other type of IVR response is considered an exception, and the hospital/survey vendor must submit an Exception Request Form for review by the HCAHPS Project Team and receive approval before the requested exception can be implemented. (See the *Exception Request/Discrepancy Report Processes* chapter.)

- 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
- Survey vendors may program the caller ID to display "on behalf of [HOSPITAL NAME]," with the permission and compliance of the hospital's HIPAA/Privacy Officer. Survey vendors **must not** program the caller ID to display only "[HOSPITAL NAME]."

A key feature of the active IVR methodology is the use of the live operator. Hospitals/Survey vendors are required to use live operators to:

- introduce the patient to the Active Interactive Voice Response system and to get their consent to proceed with data collection in this manner
- provide customer support for interviews in progress when a patient wishes to speak to a live operator for assistance
- either triage the patient to an electronic telephone interviewing system, or conduct the HCAHPS interview live when a patient does not wish to continue with the IVR interview

Monitoring/Recording Telephone Calls

Survey vendors must be aware of and follow applicable state regulations when monitoring and/or recording telephone calls, including those that permit monitoring/recording of telephone calls only after the interviewer states, "*This call may be monitored (and/or recorded) for quality improvement purposes*." This statement is found at the end of the INTRO section in the HCAHPS Active Interactive Voice Response Script located in Appendices L and M.

IVR Attempts

Hospitals/Survey vendors must attempt to reach each and every patient in the sample. It is strongly recommended that hospitals/survey vendors use both the primary (Patient Telephone Number 1) and secondary (Patient Telephone Number 2) numbers provided by the hospital. If the first telephone number is found to be bad/non-working, then the second telephone number should be used. It is up to the hospitals'/survey vendors' discretion to determine the number of attempts made to each telephone number; however, no more than a total of five call attempts can be made to a sampled patient.

IVR call attempts are to be made between the hours of 9 AM and 9 PM respondent time. Repeated attempts must be made until the patient is contacted, found ineligible or five attempts have been made. After five attempts to contact the patient have been made, no further attempts are to be made. An IVR attempt is defined as one of the following:

- The telephone rings six times with no answer
- The interviewer reaches a wrong number
- An answering machine/voice mail is reached. In this case, the interviewer must not leave a message.
- The interviewer reaches a household member and is told that the patient is not available to come to the telephone or has a new telephone number. The interviewer must not leave a message.
- The interviewer reaches the patient and is asked to call back at a more convenient time
  - The callback must be scheduled at the patient's convenience. When requested, hospitals/survey vendors must schedule a telephone callback that accommodates a patient's request for a specific day and time (i.e., between the hours of 9 AM and 9 PM respondent time within the 42 calendar day data collection period).
- The interviewer reaches a 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
- The interviewer reaches a "screening" number (e.g., privacy screen, privacy manager, phone intercept or blocked call)
  - Hospitals/Survey vendors count this as one telephone attempt and continue to make additional attempts (up to five) to reach the patient before dispositioning the call as "8 – Non-response: Non-response after maximum attempts"

Sampled patients are to be called up to five times unless the sampled patient completes the survey, is found to be ineligible or explicitly refuses to complete the survey (or if someone refuses on behalf of the patient).

- If the patient is unavailable for any reason, the operator does not conduct the interview with a proxy
- If the hospital/survey vendor learns that a patient is ineligible for HCAHPS, that patient must not receive any further IVR attempts

Hospitals/Survey vendors must adhere to the following guidelines in their attempts to contact patients:

- IVR attempts are made at various times of the day, on different days of the week and in different weeks to maximize the probability that the hospital/survey vendor will contact the patient

  Note: More than one IVR attempt may be made in a week (seven calendar days). However, the five IVR attempts cannot be made in only one week (seven calendar days). The five IVR attempts must span more than one week (eight days or more), and it is strongly recommended that call attempts also include weekends.

- Patients who call back after an initial contact can be scheduled for an interview or forwarded to an available IVR operator

- IVR operators must not leave messages on answering machines or with household members since this could violate a patient's privacy. Hospitals/Survey vendors must instead attempt to re-contact the patient to complete the HCAHPS Survey.
- When a patient requests to complete at a later date a survey already in progress, a callback should be scheduled. At the time of the callback, the interview should resume with the next questions where the patient left off from the previous call.
- If on the fifth attempt, the patient requests to schedule an appointment to complete the survey, it is permissible to schedule that appointment and call the patient back provided that the appointment is within the 42 calendar day data collection time period. If on the callback at the scheduled time, no connection is made with the patient, then no further contact may be attempted. This additional (sixth) call attempt would be coded as "5 – Fifth Telephone attempt" for data submission.

Hospitals/Survey vendors must take the following steps to contact **difficult to reach patients**:

- If the patient's telephone number is incorrect, make every effort to find the correct telephone number. If the person answering the telephone knows how to reach the patient, the new information must be used.
- It is strongly recommended that the secondary telephone number be contacted if there is more than one telephone number available for the patient
- If the patient is away temporarily, he or she is contacted upon return, provided that it is within the data collection time period. If it is known that the patient may be available in the latter part of the 42 calendar day data collection time period (i.e., patient is on vacation the first 2 or 3 weeks of the 42 calendar day data collection time period and there would be an opportunity to reach the patient closer to the end of the data collection time period), then hospitals/survey vendors must use the entire data collection time period to schedule telephone calls.
- If the patient does not speak the language the survey is being administered in, the operator thanks the patient for his or her time and terminates the interview
- If the patient is temporarily ill or re-admitted to the hospital, the operator must re-contact the patient before the end of data collection period to see if there has been a recovery and the patient can now complete the survey
- If the patient is unavailable for any reason, the operator does not conduct the interview with a proxy
- If the call is inadvertently dropped and the interview is interrupted, the patient should be re-contacted immediately to complete the remainder of the survey. This re-contact does not constitute an additional call attempt.

Obtaining and Updating Telephone Numbers

Hospitals/Survey vendors normally obtain telephone numbers from the hospital's patient discharge records. It is strongly recommended that two telephone numbers are collected and used for each patient, if available. Hospitals/Survey vendors must use commercial software or other means to update telephone numbers provided by the hospital for **all** sampled patients. Requisite attempts must be made to contact every eligible patient drawn into the sample, whether or not there is a complete and correct telephone number for the patient when the sample is created. Hospitals/Survey vendors must retain a record of attempts to acquire missing telephone numbers. All materials relevant to survey administration are subject to review.

In addition to working with the client hospitals to obtain the most current patient contact information, hospitals/survey vendors must employ various methods for updating telephone numbers:

- Running update program software against the sample file just before or after uploading data to survey management systems
- Utilizing commercial software, Internet directories, and directory assistance

Note: It is strongly recommended that hospitals/survey vendors check the accuracy of sampled patients' contact information prior to survey fielding.

Data Receipt and Retention

Hospitals/Survey vendors utilizing the IVR mode of survey administration must keep track of the mode in which the survey was completed (i.e., IVR or Telephone). To illustrate, examples are provided of patients who completed the HCAHPS Survey by IVR and Telephone, with enough of the questions applicable to all patients answered for the survey to be considered a completed survey (based on the calculation of percent complete, for more information see the *Data Specifications and Coding* chapter).

- If a patient completed the HCAHPS Survey with the IVR system, then the hospital/survey vendor must:
  - retain documentation in their survey management system that the patient completed the survey in the **IVR** methodology of the IVR mode of survey administration
  - assign the appropriate "Survey Completion Mode" in the administrative record for this patient (see the *Data Specifications and Coding* chapter on "Survey Completion Mode" for more information)
  - document the telephone attempt "Number Survey Attempts – Telephone" in which the "Final Survey Status" is determined. For example, if the interview was conducted and finished with the patient on the fourth telephone attempt then the hospital/survey vendor must document the "Number Survey Attempts – Telephone" as "4 – Fourth Telephone attempt." Please see the *Data Specifications and Coding* chapter for more information regarding coding the "Number Survey Attempts – Telephone" field.
- If a patient completed the HCAHPS Survey with an interviewer by telephone, then the hospital/survey vendor must:
  - retain documentation that the patient completed the survey in the telephone methodology of the IVR mode of survey administration
  - assign the appropriate "Survey Completion Mode" in the administrative record for this patient (see the Data Specifications and Coding chapter on "Survey Completion Mode" for more information)
  - document the "Number Survey Attempts – Telephone" for the telephone attempt in which the "Final Survey Status" is determined. For example, if the interview was conducted and finished with the patient on the fourth telephone attempt; then the "Number Survey Attempts – Telephone" would be coded as "4 – Fourth Telephone attempt." Please see the Data Specifications and Coding chapter for more information on coding the "Number Survey Attempts – Telephone" field.

Hospitals/Survey vendors must record the date of the IVR interview and must link survey responses from the IVR interview to their survey management system, regardless of the IVR

interviewing system employed. Hospitals/Survey vendors must maintain a crosswalk of their interim disposition codes to the HCAHPS "Final Survey Status" codes and include the crosswalk in the hospital's/survey vendor's QAP.

IVR

Survey data are recorded in a timely manner after the hospital/survey vendor completes the survey using the IVR protocol. Hospitals'/Survey vendors' IVR systems are linked to the survey management system so that obtained responses from IVR surveys are automatically added to the survey management system. Hospitals'/Survey vendors' IVR systems record the date of the IVR interview.

Telephone

For surveys initiated in IVR, but completed in the electronic telephone interviewing system or manually over the telephone, the survey management system must also be linked to the completed surveys. Hospitals/Survey vendors must follow the appropriate data receipt rules for the electronic telephone interviewing system or manual data entry:

1. Electronic Telephone Interviewing System – The electronic telephone interviewing systems employed by hospitals/survey vendors must be electronically linked to their survey management system to enable responses obtained from the electronic telephone interviewing system to be automatically added to the survey management system.
2. Manual Data Collection – Only hospitals self-administering the survey may use manual data collection methods. Hospitals using manual data entry (paper questionnaires) to collect survey data over the telephone must follow the guidelines below for linking survey responses to the survey management system. Either key-entry or scanning may be used.
    - Key-entry
        - *Unique record verification system:* The survey management system performs a check to verify that the patient response data have not already been entered in the survey management system
        - *Valid range checks:* The data entry system identifies responses/entries that are invalid or out-of-range
        - *Validation:* The hospital must perform checks to confirm that key-entered data accurately capture the responses of the telephone interview. A different staff member (preferably the data entry supervisor) must reconcile any discrepancies. It is strongly suggested that hospitals using the HCAHPS Data Form, formerly the Online Data Entry Tool, download Excel spreadsheets containing entered data and compare entered data to the original survey completed by the telephone interviewer. This validation process must be performed by someone other than the person doing data entry via the HCAHPS Data Form.
    - Scanning
        - *Unique record verification system:* The survey management system performs a check to confirm that the patient's survey responses have not already been entered in the survey management system
        - *Valid range checks:* The software identified invalid or out-of-range responses
        - *Validation:* The hospital must perform checks to confirm that scanned data accurately capture the responses on the original survey completed by the telephone interviewer. A staff member must reconcile any responses not recognized by the scanning software.

Data Storage

The following data storage guidelines must be followed for HCAHPS IVR surveys:

- Data collected through an IVR and/or electronic telephone interviewing system must be retained in a secure manner for a minimum of three years and must be easily retrievable
- Data collected manually by telephone with paper questionnaires and then key-entered must be de-identified and stored in a secure and environmentally controlled location for a minimum of three years and must be easily retrievable
- Optically scanned questionnaire images of telephone interviews collected with paper questionnaires also must be de-identified and retained in a secure and environmentally controlled location for a minimum of three years and must be easily retrievable
- Hospitals/Survey vendors must destroy HCAHPS-related data files, including paper copies or scanned images of the questionnaires and electronic data files in a secure and environmentally safe location. Obtain a certificate of the destruction of data.

Quality Control Guidelines

Hospitals/Survey vendors are responsible for the quality of work performed by any staff members and subcontractor(s). Hospitals/Survey vendors must employ the following guidelines for proper operator training, monitoring, and oversight regardless of whether they are using organizational staff or subcontractor(s) to perform this work.

IVR Operator Training

Consistent monitoring of IVR operators is essential to achieve standardized and accurate results. Properly trained and supervised operators ensure that standardized, non-directive interview introductions are conducted. The operators initiating the IVR survey must be trained prior to initial contact with patients. Operators must be trained to read introductions exactly as worded in the HCAHPS script and maintain a neutral and professional relationship with the respondent. (See Appendix N for more information on interviewing guidelines.)

If a hospital/survey vendor uses a subcontractor to conduct active interactive IVR interviewing, then the hospital/survey vendor is responsible for attending/participating in the subcontractor's IVR operator training to confirm compliance with HCAHPS protocols and guidelines. Hospitals/Survey vendors must conduct on-site verification of subcontractor's interviewing processes (strongly recommended on an annual basis, at a minimum).

IVR Monitoring and Oversight

Each hospital/survey vendor employing the IVR mode of survey administration must institute a monitoring and evaluation program. The monitoring and evaluation program must include, but is not limited to, the following oversight activities:

- Hospitals/Survey vendors must monitor at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of all HCAHPS IVR operator contacts in their entirety (both English and Spanish) through silent monitoring of operators using the IVR interviewing system. Silent monitoring must be performed at the hospital's/survey vendors' or their subcontractors' business locations. All staff conducting HCAHPS interviews must be included in the monitoring. Hospitals'/Survey vendors' supervisory staff monitoring the telephone interviewers should use the electronic telephone interviewing system to observe the interviewer conducting the interview while listening to

the audio of the call at the same time. Additionally, it is required that hospitals/survey vendors provide "floor rounding" in their call-center(s) to visually observe and ensure the professionalism of the operators and telephone interviewers.

Note: Telephone interviews/monitoring must not be conducted from a residence or non-business location.

- **Hospitals/Surveys vendors using a subcontractor must monitor at least 10 percent (on an ongoing and continuous basis throughout the survey administration period) of the subcontractor's HCAHPS IVR operators, provide feedback to the subcontractor's operators about their performance and confirm that the subcontractor's operators correct any areas that need improvement. Feedback must be provided to operators as soon as possible following a monitoring session.**

  Note: HCAHPS protocols currently require that approved HCAHPS Survey vendors who subcontract the task of HCAHPS telephone interviewing monitor at least 10 percent of all HCAHPS calls/attempts/completed surveys (on an ongoing and continuous basis throughout the survey administration period). The HCAHPS Project Team also expects that a survey vendor's subcontractor will conduct internal monitoring of their telephone interviewers as a matter of good business practice that incorporates quality checks. While it is preferred that each organization continue to monitor 10 percent of HCAHPS interviews (for an overall total of 20 percent), it is permissible for the survey vendor and its subcontractor to conduct a combined total of at least 10 percent monitoring, as long as each organization conducts a portion of the monitoring. Therefore, the survey vendor and its subcontractor can determine the ratio of monitoring that each organization conducts, as long as the combined total meets or exceeds 10 percent. Please note that HCAHPS interviews monitored concurrently by the survey vendor and its subcontractor do not contribute separately to each organization's monitoring time.

- Staff who are found to be consistently unable to follow the script verbatim, remain objective and courteous, be clearly understood, or operate the IVR system competently, must be identified and retrained or, if necessary, replaced

In addition, hospitals/survey vendors must institute a telephone monitoring and evaluation program for surveys initiated in IVR, and completed via telephone (see Telephone Monitoring and Oversight section of the *Telephone Only Survey Administration* chapter).

Note: Hospitals/Surveys vendors must retain a record of all quality control activities and document these activities in the hospital's/survey vendor's QAP. All materials relevant to survey administration are subject to review.

Data Specifications and Coding

Overview

The CAHPS Hospital Survey (HCAHPS) uses standardized protocols for file specifications, coding and submission of data. Consistent and uniform coding of all data elements by all hospitals/survey vendors is necessary in order to produce publicly reported HCAHPS scores that are comparable across all providers and time periods. This chapter provides an overview and key details on the requirements for assigning the random, unique, de-identified patient identification number; coding and interpreting ambiguous or missing data elements in returned surveys; preparing data files for submission to the HCAHPS Data Warehouse via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal; and determining the rate of response.

Random, Unique, De-identified Patient Identification Number

The hospital/survey vendor must assign each patient in the sample a random, unique, de-identified patient identification number (Patient ID). This Patient ID is used to track and report whether the patient has returned the survey, or needs a repeat mailing or telephone/IVR follow-up. Any de-identified alphanumeric combination of up to 16 letters and numbers may be used. Do not use symbols or special characters (^*@#&) of any kind as they are not valid for data submission. The Patient ID must not include any combination of letters, numbers or dates that can otherwise identify the patient. For example, the discharge date (month, date and/or year), the birth date (month, date and/or year) and hospital ID number (i.e., patient's hospital medical record number) must not be combined in any manner to generate the Patient ID. Each month, sampled patients must be assigned a new Patient ID; numbers must not 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.

File Specifications

The hospital/survey vendor must organize survey data into monthly files and then submit the files to the HCAHPS Data Warehouse via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/) on either a monthly or quarterly basis. Data must be submitted for all three months of the quarter. There are two methods for submitting surveys to the HCAHPS Data Warehouse via the HQR system: the XML file format or the HCAHPS Data Form, formerly the Online Data Entry Tool.

Survey vendors are required to submit their data files to the HQR system in the XML file format. The HCAHPS Data Form was designed expressly for self-administering hospitals with low monthly survey volume. With the HCAHPS Data Form, data are submitted one survey at a time.

Hospitals with zero eligible HCAHPS patient discharges (zero cases) should submit a Header Record (Survey Month Data) information online via the HQR system. Hospitals with five or fewer eligible HCAHPS patient discharges in a month may choose not to survey those patients for that month. If patients are not surveyed, a Header Record (Survey Month Data) still must be submitted online via the HQR system.

Note: "Zero cases" and "five or fewer eligible HCAHPS patient discharges" submissions should not be used when hospitals or survey vendors missed surveying eligible patients, such as when hospitals do not submit any discharge lists for the month to their survey vendor in a timely manner. In situations such as these, a Discrepancy Report must be completed and submitted.

XML File Specifications

The XML format allows a hospital's sampled patient records for a given month to be submitted in one file. If a hospital's monthly data file is submitted more than once, the most recent submission will completely overwrite the previous file for that month, and only the most recent submission will be stored in the data warehouse. Therefore, the final file submission must contain all of a hospital's sampled discharge cases for that month. No substitutions for valid data element values are acceptable. See Appendix Q for the listing of valid values.

Each XML file consists of three parts:

1. Header Record
2. Administrative Data Record
3. Patient Response/Survey Results Record

1. Header Record

Each monthly data file submitted by a hospital/survey vendor begins with the Header Record. The Header Record contains identification and sampling information that is applicable to every survey record in that month. The Header Record includes: hospital's name; CCN; National Provider Identifier (NPI), which is an optional field; the discharge year and month; mode of survey administration; methodology for determination of service line; the total number of inpatient discharges in the month; the number of eligible discharges; the number of sampled discharges; and the type of sampling used.

A critical component in the Header Record is the "Type of Sampling" used. See the *Sampling Protocol* chapter for information on sampling options. If a hospital/survey vendor elects to employ Disproportionate Stratified Random Sampling (DSRS), which requires an Exception Request, additional information is required in the Header Record.

For DSRS, three additional data elements of information about each stratum must be included in the Header Record in the XML file:

- "DSRS Strata Name" – The name of each stratum (at least two unique strata names should be defined)
- "DSRS Inpatient" – The total number of inpatient discharges in each stratum
- "DSRS Eligible" – The number of eligible patients in each stratum
- "DSRS Sample Size" – The number of sampled patients in each stratum (must be a minimum of 10 sampled patients per stratum)

Hospitals/Survey vendors using DSRS are required to have a minimum of 10 sampled discharges in every stratum in every month. *Hospitals/Survey vendors that are uncertain about their ability to meet this requirement should not use DSRS.*

Each field of the Header Record requires an entry for a valid data submission, with the exception of "NPI," which is an optional data element. It should be noted that "DSRS Strata Name," "DSRS

Inpatient," "DSRS Eligible," and "DSRS Sample Size" are only required when "Type of Sampling" is "3 – Disproportionate Stratified Random Sample."

2. Administrative Data Record

The second part of the monthly data submission file is the Administrative Data Record. This record contains de-identified information on each patient sampled that month, including CCN; discharge year and month; Patient ID; point of origin for admission; service line; patient discharge status; DSRS strata name, if applicable; final survey status; survey completion mode, if applicable; survey language in which the survey was administered or attempted to be administered; supplemental question count; lag time; gender; and age at admission. Some of this information comes from the hospital's/survey vendor's survey records, while other information is taken from the patient's hospital administrative record. The Administrative Data Record also includes:

- The "Number Survey Attempts – Telephone" is required when "Survey Mode" in the Header Record is "2 – Telephone Only" or "4 – IVR." It is also required when "Survey Mode" in the Header Record is "3 – Mixed Mode" **and** "Survey Completion Mode" is "2 – Mixed Mode-phone."
- The "Number Survey Attempts – Mail" is required when "Survey Mode" in the Header Record is "1 – Mail Only."

  Note: The "Number Survey Attempts – Telephone" and the "Number Survey Attempts – Mail" fields are submitted in accordance with the requirements identified above for all HCAHPS "Final Survey Status" codes.

An Administrative Data Record is required for each patient sampled for the HCAHPS Survey, whether or not the patient responded to the survey. For successful submission of the monthly data file, each field of the Administrative Data Record must contain a valid value.

3. Patient Response/Survey Results Record

The third part of the monthly data submission file is the Patient Response/Survey Results Record. This set of records contains the actual survey responses from each patient who responded to the HCAHPS Survey for that month.

The Patient Response/Survey Results Record is required only when "Final Survey Status" in the Administrative Data Record is coded either "1 – Completed survey" or "6 – Non-Response: Break-off." Once the Patient Response/Survey Results Record is included, <u>all</u> response fields must have a valid value, which may include "M – Missing/Don't Know" and "8 – Not Applicable." The opening and closing <patientresponse> XML tags (which enclose the Patient Response/Survey Results Record) are not necessary when there are no survey responses to submit for a given patient.

Note: The Patient Response/Survey Results Record is not required for "Final Survey Status" of anything other than "1 – Completed survey" or "6 – Non-Response: Break-off;" however, if the Patient Response/Survey Results Record is included, then all fields must have a valid value.

For details on the XML file specifications and for a sample XML file layout, see Appendix R.

HCAHPS Data Form, formerly the Online Data Entry Tool

The HCAHPS Data Form was expressly designed for use by self-administering hospitals with low monthly survey volume that do not have the ability to submit data in the XML file format. The HCAHPS Data Form requires hospitals to enter data one survey at a time on the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/). The monthly data submitted via the HCAHPS Data Form is comprised of three parts:

1. Header Record (Survey Month Data)
2. Administrative Data Record (Administrative Data)
3. Patient Response/Survey Results Record (Survey Results)

1. Header Record (Survey Month Data)

The Header Record contains identification and sampling information that is applicable to every survey record in that month. The Header Record includes: hospital's name; CCN; National Provider Identifier (NPI), which is an optional field; the discharge year and month; mode of survey administration; methodology for determination of service line; the number of total inpatient discharges; the number of eligible discharges; the number of sampled discharges; survey mode; and the type of sampling used.

2. Administrative Data Record (Administrative Data)

The second part of the monthly data submission is the Administrative Data Record. This record contains de-identified information on each patient sampled that month, including CCN; discharge year and month; Patient ID; point of origin for admission; service line; patient discharge status; DSRS strata name, if applicable; final survey status; survey completion mode, if applicable; survey language; supplemental question count; lag time; gender; and age at admission. Some of this information comes from the hospital's/survey vendor's survey records, while other information is taken from the patient's hospital administrative record. The Administrative Data Record also includes:

- The "Number Survey Attempts – Telephone" is required when "Survey Mode" in the Header Record is "2 – Telephone Only" or "4 – IVR." It is also required when "Survey Mode" in the Header Record is "3 – Mixed Mode" **and** "Survey Completion Mode" is "2 – Mixed Mode-phone."
- The "Number Survey Attempts – Mail" is required when "Survey Mode" in the Header Record is "1 – Mail Only"

  Note: The "Number Survey Attempts – Telephone" and the "Number Survey Attempts – Mail" fields are submitted in accordance with the requirements identified above for all HCAHPS "Final Survey Status" codes.

An Administrative Data Record is required for each patient sampled for the HCAHPS Survey, whether or not the patient responded to the survey. For successful submission of the monthly data file, each field of the Administrative Data Record must contain a valid value.

3. Patient Response/Survey Results Record (Survey Results)

The third part of the monthly data submission is the Patient Response/Survey Results Record. This set of records contains the actual survey responses from each patient who responded to the HCAHPS Survey for that month.

Patient survey responses are required for valid data submission via the HCAHPS Data Form only when "Final Survey Status" is coded either "1 – Completed survey" or "6 – Non-Response: Break-off." Once patient survey responses are included, all response fields must have a valid value, which may include "M – Missing/Don't Know" and "8 – Not Applicable."

For further information regarding use of the HCAHPS Data Form, see the *Data Preparation and Submission* chapter of this manual.

Decision Rules and Coding Guidelines

In order to ensure the accurate collection of all survey data, hospitals/survey vendors administering the HCAHPS Survey must develop, implement and document quality control procedures for all survey administration activities. The HCAHPS decision rules and coding guidelines were developed to address situations in which survey responses are ambiguous, missing or incorrectly provided; and to capture appropriate information for data submission. Hospitals/Survey vendors must adhere to the following guidelines to ensure valid and consistent coding of such instances.

Mail Surveys

A common problem in mail surveys is ambiguity of responses on returned questionnaires. In order to ensure uniformity in data coding, hospitals/survey vendors must strictly apply the following guidelines. Hospitals/Survey vendors that scan or key-enter mail surveys must employ the following decision rules for resolving common ambiguous situations.

- If a mark falls between two response options but is obviously closer to one than the other, then select the choice to which the mark is closest
- If a mark falls equidistant between two response options, then code the value of the item as "M – Missing/Don't Know"
- If a value is missing, then code the response as "M – Missing/Don't Know." Hospitals/Survey vendors must not impute a response; in other words, do not try to determine what the patient would have responded for the missing value based on answers to other questions.
- When more than one response option is marked, code the value as "M – Missing/Don't Know"
  - Exception: Question 28, *"What is your race? Please choose one or more."* For Question 28, enter responses for ALL of the categories that the respondent has selected.
- Question 28, *"What is your race? Please choose one or more."*, if respondent writes Caucasian code as "1 – White"
- Question 29, "*What language do you mainly speak at home?"*, if respondent writes American code as "1 – English"

In instances where there are multiple marks, **but** the patient's intent is clear, hospitals/survey vendors should code the survey with the patient's **clearly identified** intended response.

Skip Patterns for Mail Surveys

There are several items in the HCAHPS Survey that can and should be skipped by certain patients. These items form skip patterns. Three questions in the HCAHPS Survey serve as screener questions (Questions 10, 12, and 15) that determine whether the associated dependent questions require an answer. The following decision rules are provided to assist in the coding of patient responses to skip pattern questions.

Decision Rules for Screener and Dependent Questions

Decision rules for coding **screener questions** 10, 12, and 15:

- Enter the value provided by the patient. Do not impute a response based on the patient's answers to the dependent questions.
- If the screener question is left blank, then code it as "M – Missing/Don't Know." Do not impute a response based on the patient's answers to the dependent questions.

Decision rules for coding **dependent questions** 11, 13, and 14:

- If the corresponding screener question is answered "Yes" and the dependent question(s) is left blank, then code the dependent question(s) as "M – Missing/Don't Know"
- If the corresponding screener question is answered "Yes" and the dependent question(s) is not left blank, then enter the value provided by the patient for the dependent questions(s)
- If the corresponding screener question is answered "No" and the dependent question(s) is left blank, then code the dependent question(s) as "8 – Not Applicable"
- If the corresponding screener question is answered "No" and the dependent question(s) is not left blank, then enter the value provided by the patient for the dependent question(s)
- If the corresponding screener question is left blank and the dependent question(s) is left blank, then code both the corresponding screener question and dependent question(s) as "M – Missing/Don't Know"
- If the corresponding screener question is left blank and the dependent questions(s) is not left blank, then code the corresponding screener question as "M – Missing/Don't Know" and enter the value provided by the patient for the dependent questions(s)

Decision rules for collecting data from **dependent questions** 16 and 17:

- If screener Question 15 is answered "1 – Own home" or "2 – Someone else's home" and the dependent question(s) is left blank, then code the dependent question(s) as "M – Missing/Don't Know"
- If Question 15 is answered "1 – Own home" or "2 – Someone else's home" and the dependent question(s) is not left blank, then enter the value provided by the patient for the dependent questions(s)
- If Question 15 is answered "3 – Another health facility" and the dependent question(s) is left blank, then code the dependent question(s) as "8 – Not Applicable"
- If Question 15 is answered "3 – Another health facility" and the dependent question(s) is not left blank, then enter the value provided by the patient for the dependent question(s)
- If Question 15 is left blank and the dependent question(s) is left blank, then code both Question 15 and the dependent question(s) as "M – Missing/Don't Know"
- If Question 15 is left blank and the dependent question(s) is not left blank, then code Question 15 as "M – Missing/Don't Know" and enter the value provided by the patient for the dependent question(s)

In summary, dependent questions that are appropriately skipped are coded as "8 – Not Applicable." In instances where the patient made an error in the skip pattern, dependent questions are coded with the response provided by the patient. That is, hospitals/survey vendors must not "clean" or correct skip pattern errors returned by a patient. For further information on screener and dependent questions, see Appendix Q.

Telephone and IVR Surveys

It is important for telephone interviewers and IVR operators to be able to appropriately skip dependent questions while conducting the HCAHPS Survey. In order to uniformly code HCAHPS data, hospitals/survey vendors must strictly apply the following guidelines.

Skip Patterns for Telephone and IVR Surveys

For the telephone and IVR survey modes, skip patterns should be programmed into the electronic telephone interviewing/IVR system.

- If screener questions 10 and 12 are answered "No," then the corresponding dependent questions must be skipped. If screener question 15 is answered "3 – Another Health Facility," the corresponding dependent question must be skipped.
  - In these instances, appropriately skipped dependent questions must be coded as "8 – Not Applicable." For example, if a respondent answers "No" to Question 10 of the HCAHPS questionnaire, the program should skip Question 11 and go to Question 12. Question 11 must then be coded as "8 – Not Applicable." Coding may be done automatically by the telephone interviewing/IVR system or later during data preparation.
- If screener questions 10, 12 and 15 are not answered and therefore coded as "M – Missing/Don't Know," then the corresponding dependent questions must be skipped and coded as "M – Missing/Don't Know"
  - In instances where an interviewer is unable to obtain a response to a screener question, the screener question and any question in the skip pattern must be coded as "M – Missing/Don't Know." For example, if a respondent does not provide an answer to Question 10 of the HCAHPS questionnaire and the interviewer selects "M – Missing/Don't Know" to Question 10, then the telephone interviewing system should be programmed to skip Question 11 and go to Question 12. Question 11 must then be coded as "M – Missing/Don't Know." Coding may be done automatically by the telephone interviewing/IVR system or later during data preparation.

Header Record

- All fields in the Header Record must have a valid value entered with the exception of "NPI," "DSRS Strata Name," "DSRS Inpatient," "DSRS Eligible," and "DSRS Sample Size" fields. The DSRS fields are required only when "Type of Sampling" is "3 – Disproportionate Stratified Random Sample."
- Once the "Survey Mode" field has been defined for the first month in a quarter, the survey mode for the quarter can be changed by resubmitting this file **ONLY** if the data files for another month in the quarter have not yet been submitted to the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/)
  - The "Survey Mode" field must be coded with the approved survey mode for the hospital. For example, if the hospital is using the IVR survey mode and has patients who opt to complete the survey by telephone, the "Survey Mode" field must still be coded as "4 – IVR." (See the *Patient Administrative Data Record* in this chapter for more information regarding "Survey Completion Mode.")
- The "Total Inpatient Discharges" field is the total number of inpatient discharges in the month. If a hospital excludes any patients from the discharge list provided to their survey

vendor, they must submit to their survey vendor a count of total inpatient discharges to be included for data submission.

- In calculating the "Eligible Discharges" field, the number of eligible discharges in the sample frame in the month must not include patients who are determined to be ineligible or excluded, regardless of whether they are selected for the survey sample
  - "Sample Size" can therefore be larger than the number of "Eligible Discharges." For example, 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"), then the patient must be subtracted from the number of eligible discharges in the month. However, this does NOT apply to "Final Survey Status" codes of "2 – Ineligible: Deceased," "4 – Ineligible: Language barrier," or "5 – Ineligible: Mental/physical incapacity." See Example 1 below.

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

In this example:

- The initial "Eligible Discharges" is 100 and "Sample Size" is 100 (i.e., census sampling)
- Five patients were subtracted from the "Eligible Discharges" because they had a "Final Survey Status" code of "3 – Ineligible: Not in eligible population," resulting in 95 "Eligible Discharges"
- Patients with a "Final Survey Status" code of 2, 4 or 5 were not subtracted
- In the Header Reader, "Sample Size" of 100 is larger than the number of "Eligible Discharges" of 95

  - If a patient is not selected for the survey sample and is later determined to be ineligible (for example, if the patient is later found to have an ineligible MS-DRG code), then the patient must be subtracted from the number of eligible discharges in the month. See Example 2 below.

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

In this example:

- The initial "Eligible Discharges" is 100 and "Sample Size" is 50
  - The final "Eligible Discharges" is 85
  - Five patients were subtracted from the "Eligible Discharges" because they had a "Final Survey Status" code of "3 – Ineligible: Not in eligible population"
  - Patients with Final Survey Status code of 2, 4 and 5 were not subtracted
  - Ten patients were subtracted from the "Eligible Discharges" because they had an updated ineligible MS-DRG code, resulting in 85 "Eligible Discharges"

- The "Eligible Discharges" field must include the count of patients who are eligible for the HCAHPS Survey
  - Include even if the patient's 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

Note: A Discrepancy Report must be filed to account for patient information received beyond the 42 calendar day initial contact period. These patients must NOT be included in the HCAHPS Survey sample and the Patient Administrative Data Record must not be included for these late patients who are not sampled.

- Once the "Type of Sampling" field has been defined for the first month in a quarter, the sample type for the quarter can be changed by resubmitting this file **ONLY** if the data files for another month in the quarter have not yet been submitted to the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/)
- When using DSRS as "Type of Sampling," at least two strata should be defined, with a minimum of 10 sampled patients per stratum. Once the strata names are defined, they should not be changed until the beginning of the next quarter.

- When small hospitals sample 100% of the eligible discharges (i.e., a census) in order to obtain as close to 300 completes as possible, the "Type of Sampling" must be coded as "1 – Simple Random Sample"

Note: Hospitals with zero cases or five or fewer eligible HCAHPS patient discharges in a month, must submit an HCAHPS Header Record (Survey Month Data) online via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/).

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:
  - When "Point of Origin for Admission" is missing, it is coded as "9 – Information not available"
  - The "language" field must be completed with the appropriate valid value indicating the survey language in which the survey was administered, even if a patient does not complete the survey (English, Spanish, Chinese, Russian, Vietnamese, Portuguese, or German).
- Patient administrative information must be submitted for all patients selected for the survey sample, including patients found to be ineligible prior to survey administration
  - If a patient is found to be ineligible or excluded after the sample is drawn, the patient should be assigned a "Final Survey Status" code of "3 – Ineligible: Not in eligible population"
- If a patient is discharged into a swing bed (except code "61 – SNF Swing Bed Within Hospital"), use the discharge date from the acute care setting, not the discharge date from the swing bed
- The "Survey Completion Mode" field must be submitted if the "Survey Mode" in the Header Record is "3 – Mixed Mode" or "4 – IVR" and the "Final Survey Status" is "1 – Completed survey" or "6 – Non-response: Break-off." For other "Final Survey Status" codes, code "Survey Completion Mode" as "8 – Not Applicable."

  Note: "Survey Completion Mode" is not a required field for "Survey Mode" of "1 – Mail Only" and "2 – Telephone Only."

- The "Number Survey Attempts – Telephone" field must be submitted when:
  - the "Survey Mode" in the Header Record is "2 – Telephone Only" or "4 – IVR"
  - the "Survey Mode" in the Header Record is "3 – Mixed Mode" and "Survey Completion Mode" is "2 – Mixed Mode-phone"
  - the "Number Survey Attempts – Telephone" field is coded with the attempt that corresponds to the time of final survey status determination

  Note: "Number Survey Attempts – Telephone" is not a required field for "Survey Mode" of "1 – Mail Only." If this field ("Number Survey Attempts – Telephone") is included with "Survey Mode" of "1 – Mail Only," then code "Number Survey Attempts – Telephone" as "8 – Not Applicable."

- The "Number Survey Attempts – Mail" field must be submitted when:
  - the "Survey Mode" in the Header Record is "1 – Mail Only"
  - the "Number Survey Attempts – Mail" field is coded with the attempt that corresponds to the time of final survey status determination

Note: If a survey is returned from the first wave mailing, the mail attempt should be coded as "1 – First wave mailing" even if a second survey was mailed to the patient. If a patient does not return a first or second wave mailing, the mail attempt should be coded as "2 – Second wave mailing."

Note: "Number Survey Attempts – Mail" is not a required field for "Survey Mode" of "2 – Telephone Only," "3 – Mixed Mode" or "4 – IVR." If this field ("Number Survey Attempts – Mail") is included with "Survey Mode" of "2 – Telephone Only," "3 – Mixed Mode" or "4 – IVR," then code "Number Survey Attempts – Mail" as "8 – Not Applicable."

Note: The "Number Survey Attempts – Telephone" and the "Number Survey Attempts – Mail" fields are submitted in accordance with the requirements identified above for all HCAHPS "Final Survey Status" codes.

- The "Lag Time" is calculated for each patient in the sample and is 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
  - All surveys (i.e., "Final Survey Status" codes of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, or M) **must contain** the actual lag time
  - Surveys must **NOT** have a lag time coded as "888 – Not Applicable"

*Note: Although a completed or break-off survey may have a maximum lag time of up to 84 days, survey administration must be completed within 6 weeks (42 calendar days) of initial contact **(first mailing of the mail survey or first telephone/IVR attempt).***

  - The following are brief illustrations of how lag time would be determined for each Final Survey Status (<survey-status> or "Disposition of survey") in HCAHPS:
    - **Completed survey** (code 1): Lag time is the number of days between the patient's discharge date from the hospital and the receipt of a completed mail survey or the completion of a telephone or IVR survey
    - **Ineligible: Deceased** (code 2): Lag time is the number of days between the patient's discharge date from the hospital and the date it is determined that the patient is deceased
    - **Ineligible: Not in eligible population** (code 3): Lag time is the number of days between the patient's discharge date from the hospital and the date it is determined that the patient is not eligible for the HCAHPS Survey
    - **Ineligible: Language barrier** (code 4): Lag time is the number of days between the patient's discharge date from the hospital and the date it is determined that a language barrier prevents the patient from completing the HCAHPS Survey

- **Ineligible: Mental/physical incapacity** (code 5): Lag time is the number of days between the patient's discharge date from the hospital and the date it is determined that a mental or physical incapacity prevents the patient from completing the HCAHPS Survey
- **Non-response: Break-off** (code 6): Lag time is the number of days between the patient's discharge date from the hospital and the date the patient "breaks off" or fails to complete the HCAHPS Survey after the survey has started
- **Non-response: Refusal** (code 7): Lag time is the number of days between the patient's discharge date from the hospital and the date the patient (or someone on the patient's behalf) refuses to take the HCAHPS Survey
- **Non-response: Non-response after maximum attempts** (code 8): Lag time is the number of days between the patient's discharge date from the hospital and the date of the maximum attempt (Mail: non-return of the second mailing of survey; Telephone: fifth call attempt; IVR: fifth call attempt) to administer the HCAHPS Survey
- **Non-response: Bad address** (code 9): Lag time is the number of days between the patient's discharge date from the hospital and the date it is determined that the patient's actual mailing address is not viable
- **Non-response: Bad/no phone number** (code 10): Lag time is the number of days between the patient's discharge date from the hospital and the date it is determined that the patient's actual telephone number is not viable

To illustrate the calculation of lag time, two examples are provided:

Patient A: Lag Time Calculation Mail	
Mode of Survey Administration	Mail Only
Discharge Date	July 1
Date of First Mail Attempt	August 12 (42 calendar days after discharge)
Date of Follow-up Mail Attempt	September 2 (21 days after first mail attempt)
Date Data Collection Activities Ended for this Patient	September 23 (42 calendar days after first mail attempt) Patient never returned the HCAHPS Survey
HCAHPS Final Survey Status	Code as "8 – Non-response: Non-response after maximum attempts" because the data collection protocol of 42 calendar days has been reached and the patient has not returned the HCAHPS Survey
Lag Time	Calculated as 84 Days (number of days between the patient's discharge [July 1] from the hospital to the date data collection activities ended [September 23])

Patient B: Lag Time Calculation Telephone	
Mode of Survey Administration	Telephone Only
Discharge Date	July 1
Date of First Attempt	July 3 (48 hours after discharge)
Date Data Collection Activities Ended for this Patient	August 14 (42 calendar days after the first telephone attempt)
HCAHPS Final Survey Status	Code as "8 – Non-response: Non-response after maximum attempts" because the data collection protocol of 42 calendar days had ended and the patient had not been reached although five attempts were made
Lag Time	Calculated as 44 Days (number of days between the patient's discharge from the hospital [July 1] to the date data collection activities ended [August 14])

- The "Supplemental Question Count" field must be submitted for all HCAHPS "Final Survey Status" codes. The count is the maximum number of supplemental questions available for the patient regardless if the questions are asked and/or answered.

  Note: For supplemental questions containing multi-response items (e.g., questions a. through e.), each response item will count as one question. For example, a supplemental question with sections a. through e. will count as five questions (a = 1, b = 2, c = 3, d = 4, e = 5) toward the total number of supplemental questions available to the patient.

- Patient administrative information must be submitted for all patients selected for the survey sample, including patients found to be ineligible prior to survey administration

Patient Response/Survey Results Record

- Enter all survey responses as provided by the patient for each survey item
- All survey questions must have a valid value. For "Final Survey Status" of "1 – Completed survey" or "6 – Non-Response: Break-off," code missing answers as "M – Missing/Don't Know," unless the questions were appropriately skipped dependent questions which would be coded as "8 – Not Applicable"
- Patients may select more than one response category in Question 28, *"What is your race? Please choose one or more."*
  - Mail Survey
    - Enter **all** of the race categories that the patient has selected. For any race category not selected, enter "0." If no race categories are selected, enter "M – Missing/Don't Know" for all race categories.
  - Telephone and IVR Surveys
    - Enter **all** of the race categories that the patient has selected. If the patient responds "Yes" to a race category, enter "1." If the patient responds "No" to a race category, enter "0." If the patient does not provide a response to any of the race categories or skips the question, enter "M – Missing/Don't Know."

  Note: A valid value must be submitted for each race category.

- If the same patient completes two surveys for the same hospital visit (i.e., the patient returns both mail surveys), the hospital/survey vendor uses the first HCAHPS questionnaire received

Survey Disposition Codes

Maintaining up-to-date dispositions of survey codes is a required part of the HCAHPS Survey administration process. Using the random, unique, de-identified Patient ID, the hospital/survey vendor assigns each patient in the sample a survey status code, which is used to track and report whether the patient has completed a questionnaire or requires further follow-up. Typically, survey status codes are either interim (which indicate the status of each sampled patient during the data collection period), or final (which indicate the final outcome of each patient surveyed at the end of data collection, that is – "Final Survey Status").

Interim disposition codes are to be used only for internal tracking purposes. The data files that are submitted to the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/) must contain the HCAHPS final survey status codes. Interim survey status codes allow the hospital/survey vendor to calculate and report the number of completed questionnaires and the response rate at any time during the data collection period. After data collection is completed, the hospital/survey vendor assigns each sampled patient a final survey status code.

The following table provides details on the assignment of the "Final Survey Status" field.

Code	Description
1	**Completed survey**[11] Hospitals/Survey vendors assign a patient a "Final Survey Status" code of "1 – Completed survey" when the patient answers at least 50 percent of the questions applicable to all patients (questions 1-10, 12, 15, and 18-22). Appropriately skipped questions do not count against the required 50 percent. There must be no evidence that the patient is ineligible. The following questions are not included in the calculation of percentage complete: 11, 13, 14, 16, 17, and 23-29.
2	**Ineligible: Deceased** Hospitals/Survey vendors assign a "Final Survey Status" code of "2 – Ineligible: Deceased" when the patient was alive at the time of discharge but deceased by time of survey administration.

[11] For detailed information on a completed survey, refer to *Definition of a Completed Survey* in this section.

HCAHPS Final Survey Status/Disposition Codes

Code	Description

3 Ineligible: Not in eligible population[12]

Hospitals/Survey vendors assign a "Final Survey Status" code of "3 – Ineligible: Not in eligible population" when there is evidence that the patient does not meet one or more of the following eligibility criteria or is determined to fall within an exclusion category:

Eligibility Criteria

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

Exclusions

- "No-Publicity" Patient
- Court/Law Enforcement patient (i.e., prisoners) with an "Admission Source" of "8 – Court/Law Enforcement," "Discharge Status" of "21 – Discharged/Transferred to Court/Law Enforcement," or "Discharge Status" of "87 – Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission." This does not include patients residing in halfway houses.
- Has a foreign home address (the U.S. territories – Virgin Islands, Puerto Rico, Guam, American Samoa, and Northern Mariana Islands are not considered foreign addresses; and therefore, are not excluded)
- Discharged to Hospice (whether at home or another facility)
- Eliminated from participation based on state regulations
- Patients Discharged to Nursing Homes and Skilled Nursing Facility (this applies to patients with a "Discharge Status" of: "03 – Medicare Certified Skilled Nursing Facility" "61 – Medicare Approved Swing Bed Within Hospital," "64 – Medicaid Certified Nursing Facility," "83 – Medicare Certified Skilled Nursing Facility with a Planned Acute Care Hospital Inpatient Readmission," and "92 – Medicaid Certified Nursing Facility with a Planned Acute Care Hospital Inpatient Readmission")

Note: If a patient was not discharged with discharge status codes of 3, 61, 64, 83 or 92 and the patient is drawn into the HCAHPS sample, then the hospital/survey vendor must attempt to contact that patient. Upon a minimum of one contact attempt to the facility, patients who are positively confirmed by the hospital/survey vendor to be residing in a Medicare Certified Skilled Nursing Facility (discharge code 3), Medicare Approved Skilled Nursing Facility Swing Bed Within Hospital (discharge code 61), Medicaid Certified Nursing Facility (discharge code 64), Medicare Certified Skilled Nursing Facility with a Planned Acute Care Hospital Inpatient Readmission (discharge code 83), or Medicaid Certified Nursing Facility with a Planned Acute Care Hospital Inpatient Readmission (discharge code 92), are considered ineligible and coded as "3 - Ineligible: Not in eligible population."

[12] Refer to the Eligibility for HCAHPS and Exclusions described in the *Sampling Protocol* chapter.

HCAHPS Final Survey Status/Disposition Codes	
Code	**Description**
4	**Ineligible: Language barrier** Hospitals/Survey vendors assign a "Final Survey Status" code of "4 – Ineligible: Language barrier" when there is evidence that the patient does not read or speak the language in which the survey is being administered.
5	**Ineligible: Mental or physical incapacity** Hospitals/Survey vendors assign a "Final Survey Status" code of "5 – Ineligible: Mental/physical incapacity" when the patient is unable to complete the survey because he/she is mentally or physically incapacitated. This includes patients who are visually/hearing impaired.
6	**Non-response: Break-off**[13] Hospitals/Survey vendors assign a "Final Survey Status" code of "6 – Non-response: Break-off" when a patient provides a response to at least one HCAHPS Core question applicable to all patients (questions 1-10, 12, 15, and 18-22), but answered too few Core questions to meet the criteria for a completed survey.
7	**Non-response: Refusal** Hospitals/Survey vendors assign a "Final Survey Status" code of "7 – Non-response: 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. Surveys completed by a proxy respondent are coded as "7 – Non-response: Refusal." *Note: Proxy respondents to the HCAHPS Survey are not permitted. In the event that it is determined a survey has been completed by a proxy respondent, the patient is assigned a "Final Survey Status" code of "7 – Non-Response: Refusal." The hospital/survey vendor submits the Administrative Data Record but does not submit the proxy-provided survey responses. The hospital/survey vendor retains a copy of such a survey and any accompanying documentation. If a survey is returned with a note or someone verbally refuses on behalf of the patient, the hospital/survey vendor should code the survey as "7 – Non-Response: Refusal."*

[13] For detailed information on a completed survey, refer to *Definition of a Completed Survey* in this chapter.

HCAHPS Final Survey Status/Disposition Codes	
Code	**Description**
8	**Non-response: Non-response after maximum attempts** Hospitals/Survey vendors assign a "Final Survey Status" code of "8 – Non-response: Non-response after maximum attempts" when one of the following occurs: ➢ There is no evidence to suggest that a patient's contact information is bad (e.g., bad address in Mail Only methodology, bad telephone number in Telephone Only or IVR methodologies, and both bad address and bad telephone number in a Mixed Mode methodology), or ➢ If after the maximum number of attempts (two mail attempts for Mail Only; five telephone attempts for Telephone Only or Active IVR; and one mail attempt and five telephone attempts for Mixed Mode), the patient has not completed the survey by the end of the survey administration time period (i.e., 42 calendar days from initial contact), or ➢ If the survey is returned by mail or completed by telephone or IVR with a lag time greater than 84 days ***Note: A Discrepancy Report must be filed to account for patient information received beyond the 42 calendar day initial contact protocol. These patients must NOT be included in the HCAHPS Survey sample and the Patient Administrative Data Record must not be included for these late patients who are not sampled.***
9	**Non-response: Bad address** This disposition code applies only to the Mail Only mode. Hospitals/Survey vendors assign a "Final Survey Status" code of "9 – Non-response: Bad Address" when there is evidence that a patient's address is bad (e.g., the post office returns the questionnaire to the hospital/survey vendor, etc.).
10	**Non-response: Bad/no telephone number** This disposition code applies to the Telephone Only, IVR and Mixed Modes of administration. For the Telephone Only and IVR modes, hospitals/survey vendors assign a "Final Survey Status" code of "10 – Non-response: Bad/no phone number" when there is evidence that a patient's telephone number is bad (e.g., no telephone number available or a disconnected telephone number, etc.). For the Mixed Mode, "10 – Non-response: Bad/no phone number" is used when there is evidence that a patient's address and telephone number are both bad.

Assigning Bad Address and Bad/No Telephone Number Disposition Codes

The "Final Survey Status" codes of "8 – Non-response: Non-response after maximum attempts," "9 – Non-response: Bad address" and "10 – Non-response: Bad/no phone number" are assigned based on the viability of the address and telephone number for the patient. Hospitals/Survey vendors must track the viability of the mailing address and telephone number for each patient during survey administration. In general, the contact information is assumed to be viable unless there is sufficient evidence to suggest otherwise. If the evidence is insufficient, the hospital/survey vendor must continue attempting to contact the patient until the required number of attempts has been exhausted.

Note: Attempts must be made to contact every eligible patient drawn into the sample, whether or not they have a complete mailing address and/or telephone number. Hospitals/Survey vendors have flexibility in not sending mail surveys to patients without mailing addresses, such as the homeless. However, hospitals/survey vendors must first make every reasonable attempt to obtain a patient's address including re-contacting the hospital client to inquire about an address update for patients with no mailing address. Hospitals/Survey vendors must use commercial software or other means to update addresses and/or telephone numbers provided by the hospital for sampled patients. If the hospital/survey vendor is unsuccessful in obtaining a viable mailing address and/or telephone number, they must retain a record of their attempts to acquire the missing information. All materials relevant to survey administration are subject to review by CMS.

The following examples illustrate what constitutes sufficient or insufficient evidence of viability.

For a Mail Only survey, sufficient evidence regarding the viability of a patient's address includes:

- The hospital does not provide an address in the patient discharge list, and the hospital/survey vendor is unable to obtain an address for the patient
- Mail is returned marked "Address Unknown"
- Mail is returned marked "Moved – No Forwarding Address"

For a Mail Only survey, *insufficient evidence* regarding the viability of a patient's address includes:

- Address updating search does not result in an exact "match." If the search does not result in an exact "match," the hospital/survey vendor must attempt to mail using the address that is available.

For all modes of administration **except** Mail Only, sufficient evidence regarding the viability of a patient's telephone number includes:

- The hospital does not provide a telephone number in the patient discharge list, and the hospital/survey vendor is unable to obtain a telephone number for the patient
- The telephone interviewer dials the patient's telephone number and receives a message that the telephone number is non-working or out of order, and no updated number is available or obtained
- The telephone interviewer dials the patient's telephone number, speaks to a person, and is informed that he/she has the wrong telephone number and other attempts to obtain the correct telephone number are not successful

For all modes of administration **except** Mail Only, *insufficient evidence* regarding the viability of a patient's telephone number includes:

- The hospital/survey vendor obtains a busy signal every time a telephone attempt is made

The following table summarizes how hospitals/survey vendors assign the "Final Survey Status" codes of "8 – Non-response: Non-response after maximum attempts," "9 – Non-response: Bad address" and "10 – Non-response: Bad/no phone number" after assessing the patient's contact information for viability. Due to the nature of the information available in the four modes of survey administration, different coding rules apply for surveys administered in each mode.

Mail Only Methodology Assigning Final Survey Status/Disposition Codes 8, 9, and 10		
	Viable Address and No Response After Maximum Attempts	**Evidence of a Bad Address**
Final Survey Status Code	**8**	**9**

Telephone Only and Active IVR Methodologies Assigning Final Survey Status/Disposition Codes 8, 9, and 10		
	Viable Telephone Number and No Response After Maximum Attempts	**Evidence of a Bad/No Telephone Number**
Final Survey Status Code	**8**	**10**

Mixed Mode Methodology Assigning Final Survey Status/Disposition Codes 8, 9, and 10		
	Viable Address and/or Telephone Number and No Response After Maximum Attempts	**Evidence of Both a Bad Address and a Bad/No Telephone Number**
Final Survey Status Code	**8**	**10**

Definition of a Completed Survey

Hospitals/Survey vendors should be aware that a survey can be considered "complete" for HCAHPS purposes even if a patient did not answer all items. Hospitals/Survey vendors assign a patient's survey a "Final Survey Status" code of "1 – Completed survey" when at least 50 percent of the questions applicable to all patients (Questions 1-10, 12, 15, and 18-22) are answered. Appropriately skipped questions and the following questions are not included in the calculation of percentage complete: 11, 13, 14, 16, 17, and 23–29.

The following steps describe how to determine if a survey is completed:

Step 1 – Sum the number of questions that have been answered by the patient that are applicable to all patients (i.e., questions 1-10, 12, 15, and 18-22).

R = total number of questions answered

Step 2 – Divide the total number of questions answered by 17, which is the total number of questions applicable to all patients, and then multiply by 100.

Percentage Complete = (R/17) x 100

Step 3 – If the Percentage Complete is at least 50 percent, then assign the survey a "Final Survey Status" code of "1 – Completed survey."

The following examples illustrate how to determine if a survey is "completed."

Determining if a Survey is Completed: Example A

A mail survey is returned to the hospital/survey vendor, or a telephone or IVR survey is conducted. Of the questions that are applicable to all patients, the patient answered the following: 1, 2, 3, 4, 5, 8, 9, 12, and 15. The remaining items applicable to everyone were left blank or were coded as "M – Missing/Don't Know."

Step 1:

R = total number of questions answered = 9

Step 2:

Percentage Complete = (9/17) x 100 = 52.9%

Step 3:

Percentage Complete = 52.9% which meets the criteria for a completed survey (≥ 50%). Hospital/ Survey vendor assigns a "Final Survey Status" code of "1 – Completed survey" to this survey.

Determining if a Survey is Completed: Example B

A mail survey is returned to the hospital/survey vendor, or a telephone or IVR survey is conducted. Of the questions that are applicable to all patients, the patient answered the following: 1, 3, 4, 8, 12, and 15. The remaining items applicable to everyone were left blank or were coded as "M – Missing/Don't Know."

Step 1:

R = total number of questions answered = 6

Step 2:

Percentage Complete = (6/17) x 100 = 35.3%

Step 3:

Percentage Complete = 35.3% which does not meet the criteria for a completed survey (≥ 50%). Hospital/Survey vendor assigns a "Final Survey Status" code of "6 – Non-response: Break-off" to this survey.

Survey Response Rate

The following formula is included for informational purposes only; hospitals/survey vendors are not required to perform this calculation.

This formula is for a given four rolling quarters (12-month) public reporting period.

$$\text{Response Rate} = \frac{\text{Total Number of Completed Surveys}}{\text{Total Number of Surveys Fielded} - \text{Total Number of Ineligible Surveys}}$$

- **Total Number of Completed Surveys** is the total number of surveys with a "Final Survey Status" of 1
- **Total Number of Surveys Fielded** is the total sample, which includes "Final Survey Status" codes of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and M
- **Total Number of Ineligible Surveys** is the total number of surveys with a "Final Survey Status" code of 2, 3, 4, or 5

It is important to emphasize that the remaining non-response disposition codes (i.e., "6 – Break-off," "7 – Refusal," "8 – Non-response: Non-response after maximum attempts," "9 – Bad address," and "10 – Bad/no telephone number") are **not** removed from the denominator of the response rate calculation.

The following example illustrates how to calculate a survey response rate.

Calculating a Survey Response Rate

A hospital administers the HCAHPS Survey to 833 discharged patients during a one-year period. Of the 833 surveys sent to patients, there were 300 returned completed surveys and an additional 85 were determined to be ineligible. The hospital would like to determine its survey response rate.

$$\text{Response Rate} = \frac{\text{(Total Number of Completed Surveys)}}{\text{(Total Number of Surveys Fielded} - \text{Total Number of Ineligible Surveys)}}$$

$$= \frac{(300)}{(833\text{-}85)}$$

$$= 0.401 = 40.1\%$$

The hospital's survey response rate is **40.1** %.

Data Preparation and Submission

Overview

The CAHPS Hospital Survey (HCAHPS) uses a standardized protocol for the preparation and submission of all data. This chapter describes the preparation, registration and instructions for data submission via the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal, a CMS-approved web site for the secure data transmission of healthcare quality data. Questions about HQR user sign-up, vendor management, data submission via HQR, or general inquiries about using the HQR system should be directed towards the QualityNet Help Desk via telephone (1-866-288-8912) or email (qnetsupport@hcqis.org). Please keep the HCAHPS Project Team informed of any HCAHPS-related QualityNet tickets by emailing HCAHPS Technical Assistance at hcahps@hsag.com and including the Help Desk ticket number(s).

Preparation for Data Submission

Hospitals/Survey vendors should prepare for HCAHPS data submission by performing the following steps:

1. Ensure the user's HARP (HCQIS Access Roles and Profile) account is active by logging into the Hospital Quality Reporting (HQR) system at https://hqr.cms.gov/ or create a HARP account for new users
2. Register as a Basic User or Security Administrator in the HQR system and ensure any necessary HCAHPS data submission permissions are activated
3. Authorize HCAHPS Survey vendor via Vendor Management in HQR (for hospitals contracting with a survey vendor)
4. Submit data in HQR using the HCAHPS Data Form (Online Data Entry Tool) or File Upload (XML file submission)

Registration for Data Submission via HQR

Hospitals/Survey vendors are required to have an active HARP account to access HQR and submit HCAHPS data for public reporting. Users can ensure their account is active by logging into the HQR system at https://hqr.cms.gov/. A new user will need to create a HARP account and request the appropriate user roles. Users are classified as either HQR Security Administrators or as Basic Users. Each type of user requires a specific registration process. Basic Users must be individually approved by the HQR Security Administrator. Questions regarding Security Administrator or Basic User registration should be directed towards the QualityNet Help Desk via telephone (1-866-288-8912) or email (qnetsupport@hcqis.org).

Assignment of an HQR Security Administrator

Each hospital participating in HCAHPS and each approved HCAHPS Survey vendor is required to have an HQR Security Administrator within their organization. In addition to this primary HQR Security Administrator, hospitals/survey vendors are required to maintain a backup or secondary HQR Security Administrator. The secondary HQR Security Administrator would have the same roles as the primary and be used on the occasions the primary is unavailable. Security Administrators are the main HQR contacts for the organization. A hospital cannot delegate the

HQR Security Administrator role to any other organization, including their HCAHPS Survey vendor.

The registered hospital/survey vendor HQR Security Administrator(s) is responsible for registering and maintaining individual Basic Users within their organization. Basic Users are all individuals within a hospital or survey vendor organization who can:

- submit data, view Submission or Feedback Reports and/or authorize a survey vendor

The hospital/survey vendor HQR Security Administrator's role(s) will be to:

- register as a Security Administrator
- register or approve each new HQR Basic User within the organization
- edit users' access to specific applications or functions, such as the ability to view reports or to upload data
- suspend or restore users as needed
- remove access for their users who are no longer active or no longer require access to HQR
- monitor HQR secure access to maintain proper security and confidentiality measures
- validate the users and the type of functionality each user at their organization should have within the HQR system
- serve as a point of contact at the organization for information regarding HQR

If the hospital's/survey vendor's Project Manager does not know who the HQR Security Administrator is, he/she should contact the QualityNet Help Desk by calling 1-866-288-8912.

If a hospital's/survey vendor's HQR Security Administrator is leaving the organization, he/she must notify their back-up administrator and the QualityNet Help Desk.

HQR Security Administrator Registration

If the user is the first individual requesting to be HQR Security Administrator at the organization, contact the QualityNet Help Desk for assistance and further instruction. If there is an existing HQR Security Administrator at your organization, registering as another Security Administrator for the organization can be achieved using the "Access Management" feature as follows:

1. Sign into the HQR system at https://hqr.cms.gov/ using a HARP account
2. Once logged into HQR, go to "My Profile"
3. From this page, Request Access or View Current Access
4. Between the Basic User or Security Administrator/Official type, choose the Security Administrator/Official User type
5. Choose which permissions are needed as a Security Administrator. Ensure the correct permissions for submitting HCAHPS data and reviewing HCAHPS submission results are selected and submitted.

HQR Basic User Registration

Once the hospital/survey vendor has an HQR Security Administrator, they may register Basic Users within the organization. Users wanting to request Basic User access must already have an organization associated with their account to follow the instructions below. New users not associated with an organization must contact their HQR Security Administrator to request access.

The steps for registering HQR Basic Users with an existing organization affiliation are as follows:

1. Sign into the HQR system at https://hqr.cms.gov/ using a HARP account. Create a HARP account if the user does not have one.
2. Once logged into HQR, go to "My Profile"
3. From this page, Request Access or View Current Access
4. Between the Basic User or Security Administrator/Official type, choose the Basic User type
5. Choose which permissions are needed as a Basic User. Ensure the correct permissions for submitting HCAHPS data and reviewing HCAHPS submission results are selected and submitted.

The organization's Security Administrator will need to approve the Basic User's access requests before the user can submit HCAHPS data or view HCAHPS reports.

HQR HCAHPS Roles

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

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

HCAHPS Survey Vendor Authorization Process

The following two sections outline the steps a hospital must complete in order to authorize, de-authorize or switch a survey vendor or a hospital acting as a survey vendor, to submit data via the HQR system on the hospital's behalf.

Survey Vendor Authorization

Hospitals that will be using a survey vendor or a hospital administering HCAHPS for multiple sites to submit their HCAHPS data must first authorize the survey vendor or multi-site hospital before their data can be successfully submitted via the HQR system. Survey vendors should work closely with their hospital clients, who are unfamiliar with HQR, to complete the authorization at least 90 days prior to the data submission deadline. Questions pertaining to vendor authorization in the HQR system should be directed towards the QualityNet Help Desk via telephone (1-866-288-8912) or email (qnetsupport@hcqis.org). Please keep the HCAHPS Project Team informed of any HCAHPS-related QualityNet tickets by emailing HCAHPS Technical Assistance at HCAHPS@hsag.com and including the Help Desk ticket number(s).

If a survey vendor attempts to submit the hospital's survey data without authorization, the data will be rejected by the data warehouse. The survey vendor must contact the hospital about the authorization and re-submit the data once authorization has been obtained. Survey vendor authorization takes effect immediately once the survey vendor authorization has been successfully submitted via the Vendor Management system on HQR.

Hospitals must use the Vendor Management System on HQR to authorize their HCAHPS Survey vendors. After logging into HQR with a HARP ID, hospitals may navigate to the Vendor Management System by clicking on "Administration" from the menu, and selecting "Vendor

Management." From the Vendor Management page, hospitals can click on "Add Vendor" and search for the desired vendor by organization name or Vendor ID. Hospitals can then select from a list of approved survey vendors and will be taken to an "Assign Access" page. Hospitals must select "Add" for the desired measure program to grant vendor access. For HCAHPS, hospitals must add the correct permissions for "HCAHPS" measure access. A pop-up will appear, and hospitals may change the access options from "No Access" to "Upload/Edit." Hospitals will also need to enter correct information for the Discharge Quarters and Submission Date fields. The definitions of the Discharge Quarters and Submission Start and End Dates are as follows:

- The Discharge Start Quarter and Start Year represent the first quarter and year the survey vendor has been contracted to work and from which eligible discharges will be sampled for surveying
- The Discharge End Quarter and End Year can be completed with the last quarter and year the hospital wishes the survey vendor to sample from eligible discharges for the purpose of administering the survey. **However, it is strongly recommended that these fields be left blank by checking the box "Do not include an end date."**
- The Submission Start Date (formerly the Transmission Start Date) represents the first calendar day the survey vendor is authorized to submit data on a hospital's behalf
- The Submission End Date (formerly the Transmission End Date) can be completed with the last date the hospital wishes the survey vendor to submit data on their behalf. **However, it is strongly recommended that this field be left blank by checking the box "Do not include an end date."**

Authorizing a New HCAHPS Survey Vendor

Discharge Start Quarter and Start Year	Data Submission Start Date (MM/DD/YYYY)
4Q 2021	10/1/2021
Discharge End Quarter and End Year	**Data Submission End Date (MM/DD/YYYY)**
(*Strongly recommend that these fields remain blank until survey vendor authorization is terminated, by checking the box "Do not include an end date"*)	

Switching Survey Vendors

Hospitals that choose to switch from one approved survey vendor to another can only do so at the beginning of a calendar quarter. Survey vendors should work closely with their hospital clients, who are unfamiliar with the HQR platform, to complete the authorization at least 90 days prior to the data submission deadline. Questions pertaining to switching survey vendors in the HQR system should be directed towards the QualityNet Help Desk via telephone (1-866-288-8912) or email (qnetsupport@hcqis.org). Please keep the HCAHPS Project Team informed of any HCAHPS-related QualityNet tickets by emailing HCAHPS Technical Assistance at hcahps@hsag.com and including the Help Desk ticket number(s).

In order to switch from one approved survey vendor to another, an HQR user should access the Vendor Management feature and enter or change the Submission End Date, Discharge End Quarter

and End Year associated with the current survey vendor. The following steps must be completed before a new survey vendor can be successfully authorized:

1. For the current survey vendor, the Submission End Date should be the last day for which the current survey vendor will be submitting data on the hospital's behalf

   Note: This will be the last date the HQR system will allow this vendor to upload. Make sure to provide the survey vendor with enough time to submit the data from this quarter. For example, if the survey vendor is authorized to submit 3Q21 data, the survey vendor must have a Submission End Date AFTER the submission deadline for that quarter (which is projected to be January 5, 2022 followed by the Review and Correct Period that will run until January 12, 2022). Therefore, the Submission End Date for this example should be no earlier than January 13, 2022.

2. In the current survey vendor's account, the Discharge End Quarter and End Year should be the last quarter and year the hospital will allow the current survey vendor to sample from eligible discharges

   Note: The Discharge End Quarter and End Year is the last quarter and year the current survey vendor is under contract to collect survey data on behalf of the hospital. If the survey vendor is under contract only until the end of 3Q21, then the current survey vendor's Discharge End Quarter would be Q3 and the Discharge End Year would be 2021. The new survey vendor should have a Discharge Start Quarter of Q4 and Discharge Start Year of 2021. ***The Discharge End Quarter and End Year of the existing vendor <u>CANNOT</u> overlap with the Discharge Start Quarter and Start Year of the new survey vendor.***

3. The new survey vendor's Submission Start Date must be the first day that this survey vendor will submit data for the hospital

   Note: The Submission Start Date of the new survey vendor ***<u>CAN</u>*** *overlap the Submission End Date of the former survey vendor. Due to the lead time between discharge quarters and submission deadlines, the new survey vendor will need the ability to begin submission of their collected HCAHPS data* ***before*** *the previous survey vendor has completed data submission. For example, if 3Q21 is the last quarter the expiring survey vendor can collect and submit data, the expiring survey vendor's submission deadline should be no earlier than January 13, 2022. However, the new survey vendor for 4Q21 should be allowed to begin HCAHPS Survey administration on October 1, 2021, the beginning of fourth quarter 2021. Therefore, the new survey vendor should have a Submission Start Date of October 1, 2021.*

4. The new survey vendor's Submission End Date can be completed with the last date that the hospital wishes the survey vendor to submit data on their behalf. **<u>However, it is strongly recommended that this field be left blank by checking the box "Do not include an end date</u>."**

5. The new survey vendor should be given a Discharge Start Quarter and Start Year corresponding with the first quarter and year for which the new survey vendor will be collecting data for the hospital

*Note: The Discharge Start Quarter and Start Year of the new survey vendor **CANNOT** overlap with the DISCHARGE END QUARTER AND END YEAR of the previous survey vendor.*

6. The new survey vendor's Discharge End Quarter and End Year should be the last quarter and year that the hospital contracts with the new survey vendor to collect data for the hospital. **However, it is strongly recommended that this field be left blank by checking the box "Do not include an end date."**

EXAMPLE – Switching Survey Vendors

The example below cites the current survey vendor being terminated after 3Q21 patient discharge data collection and the new survey vendor beginning with collection of 4Q21 patient discharge data.

Step 1 – Close Out "Current" HCAHPS Survey Vendor

Discharge Start Quarter and Year	Data Submission Start Date (MM/DD/YYYY)
4Q 2020	10/01/2020
Discharge End Quarter and Year	Data Submission End Date (MM/DD/YYYY)
3Q 2021	01/13/2022
(Last quarter and year current Survey Vendor will collect data)	(One day after HCAHPS data submission deadline Review and Correct Period)

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

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

Step 2 – Authorize "New" HCAHPS Survey Vendor

Discharge Start Quarter and Year	Data Submission Start Date (MM/DD/YYYY)
4Q 2021	10/01/2021
Discharge End Quarter and Year	Data Submission End Date (MM/DD/YYYY)
(*Strongly recommend that these fields remain blank until survey authorization is terminated*)	
(Last quarter and year current Survey Vendor will collect data)	(One day after HCAHPS data submission deadline Review and Correct Period)

Data Submission via HQR

In order for hospitals or survey vendors to submit HCAHPS data, they must have an active HARP account and log in to HQR. Any issues encountered logging into HQR or submitting HCAHPS data should be directed towards the QualityNet Help Desk via telephone (1-866-288-8912) or email (qnetsupport@hcqis.org). Alert HCAHPS Technical Assistance (hcahps@hsag.com) when an HCAHPS-related QualityNet Help Desk ticket has been opened and provide the ticket number so the HCAHPS Project Team can track ongoing issues.

To add surveys to the HCAHPS Data Warehouse, the end user must have the appropriate HCAHPS File Upload permission. Survey vendors must submit data files using the XML format only, and each XML file should contain one month's worth of survey data (by hospital). For further information on the XML file specifications and structure, see Appendix R. Hospitals/Survey vendors that require assistance with the XML format should contact HCAHPS Information and Technical Support at 1-888-884-4007 or via email at hcahps@hsag.com.

Data can be submitted on a monthly or quarterly basis and there are no fees associated with submitting data via HQR.

HQR Reports

Following submission of data, both XML users and Data Form users can access reports about the data submission in HQR. Appropriate HCAHPS Submission Result permissions must be active to view reports. Questions about accessing HQR reports should be directed towards the QualityNet Help Desk via telephone (1-866-288-8912) or email (qnetsupport@hcqis.org).

HCAHPS Data Submission Reports

Three HCAHPS Data Submission Results are accessible by survey vendors or self-administering hospitals if they have been given "View" permissions for HCAHPS Submission Results.

- **Data Submission Detail Report** – includes the upload date and status of files (accepted or rejected) under a given Batch ID, and lists Patient IDs and any error codes with messages
- **Submission Summary Report** – includes the Provider ID and the number of files that were accepted or rejected under a given Batch ID
- **HCAHPS Submission Results Report (formerly the Review and Correction Report)** – contains the frequency of valid values submitted for a hospital for each month in the submission quarter. Hospitals/Survey vendors are strongly encouraged to review this report for possible data errors. If errors are identified in the HCAHPS data that have been submitted, hospitals/survey vendors have the opportunity to upload corrected files during the Review and Correct Period (one week following the data submission deadline).

  Note: The Review and Correct Period is only for correcting previously submitted data. No new data files will be accepted.

The following information is intended to inform hospitals/survey vendors who submit survey data to the HCAHPS Data Warehouse via HQR about the most effective way to run and view the following two HCAHPS data submission reports:

- Submission Detail Report
- Submission Summary Report

Run these reports by navigating to the Data Results selection for HCAHPS on the left-hand navigation pane. Under the File Accuracy section, you will see the available reports listed in a drop-down menu. Select the desired report and the Discharge Quarter, and you will then be able to export a CSV version of the report.

HCAHPS Warehouse Feedback Reports

Three **HCAHPS Warehouse Feedback Reports** are accessible by hospital, survey vendor and health care system personnel with the "View" **HCAHPS Submission Results** role. **Survey vendor and health care system personnel are able to view HCAHPS File Accuracy and Submission Reports for their hospitals once permission is obtained from the Hospital Security Administrator.**

Note: All hospitals, including those contracting with a survey vendor, should review the Provider Survey Status Summary and HCAHPS Warehouse Data Submission Detail Reports on a regular basis.

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

  Note: The Review and Correct Period is only for correcting previously submitted data. No new data files will be accepted.

XML Data File Submission

The XML file upload is intended for use by survey vendors and self-administering hospitals that have a large volume of surveys. Survey vendors are required to submit data using the XML file format only.

The steps for XML data file submission via HQR File Upload are as follows:

1. Access the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/) using HARP credentials
2. Hover over the icons on the left side of the page, click on "Data Submissions"
3. Choose the "**HCAHPS**" tab
4. Click on "File Upload"
5. Using the blue "Select Files" button, select or navigate to the appropriate files for data upload

6. After files have been uploaded, files will be listed on the page. The "Status" field indicates if a file upload is successful, or has failed.
7. Access the **"Data Results"** page for HCAHPS to run **"Submission Reports."** Results in the Submission Reports can be used to verify the status of uploaded files. It also displays details of any errors found in the file.
8. Correct and resubmit files if there are data upload errors. Continue process until the upload is successful.

   Note: File names must be 50 characters or fewer and contain no special characters.

Data files in the XML file format submitted via HQR may be combined in a zip file. If a directory containing multiple XML files is uploaded, and there is an error in one or more of the files within the directory, only the invalid files will be rejected; the files that pass validation will be accepted. The rejected files will be listed in the Data Submission Reports. All the other valid files will be processed as per the validation rules.

HCAHPS Data Form Submission

Data submitted via the HCAHPS Data Form (formerly called the Online Data Entry Tool), is entered one survey at a time and should be combined into one month's worth of survey data for one hospital.

The HCAHPS Data Form was developed for hospitals that are approved to self-administer the HCAHPS Survey and submit their own data. The HCAHPS Data Form is an alternative to converting data files into the XML format.

- **A hospital cannot submit HCAHPS data via the Data Form if they have authorized a survey vendor to submit data on their behalf**
- **Survey vendors cannot submit data via the HCAHPS Data Form**

A user authorized to submit data using the **HCAHPS Data Form** can access it by clicking "Data Submissions" in the menu once the user has logged into HQR. On the "Data Submissions" page, the user should choose the "HCAHPS" tab and click on "Data Form" to enter individual surveys.

When using the HCAHPS Data Form, an individual survey should be entered in one sitting to avoid potential mistakes. After the survey is submitted, it will be listed in the table on the submission page for the month and quarter. To make changes or delete a survey after it has been submitted, first find the desired survey using the patient ID field for identification. Next click the three dots on the line associated with the desired patient ID. By clicking this, there will be options to edit or delete the survey. Make the necessary changes and carefully review and save the results. Verification of survey acceptance will be shown on the status field within the table of entered surveys.

In order to provide the end user with a record of their entered patient survey data, a PDF is available through the HCAHPS Data Form. To retrieve their data, the end user should see a button on the Data Form page to create a PDF.

QualityNet Help Desk

For assistance with navigating HQR, please contact the QualityNet Help Desk:

- Via email at qnetsupport@hcqis.org
- Via telephone 1-866-288-8912

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

Oversight Activities

Overview

In order to verify compliance with CAHPS Hospital Survey (HCAHPS) protocols, the CMS-sponsored HCAHPS Project Team conducts oversight of participating hospitals/survey vendors. This chapter describes the oversight activities for the HCAHPS Survey. All materials and procedures relevant to survey administration are subject to review. **Signing the HCAHPS Participation Form and Attestation Statement signifies agreement with all of the Rules of Participation, including all HCAHPS oversight activities**.

Oversight Activities

All hospitals/survey vendors that participate in the HCAHPS Survey are required to take part in all oversight activities, which include but are not limited to the following:

- HCAHPS Quality Assurance Plan (QAP)
  The HCAHPS QAP is a comprehensive working document that is developed, and periodically revised, by hospitals/survey vendors in order to document their current administration of the survey and compliance with the HCAHPS guidelines. The QAP should also be used as a training tool for project staff and subcontractors. The HCAHPS Project Team will review hospital/survey vendor QAPs to ensure that the hospital's/survey vendor's stated processes are compliant with HCAHPS protocols. Updated QAPs must include, but are not limited to, documentation of changes in key staff, resources, operations, and/or survey mode; along with a detailed discussion of the results of quality checks and monitoring of HCAHPS Survey administration from the prior year. Any approved Exception Requests must be thoroughly discussed in the QAP. In addition, materials relevant to the HCAHPS Survey administration, including mailing materials (questionnaires, cover letters and outgoing/return envelopes) and/or telephone/IVR scripts and interviewer screen shots are required to be submitted for each approved mode of survey administration. CMS may also request additional survey-related materials for review as needed.
- Analysis of Submitted Data
  All survey data submitted to the HCAHPS Data Warehouse by hospitals/survey vendors are reviewed by the HCAHPS Project Team. This review includes, but is not limited to, statistical and comparative analyses; preparation of data for public reporting; and other activities as required by CMS. If data anomalies are found, this will result in follow-up with the hospital/survey vendor.
- On-site Visits/Conference Calls
  All hospitals/survey vendors (and their subcontractors, as applicable) are required to participate in on-site visits and/or conference calls conducted by the HCAHPS Project Team. The on-site visits allow the HCAHPS Project Team to review and observe systems, procedures, facilities, resources, and documentation used to administer the HCAHPS Survey. The conference calls allow the HCAHPS Project Team to discuss issues related to administration of the HCAHPS Survey with the hospital/survey vendor.
- Additional Activities
  Additional activities as specified by CMS may be conducted in addition to the above.

Note: If the on-site visit/conference call, or any other oversight activity conducted by the HCAHPS Project Team, suggests that actual survey processes differ from HCAHPS protocols, immediate corrective actions may be required and sanctions may be applied.

HCAHPS Quality Assurance Plan (QAP)

Hospitals/Survey vendors approved to administer HCAHPS are obligated to develop and continually update a QAP. The QAP is a comprehensive working document that outlines the hospital's/survey vendor's implementation of, and compliance with, the HCAHPS guidelines. The main purposes of the QAP are as follows:

- Provide documentation of hospitals'/survey vendors' understanding, application and compliance with the HCAHPS *Quality Assurance Guidelines V16.0*. The following components must be addressed:
  1. Organizational background and structure for project
  2. Work plan for survey administration
  3. Role of subcontractor(s), if applicable
  4. Survey and data management system
  5. Quality controls for survey administration activities
  6. Confidentiality, privacy and security procedures in accordance with HIPAA
  7. Annual reporting of the results from quality control activities
  8. HCAHPS Survey materials
- Serve as the organization-specific guide for administering the HCAHPS Survey, training project staff to conduct the survey and conducting quality control and oversight. The **QAP should be developed in enough step-by-step detail, including flow charts, tracking forms and diagrams, such that the survey methodology is easily replicable by a new staff member in the organization's survey operations**.
- Ensure high quality data collection and continuity in survey processes

The QAP should be free of extraneous information and the emphasis should be on providing concise explanations of required HCAHPS processes. The QAP should reflect the hospital's/survey vendor's implemented survey administration processes.

The HCAHPS Project Team will notify hospitals/survey vendors when to submit an updated QAP to the HCAHPS Project Team by the specified submission due date. All QAPs must be dated and all changes from prior versions **must be clearly identified** (i.e., use Microsoft Word track changes). At a minimum, the updated submission must include, in all languages that are employed, a copy of the actual mail materials (Mail Only and Mixed Modes); a copy of the telephone script (screen shot) as viewed by the interviewers (Telephone Only and Mixed Modes); and/or a copy of the IVR script/program (Active IVR mode). The QAP should specifically address the following issues:

- Changes in survey administration processes, including any process changes due to revised HCAHPS *Quality Assurance Guidelines*
- A discussion of the results of the quality control checks performed in the prior year
- A discussion of the challenges faced by hospitals/survey vendors in survey administration in the prior year, and how those challenges were handled
- Changes in key staff
- Changes in resources

Along with the QAP update, hospitals/survey vendors may be required to submit other materials relevant to the HCAHPS Survey administration, when requested by CMS. The HCAHPS Project Team's **acceptance** of a submitted QAP and corresponding survey materials **does not** constitute or imply approval or endorsement of the hospital's/survey vendor's HCAHPS Survey administration processes. The on-site visit and/or other oversight activities are used to examine, verify and approve the actual processes by which the HCAHPS Survey is administered.

The Quality Assurance Plan Outline can be found in Appendix S. It is strongly recommended that hospitals/survey vendors use the QAP Outline as a template for developing and updating their own QAP. The QAP Outline can be downloaded from the HCAHPS Web site (https://www.hcahpsonline.org).

Analysis of Submitted Data

The HCAHPS Project Team reviews and analyzes all survey data submitted to the HCAHPS Data Warehouse through the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/) in order to ensure the integrity of the data. If significant issues are identified, the hospital/survey vendor may be contacted. Hospitals/Survey vendors must adhere to all submission requirements as specified in the HCAHPS *Quality Assurance Guidelines V16.0;* as posted on the HQR system; and those periodically posted on the HCAHPS Web site, as well as the deadline dates as posted on the HCAHPS Web site. Please monitor the HCAHPS Web site for additional data submission information and updates.

On-site Visits/Conference Calls

The HCAHPS Project Team will conduct on-site visits and/or conference calls with hospitals/survey vendors to verify compliance with the HCAHPS requirements. The size and composition of the review team will vary.

The HCAHPS Project Team conducts its on-site reviews in the presence of the hospital's/survey vendor's staff, and a confidentiality agreement is signed by all parties at the start of the on-site visit. The HCAHPS Project Team works with the visited organization to cover agenda items presented in advance to the hospital/survey vendor. The HCAHPS Project Team may also review any additional information or facilities determined to be necessary to complete the site visit, including work performed by subcontractors, if applicable. **Hospitals/Survey vendors must make their subcontractors available to participate in the on-site visits and conference calls**.

In addition to other activities, the HCAHPS Project Team will observe and review data systems and processes, which may require access to confidential records and/or protected health information. The on-site review includes a review of sampling procedures. The hospital/survey vendor must retain HCAHPS-related data files, including patient discharge files and de-identified electronic data files (e.g., HCAHPS sampling frame, XML files, etc.) for a minimum of three years. All files must be made available for review during HCAHPS oversight activities. The HCAHPS Project Team will review specific data records and trace the documentation of activities from the receipt of the discharge list through the uploading of the data to the HCAHPS warehouse. The process to review these files must be transparent and easily reproducible. The Project Director/Project Manager must be physically present during the on-site visit. If any HCAHPS processes are automated, then the programmer must be available during the on-site visit to review the programming. The on-site review may also include interviews with key staff members and

interactions with project staff and subcontractors, if applicable. Any information observed or obtained during the on-site visit review will remain confidential, as per CMS guidelines. After the on-site visit, the HCAHPS Project Team will provide the hospital/survey vendor with a summary of findings from the on-site review, and may pose follow-up questions and/or request additional information as needed.

On-site visits may be announced and scheduled in advance, or they may be unannounced. Hospitals/Survey vendors will be given a three-day window during which an unannounced site visit may be conducted.

During the on-site visit and/or conference call, the HCAHPS Project Team will review the hospital's/survey vendor's survey systems and will assess protocols based upon the HCAHPS *Quality Assurance Guidelines V16.0*. All materials relevant to survey administration will be subject to review. The systems and program review includes, but is not necessarily limited to:

- Survey management
- Data systems
- Sampling procedures
- Printed materials
- Printing, mailing and other related facilities
- Telephone/IVR materials, interview areas and other related facilities
- Telephone interviews
- Data receipt and entry
- Storage facilities
- Confidentiality, privacy and security
- Written documentation of survey processes
- Specific and/or randomly selected records covering a time period to include the data in the most recent public report period, or earlier

After the on-site visit or conference call, organizations will be given a defined time period in which to correct any problems and provide follow-up documentation of corrections for review. Hospitals/Survey vendors will be subject to follow-up on-site visits and/or conference calls, as needed.

Non-compliance and Sanctions

Non-compliance with HCAHPS protocols including program requirements, timely submission of the QAP as requested, and participation and cooperation in oversight activities, may result in sanctions being applied to a hospital and/or its survey vendor including:

- application of the appropriate footnote(s) to HCAHPS Survey results reported on the Care Compare (https://www.medicare.gov/care-compare/)
- adjustment to publicly reported scores, as needed
- increased oversight activities
- loss of approved status to administer the HCAHPS Survey
- withholding of HCAHPS Survey results from public reporting, which could affect the hospital's Annual Payment Update (APU)
- other sanctions as deemed appropriate by CMS

Note: Hospitals that contract with a survey vendor or self-administer the HCAHPS Survey should be aware that non-compliance by either hospitals or survey vendors could result in these, or other, sanctions.

Data Reporting

Overview

This chapter describes the public reporting of the CAHPS Hospital Survey (HCAHPS) results on Care Compare (https://www.medicare.gov/care-compare/). HCAHPS results are published quarterly and include the hospital's most recent quarters of data.

Discharge Periods	Anticipated Public Reporting
October 2019 – December 2019 and July 2020 – September 2020	July 2021
July 2020 – December 2020	October 2021

Public Reporting of HCAHPS Results

Hospital-level results are publicly reported on Care Compare (https://www.medicare.gov/care-compare/). This web site was created through the efforts of CMS, along with the Hospital Quality Alliance (HQA). Hospitals must have 25 completed surveys in the reporting period for HCAHPS results to be publicly reported on Care Compare (https://www.medicare.gov/care-compare/).

HCAHPS Star Ratings

Eleven HCAHPS Star Ratings appear in the new Provider Data Catalog (https://data.cms.gov/provider-data/): one for each of the 10 publicly reported HCAHPS measures, plus the HCAHPS Summary Star Rating. The HCAHPS Summary Star Rating, which combines the 10 HCAHPS measure star ratings, is also displayed on the new Care Compare Web site, where it is called the "Patient Survey Rating" (https://www.medicare.gov/care-compare/). Hospitals are able to preview the HCAHPS Star Ratings in their 30-day Public Reporting Preview Report. For more detailed information regarding the calculation of the HCAHPS Star Ratings, please visit the Star Ratings page of the HCAHPS Web site (https://www.hcahpsonline.org).

100 Completed Survey Minimum for HCAHPS Star Ratings

Hospitals must have at least 100 completed HCAHPS Surveys over a given four-quarter period in order to receive HCAHPS Star Ratings. In addition, hospitals must be eligible for public reporting of HCAHPS measures. Hospitals with fewer than 100 completed HCAHPS Surveys will not receive Star Ratings; however, their HCAHPS measure scores will be publicly reported on Care Compare (https://www.medicare.gov/care-compare/).

Publicly Reported HCAHPS Measures

HCAHPS results are reported for six composites, two individual items and two global items:

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

- Individual Items
  - Cleanliness of Hospital Environment (Q8)
  - Quietness of Hospital Environment (Q9)
- Global Items
  - Hospital Rating (Q18)
  - Recommend the Hospital (Q19)

Each of the six composites is constructed from two or three questions from the survey and reported as one composite score. To produce composite scores, the proportion of cases in each response category for each question is calculated. Once the proportions are calculated for each response category, the average proportion of those responding to each category is then calculated across all the questions that make up a specific composite. Only the questions answered by the patient are included in the composite calculation.

For public reporting purposes, the six composite scores, the two individual items and the two global items are displayed. Both national and state comparisons are reported for each of the HCAHPS scores. In addition, the number of surveys completed (in three broad categories) and the survey response rate are also reported for each participating hospital.

Bar graphs are displayed for the most positive response (or "top box") category. For instance, the graphic display of the "Hospital Rating" item shows the percentage of patients who gave their hospital a "9" or "10" on the "0 to 10" rating scale, or the percentage of patients who responded that their doctors "always" communicate well. The tables displayed on Care Compare (https://www.medicare.gov/care-compare/) show the "top-box," "middle-box" and "bottom-box" results for each HCAHPS item.

Users of Care Compare (https://www.medicare.gov/care-compare/) are able to "drill down" to get more detailed information regarding this distribution for the response categories. Researchers and other interested parties are able to access a downloadable database on Care Compare (https://www.medicare.gov/care-compare/) that includes all of the hospital-level results that are publicly reported.

Adjusting Results

HCAHPS Survey results are adjusted for survey mode and patient-mix prior to public reporting. Only adjusted results are publicly reported and considered the official HCAHPS results. The adjusted results may differ from the unadjusted results.

For hospitals that obtain fewer than 100 completes and for hospitals that obtain fewer than 50 completes, results are reported, but the lower precision of the results derived from less than 100 completed surveys (and/or less than 50 completed surveys) is noted in the public reporting on Care Compare (https://www.medicare.gov/care-compare/). Please see the HCAHPS Web site (https://www.hcahpsonline.org) for more information on these data adjustments, as well as additional information regarding HCAHPS scores.

A Note About HCAHPS "Boxes"

HCAHPS results are publicly reported on Care Compare (https://www.medicare.gov/care-compare/) as "top-box," "bottom-box" and "middle-box" scores. The **"top-box"** is the most positive response to HCAHPS Survey items. The "top-box" response is *"Always"* for four HCAHPS composites (Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, and Communication About Medicines) and two individual items (Cleanliness of Hospital Environment and Quietness of Hospital Environment), *"Yes"* for the Discharge Information composite, *"'9' or '10' (high)"* for the Hospital Rating item, *"Definitely yes"* for the Recommend the Hospital item, and *"Strongly agree"* for the Care Transition composite.

The **"bottom-box"** is the least positive response category for HCAHPS Survey items. The "bottom-box" response is *"Sometimes or Never"* for four HCAHPS composites (Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, and Communication About Medicines) and two individual items (Cleanliness of Hospital Environment and Quietness of Hospital Environment), *"No"* for the Discharge Information composite, *"'6' or lower (low)"* for the Hospital Rating item, *"'Definitely No' and 'Probably No'"* for the Recommend the Hospital item, and *"'Strongly disagree' and 'Disagree'"* for the Care Transition composite.

The **"middle-box"** captures intermediate responses to HCAHPS Survey items. The "middle-box" response is *"Usually"* for four HCAHPS composites (Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, and Communication About Medicines) and two individual items (Cleanliness of Hospital Environment and Quietness of Hospital Environment), *"'7' or '8' (medium)"* for the Hospital Rating item, *"Probably yes"* for the Recommend the Hospital item, and *"Agree"* for the Care Transition composite. There is no "middle-box" response in the Discharge Information composite.

Reporting Results

Each hospital's aggregate results are compared to national and state averages. Results are reported for the six composites, the two individual items and the two global items. Survey response rates are also reported. All surveys submitted, including those over 300 completed surveys, are used in HCAHPS public reporting.

Results are reported as a rolling four quarters of data and are updated on a quarterly basis utilizing the most recent four quarters of data. For additional information on Care Compare, refer to https://www.medicare.gov/care-compare/. Summary results for both current and historical HCAHPS public reporting can be found under "Summary Analyses" on the HCAHPS Web site (https://www.hcahpsonline.org).

Official HCAHPS scores are reported on Care Compare (https://www.medicare.gov/care-compare/). 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:

1. The introduction or executive summary of such reports must include the following statement:
   - "This report has been produced by [Survey Vendor] and does not represent official HCAHPS results, which are published on Care Compare (https://www.medicare.gov/care-compare/)."

2. 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."

Hospital Preview Reports

A preview report of the HCAHPS Survey results is generated for each hospital to review prior to their data being publicly reported. This report contains aggregate results for the 12-month reporting period, and it is not possible to view selected months or quarters in the reporting period. This preview report is available for a 30-day preview period through the Hospital Quality Reporting (HQR) system (https://hqr.cms.gov/), formerly the QualityNet Secure Portal. After the 30-day preview period has ended, the HCAHPS results are publicly reported on Care Compare (https://www.medicare.gov/care-compare/), unless the hospital chooses to suppress their results. See the next section for more information on suppression of results.

Note: For hospitals that have fewer than 25 completed HCAHPS Surveys in a 12-month reporting period, the Public Reporting Preview Report will include the hospital's HCAHPS scores and number of completed surveys. However, HCAHPS scores for hospitals with less than 25 completed surveys will not be publicly reported on Care Compare (https://www.medicare.gov/care-compare/).

Participating critical access hospitals (CAHs) must have a completed HQA pledge form on file in order for their HCAHPS results to be publicly reported. IPPS hospitals must have a completed Hospital Inpatient Quality Reporting Program (formerly known as the Reporting Hospital Quality Data Annual Payment Update [RHQDAPU]) Notice of Participation Form on file for their HCAHPS results to be publicly reported.

Suppression of Results

Critical Access Hospitals (CAHs) have the option of suppressing the public reporting of their HCAHPS scores. If a CAH chooses to suppress its HCAHPS scores, it must suppress the complete set of HCAHPS results. Suppression of selected HCAHPS results or individual quarters is not allowed. Hospitals choosing to suppress their scores are only able to do so during the 30-day preview period. Both CAHs that choose to suppress their HCAHPS scores and IPPS hospitals that do not participate in the HCAHPS initiative, will receive a footnote on Care Compare (https://www.medicare.gov/care-compare/) that indicates that HCAHPS data are not available for the public reporting period. To suppress measures, a CAH must complete the appropriate pledge form and submit it to the QualityNet Help Desk.

Exception Request/Discrepancy Report Processes

Overview

This chapter describes two different CAHPS Hospital Survey (HCAHPS) administration processes: requesting exception to the standard HCAHPS protocols before implementing any exceptions; and notifying the HCAHPS Project Team of discrepancies which have occurred in the manner survey data have been collected or submitted.

The Exception Request process and Exception Request Form have been established to handle alternative methodologies that vary from standard HCAHPS protocols. The proposed alternative methodology(ies) must not be implemented until the submitted Exception Request Form has been approved.

The discrepancy process and the Discrepancy Report Form have been established for use by hospitals/survey vendors to notify the HCAHPS Project Team of any discrepancies in following standard HCAHPS protocols. Hospitals/Survey vendors are required to notify the HCAHPS Project Team of any discrepancies in following the standard HCAHPS protocols which have been encountered during survey administration. Hospitals/Survey vendors **must** notify the HCAHPS Project Team as soon as the discrepancy is identified.

Exception Request Process

The Exception Request process has been created to provide hospitals/survey vendors with more flexibility to meet individual organizations' need for certain variations from protocol, while still maintaining the integrity of the data for standardized public reporting. The Exception Request Form must be completed with sufficient detail, including clearly defined timeframes, for the HCAHPS Project Team to make an informed decision. The requested exception from protocol must not be implemented prior to receiving approval from the HCAHPS Project Team.

- Exception Requests will be limited to a two-year approval timeframe unless otherwise specified
- Approved Exception Requests may only be implemented at the beginning of a quarter
- Approved Exception Requests are for internal hospital/survey vendor use only and must not be used for marketing purposes

To request an exception, hospitals/survey vendors are required to complete and submit an Exception Request Form (see Appendix W) online via the HCAHPS Web site (https://www.hcahpsonline.org). The form is designed to capture information on the proposed alternative to the standard protocols. Hospital CCNs **must be included on the form**.

- ***Survey Vendors must complete and submit all Exception Request Forms on behalf of their client hospitals***
- Survey Vendors may submit one Exception Request Form on behalf of multiple hospitals with the same Exception Request. **Survey vendors must include a list of contracted hospitals and each hospital's CCN on whose behalf they are submitting the Exception Request. Please be sure to include the information in the specified section of the Exception Request Form**.
- A new Exception Request Form must be submitted for hospitals not included in the original request

- Do not use symbols or special characters (^*@#&) of any kind when submitting the Exception Request Form

Common Exception Requests

The HCAHPS Project Team has identified acceptable variations from established methodologies. Requested exceptions may fall into the following categories:

- Disproportionate Stratified Random Sampling **–** The following information **must** be included for each hospital in the Exception Request:
  1. Name of each stratum to be used in the DSRS
  2. Estimated total number of inpatient discharges for each stratum and number of eligible patients for each stratum
  3. Estimated number of sampled patients for each stratum (minimum of 10 sampled discharges)
  4. A plan describing how the DSRS sampling procedures will guarantee a minimum of 10 sampled discharges for each stratum.
- Determination of Service Line – V.38 MS-DRG codes (effective October 1, 2020 and V.39 MS-DRG codes effective October 1, 2021) are the preferred means to establish the HCAHPS Service Line category (Maternity Care, Medical or Surgical). Hospitals/Survey vendors must submit an Exception Request Form online for approval to use a means, other than items 1-6 listed below, to establish the service line category:
  1. V.39, V.38, V.37, V.36, V.35, V.34, V.33, V.32, V.31, V.30, V.29, V.28, V.27, V.26, V.25 MS-DRG codes
  2. V.24 CMS-DRG codes
  3. Mix of V.39, V.38, V.37, V.36, V.35, V.34, V.33, V.32, V.31, V.30, V.29, V.28, V.27, V.26, V.25, and V.24 DRG codes based on payer source or a mix of MS-DRG and APR-DRG codes
  4. ICD-10 or ICD-9 codes
  5. Hospital Unit
  6. APR-DRG codes
  7. Other - Approved Exception Request Only – Hospitals/Survey vendors must submit an Exception Request Form online for approval to use a means, other than those listed above, to establish the service line category
     - Determination of Service Line based on a single service line – If hospitals/survey vendors are requesting Determination of Service Line based on a single service line (e.g., Medical, Surgical, Maternity), additional documentation is required:
       - Electronic or written confirmation from the hospital that they are unable to provide MS-DRG codes or other preferred means of establishing the HCAHPS Service Line Category
       - Electronic or written confirmation from the hospital delineating which patient populations are served (Medical, Surgical or Maternity)
- Participating in Another CMS or CMS-Sponsored Initiative – If a hospital accepts an offer to participate in another CMS or CMS-sponsored project that includes an inpatient survey which may contravene HCAHPS, the hospital must file an Exception Request to alert and inform the HCAHPS Project Team of its participation

- Survey Materials – An Exception Request must be filed for the use of survey materials that do not align with the examples provided in the HCAHPS *Quality Assurance Guidelines V16.0* manual
- Other – Hospitals/Survey vendors must request an exception for alternative strategies not identified in the HCAHPS *Quality Assurance Guidelines V16.0* manual
  - CMS recognizes that public health emergencies may impact hospitals'/survey vendors' survey operations. Hospitals/Survey vendors may submit an Exception Request Form to request approval to conduct survey operations from a remote location (other than hospital's/survey vendor's place of business) for the duration of the public health emergency.

No alternative modes of survey administration will be permitted other than those prescribed for the survey (Mail Only, Telephone Only, Mixed [Mail with Telephone follow-up], and IVR modes).

Review Process

Exception Requests will be reviewed by the HCAHPS Project Team. These reviews will include an assessment of the methodological soundness of the proposed alternative and the potential for introducing bias. Depending on the type of exception, a review of procedures and/or an on-site visit or conference call may be required. The HCAHPS Project Team will notify hospitals/survey vendors whether or not their exception has been approved. Updates to survey administration processes for approved Exception Requests must only be implemented at the start of a quarter.

If not approved, the HCAHPS Project Team will send the hospital/survey vendor an explanation. Hospitals/Survey vendors then have the option of appealing the decision. Hospitals/Survey vendors have five business days from the date of the Exception Request denial notification email to submit an appeal. To request an appeal, hospitals/survey vendors must resubmit the Exception Request Form (checking the box marked "Appeal of Exception Denial") and update it to provide further information about the nature of the exception. The appeal is then returned to the HCAHPS Project Team for re-review. The second review will take approximately 10 business days.

Discrepancy Report Process

On occasion, a hospital/survey vendor may identify discrepancies from HCAHPS protocols that require corrections to procedures and/or electronic processing to realign the activity to comply with HCAHPS protocols. Hospitals/Survey vendors must notify CMS of these discrepancies as soon as they are identified. In its oversight role, the HCAHPS Project Team may also identify discrepancies that require correction. Examples of discrepancies include, but are not limited to, missing eligible discharges from a particular date or computer programming that caused an otherwise eligible patient to be excluded from the sample frame.

- ***Survey vendors must complete and submit all Discrepancy Reports on behalf of their client hospitals***
  - Initial Discrepancy Reports must be submitted within 24 hours after the discrepancy has been discovered
  - All form fields must be completed to the extent this information is available
    - Detailed information such as hospital name and CCN, number of discharges, eligibles and sampled patients affected, specific time frame affected, total number of hospitals affected, and detailed information about what caused the discrepancy and how the discrepancy was corrected must be included

    - For information not immediately available, complete required form fields with "To be updated"
    - Do not use symbols or special characters (^*@#&) of any kind when submitting the Discrepancy Report Form
  - If all required information is not immediately available, submit a second Discrepancy Report to provide any missing information
    - Discrepancy Report updates are due within two weeks of the initial Discrepancy Report submission
- See Appendix X for the Discrepancy Report Form, which must be submitted online via the HCAHPS Web site (https://www.hcahpsonline.org). This report notifies the HCAHPS Project Team of the nature, timing, cause, and extent of the discrepancy, as well as the proposed correction and timeline to correct the discrepancy.
- Hospital CCNs **must be included on the form**

Note: It is strongly recommended that survey vendors notify their client hospital prior to or upon the submission of a Discrepancy Report.

Discrepancy Report Review Process

The Discrepancy Report will be thoroughly reviewed by the HCAHPS Project Team. Notification of the outcome of the review may not be forthcoming until all the data for affected reporting periods have been submitted to the HCAHPS Data Warehouse. Email notification will be distributed to the organization submitting the Discrepancy Report once the outcome of the review has been determined.

Depending on the nature and extent of the discrepancy, a formal review of the hospital's/survey vendor's procedures, and/or an on-site visit or conference call may be undertaken.

The HCAHPS Project Team will notify hospitals/survey vendors whether additional information is required to document and correct the issue. CMS will be evaluating whether hospitals/survey vendors follow all approved protocols in collecting and submitting HCAHPS data when determining application of footnotes. A footnote may be applied to publicly reported HCAHPS results to indicate that these results are derived from data whose collection or processing deviated from established HCAHPS protocols. The footnote will be applied until the affected data roll out of the public reporting cycle.

Data Quality Checks

Overview

Self-administering hospitals and survey vendors must implement quality assurance processes to verify the integrity of the collected and submitted CAHPS Hospital Survey (HCAHPS) data. This chapter describes suggested quality control activities that hospitals/survey vendors may implement, and should **not** be considered an exhaustive list of possible quality control activities that can be used by hospitals/survey vendors. It is important to note that quality control activities must be performed by a different staff member than the individual who originally performed the specific project task(s). The goals of conducting quality control activities are to minimize the probability of errors occurring in the handling of the data throughout the various steps of data processing; to verify that required fields are present and protocols are met; and to identify and explain unusual or unexpected changes in the data files. Therefore, quality checks must be operationalized for all of the key components or steps of survey administration and data processing on an ongoing and continuous basis. The preceding chapters in this manual contain sections that address various required quality control guidelines that must be adhered to. The emphasis in this chapter is on data quality checks that the HCAHPS Project Team strongly recommends.

Traceable Data File Trail

Hospitals/Survey vendors must save both original and processed HCAHPS data files for a minimum of three years. This allows for easier identification of issues and is an important component of the HCAHPS Project Team's external review activities. In addition to the requirements addressed in previous chapters, the information below provides suggestions regarding HCAHPS-related file retention:

- Preserve a copy of every file received in original form and leave unchanged (including files received from hospital clients)
- Record general summary information such as number of administrative records, eligible discharge size, and discharge month(s), etc.
  - All data files must be traceable throughout the entire HCAHPS Survey administration process, from receipt of the patient discharge list through data submission. All files must be made available for review during HCAHPS oversight activities such as on-site visits and/or teleconference calls. The process to review these files must be transparent and easily reproducible.
- Institute version controls for datasets, reports, and any software code and programs used for collecting and processing HCAHPS data records
  - Do not delete old data files
  - Keep intermediate data files, not just original and final versions

Review of Data Files

Hospitals/Survey vendors should examine their own data files and all clients' data files for any unusual or unexpected changes, including missing data. Trending or comparing data elements for individual hospitals over different time periods is one technique that can be used to determine whether any unusual or unexpected changes occurred. While the presence of such a change does not necessarily mean an error has occurred, it should prompt hospitals/survey vendors to further evaluate the data in order to verify the difference(s). Listed below are suggested activities:

- Verify that data are associated with the correct hospital CCN
- Investigate data for notable changes in the counts of patient discharges and eligible patients
- Prior to processing the patient discharge list, run frequency/percentage tables for all administrative variables received from the hospital (e.g., age, service line, discharge status, etc.), and compare to same-variable tables from previous months. If notable differences are discovered, investigate to determine the reason for the differences.
  - Look for missing administrative data elements (such as MS-DRGs and patient age), and follow-up with the hospital immediately upon receipt of the discharge list
- Prior to preparing data files for submission to the HCAHPS Data Warehouse, run frequency/percentage tables for all survey variables stored for a given hospital and month. Compare to same-variable tables from previous months; if notable differences are found, investigate and determine if the data are accurate.
  - Verify that the number of administrative records matches the value for sample size for the given month. If using DSRS, verify that the number of administrative records matches the value for sample size at the strata level.
  - Check that Header Record variables match back to raw data summary statistics for the time period
  - Review a random selection of administrative records as a quality check against original raw patient discharge data. This same activity can be performed for actual survey records.
  - Verify that required data elements for all patients in the HCAHPS Sample Frame are submitted to the HCAHPS Data Warehouse

Accuracy of Data Processing Activities

In order to ensure that HCAHPS data are valid and reliable, data processing activities must be conducted in accordance with required protocols. Data quality checks should be implemented to verify that the required protocols have been followed. Examples of data quality check activities include:

- When drawing a sample, verify that every eligible discharge has a chance of being sampled
  - For SRS and PSRS, all eligible patients must have an equal probability of being sampled
- If using DSRS, verify that at least 10 sampled patients from each stratum can be obtained
- Evaluate the frequency of break-off surveys and/or unanswered questions, and investigate possible causes
- Review HCAHPS Warehouse Data Submission Reports (for organizations submitting HCAHPS data) and/or HCAHPS Warehouse Feedback Reports (for hospitals contracting with an approved HCAHPS Survey vendor) to confirm data submission activity
- Review monthly submission results from the HCAHPS Submission Results Report (formerly the Review and Correction Report) to confirm a match with the frequency tables completed during previous quality check activities as described above

Summary

This chapter highlights a number of possible activities to assist hospitals/survey vendors in developing procedures for data quality checks. The information contained in this chapter is not meant to restrict hospitals/survey vendors only to those procedures listed in this chapter. The HCAHPS Project Team will conduct on-site visits to hospitals/survey vendors to review hospitals'/survey vendors' operations, including the types of quality control activities and documentation that demonstrates quality control activities have been performed.

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