

A top-down view of a desk with a laptop, a smartphone, a keyboard, a stethoscope, and a clipboard. The desk is light-colored wood. A person's hand is visible typing on the laptop keyboard. A smartphone is lying on the desk. A keyboard is in the foreground. A stethoscope is on the right. A clipboard with a blue folder is on the right.

# Modernizing the HCAHPS Survey

Recommendations from  
Patient Experience Leaders

# Executive Summary

The patient's health care experience is considered one indicator of quality of care. Patient experiences with care received at hospitals have been captured and publicly reported at a national level since 2008 via the *Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS) survey. The HCAHPS survey consists of 32 questions focused mainly on patients' experiences with the care they received during admission.

Public reporting of the HCAHPS survey enables consumers to make informed health care decisions, including the hospital they choose. The HCAHPS survey also uses patient experience as a measurement for value-based payments hospitals receive through federal programs.

We interviewed hospital and health system patient experience leaders (PELs) to gather their insights into the effectiveness of the HCAHPS survey in capturing patient experience. This paper will examine whether the current HCAHPS survey needs updating following the many changes and advancements that have happened in health care over the last 10 years since it was first implemented.

We found that PELs strongly support patient experience measurement and its use as an indicator of quality. However, there is wide consensus among PELs on the need to modernize the HCAHPS survey to reflect the changes in health care delivery and information technology and the shift in patient expectations. This paper delves into a variety of recommendations derived by PELs across different types of hospitals and health systems for modernizing the HCAHPS survey.

## Key Findings

- 1 Response Rates Are Falling.** PELs found that their HCAHPS survey response rates were falling each year. We examined national data and identified a drop in the national rate of patient responses from 33% in 2008 to 26% in 2017. Low response rates erode the validity of the survey data.
- 2 There Is Consensus the HCAHPS Survey Needs Updating.** While most PELs thought the HCAHPS survey's ability to provide patients with comparable data on patient experience was good, all felt the survey needs improvement.
- 3 Topics Covered Are Important but Incomplete.** PELs found that eight of the 27 core questions were important to keep. PELs further identified five topics/questions they would like to see added to the survey, such as questions related to efficiency and team-work of the care team.
- 4 Research Is Needed on Additional Factors That Influence Patient Experience.** More research needs to be done to identify social determinants of health that are outside of the hospital's influence that impact the HCAHPS survey scores to ensure a level playing field when comparing hospitals.
- 5 Literacy Levels Need to Be Re-evaluated.** PELs generally felt that the health literacy level of the survey was too high and that responses of patients with lower health literacy levels were not being captured adequately. PELs also indicated the absence of appropriate literacy levels in non-English language HCAHPS survey versions. These segments of the population risk being under-surveyed and are not properly represented in the reported HCAHPS survey results.



## Top Recommendations

1. Add a digital mode of delivery to existing modalities;
2. Shorten survey;
3. Revise the survey in light of today's shift to value-based care, changes in health care delivery, improvements in technology, and evolving patient priorities;
4. Reframe the care transitions and discharge planning sections of the HCAHPS survey; and
5. Periodically re-evaluate the HCAHPS survey.



# Introduction

For the past decade, hospitals and other providers have surveyed patients to capture their health care experiences in a national and standardized fashion. *The Hospital Consumer Assessment of Healthcare Providers and Systems* (HCAHPS) is a patient experience survey developed from the partnering of the Centers for Medicare and Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), and the CAHPS Consortium. It is managed by CMS with three goals:<sup>1</sup>

- To provide patients with useful information to make better informed decisions on hospital choice;
- To give hospitals incentives to improve the quality of their care through public reporting; and
- To enhance public accountability by increasing transparency of the quality of hospital care.

Prior to the existence of the HCAHPS survey, patient satisfaction surveys were developed and deployed by various survey vendors for hospitals. There was no standardized and scientifically rigorous evaluation of a national, representative survey that could be used for reporting and comparisons. In 2008, the HCAHPS survey filled a much-needed gap that allows CMS to provide a mechanism to fairly compare hospitals. However, more than 10 years have passed since the HCAHPS survey was initially developed and deployed, and much has changed in technological advancements and the way care is delivered.

The HCAHPS survey contains 32 questions: 25 questions focus on patient experience with the care received during their hospitalization, and seven questions in the “About You” section, which elicit patient-level information for use in patient-mix adjustment of HCAHPS survey scores. Of the 25 core questions, four are screener questions and 21 are substantive questions, all of which are divided into seven topics (see Appendix).<sup>a</sup> Hospitals may supplement the core questions with additional

questions that they can append to the end of the survey. The HCAHPS survey asks about doctor and nurse communication, staff responsiveness, the hospital environment, pain management, medication communication, discharge information, care transitions, overall rating of the hospital, and likelihood to recommend the hospital. In the Medicare Hospital Outpatient Prospective Payment System (OPPS) for Calendar Year 2019 Final Rule, CMS removed the “Communication About Pain” questions effective October 2019, which will reduce the core official survey to 29 questions.

CMS requires a minimum number of completed HCAHPS surveys to achieve statistical reliability. Hospitals paid under Medicare’s Hospital Inpatient Prospective Payment System (IPPS) must complete a minimum of 300 HCAHPS surveys over four calendar quarters.

In July 2018, the Federation of American Hospitals (FAH), in collaboration with the American Hospital Association (AHA), America’s Essential Hospitals, Association of American Medical Colleges (AAMC), and the Catholic Health Association of the United States (CHA), set out to gather perspectives from PELs to gain insights into the effectiveness of the HCAHPS survey in capturing and reporting on patient experience. The associations interviewed PELs across U.S. hospitals to:

- Examine their perspectives on the success of CMS to meet two of its goals for the HCAHPS survey;
- Identify strengths and weaknesses of the current HCAHPS survey;
- Examine hospital response to and use of the HCAHPS survey; and
- Gather recommendations for improvement.

Throughout this paper we will be referring to the 32-question HCAHPS survey instrument version 13.0.



# The Unique Perspective of the Patient Experience Leader (PEL)

PELs operate and manage the patient experience activities within their organizations. These individuals often are part of the quality and performance improvement departments of hospitals and health systems but often also have informal ties to customer service departments. PELs are responsible for developing and implementing their organizations' strategy to improve patient experiences and the health outcomes it drives. This includes such activities as deploying the HCAHPS survey, engaging and reporting progress to senior leadership and boards, tracking performance, designing and implementing experience improvement activities, engaging with frontline clinicians, and engaging with patients and families.<sup>2,3</sup> As such, PELs have a direct line of sight into the organizational aspects of patient experience and their environmental, patient-, population-, hospital-, and community-level influences. This makes PELs uniquely suited to provide a much-needed perspective on the strengths and challenges on how the HCAHPS survey achieves CMS's goals.

*Figure 1. What Does a Patient Experience Leader (PEL) Do?*



Figure 2. A Conceptual Model of the Patient Experience Leader

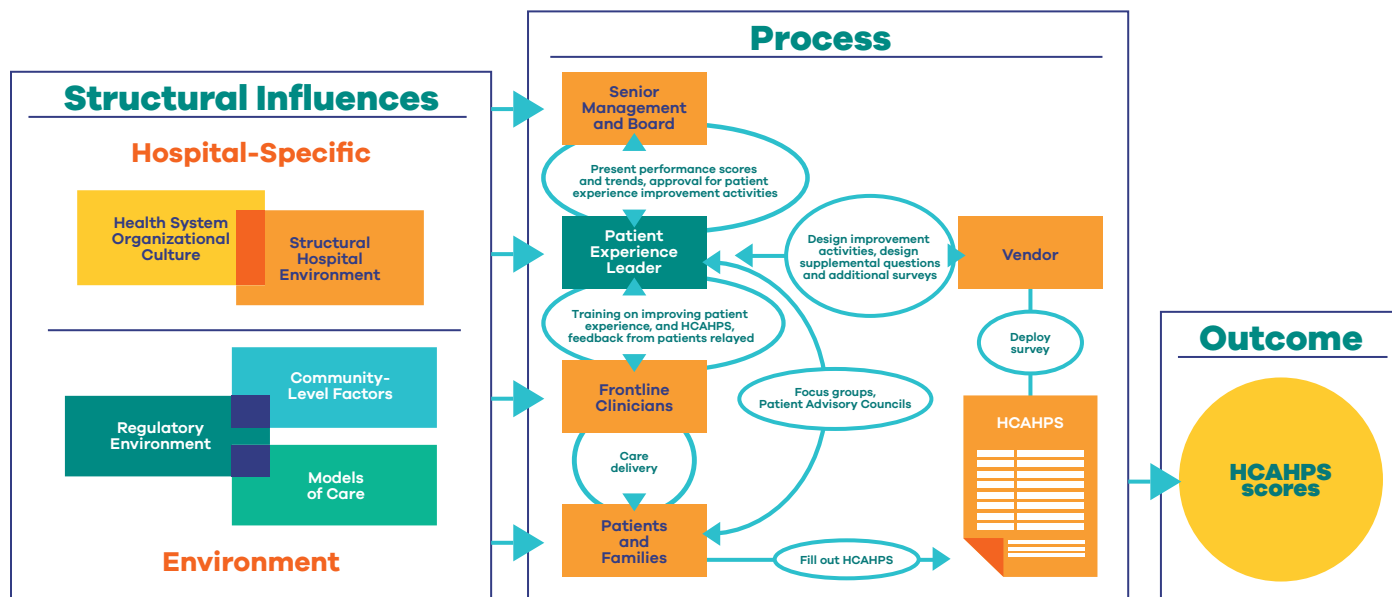


Figure 2 is a conceptual model that illustrates the role of the PEL in the context of the patient’s experience of inpatient and other hospital-based care and the HCAHPS survey administration. It leverages the three-component framework developed by Avedis Donabedian to assess the quality of health care.<sup>4</sup> The structural influences describe the factors that affect the way care is delivered. The process influences describe the transactions between entities involved in the delivery of health care. In this case, the only outcome focus is the HCAHPS survey scores.

PELs provide insight into the organizational aspects of administering the HCAHPS survey, using survey results to drive improvement, and leading their organizations’ efforts to improve the patient experience. PELs also seek out the patient voice using mechanisms other than just the HCAHPS survey, including:

- Patient representatives and patient advisory councils;
- Consumer use of online communities and social media; and
- Internal surveys and focus groups.



# Methodology and Respondent Profile

An initial literature review was conducted to construct a semi-structured interview guide. PELs from 27 hospitals and health systems were interviewed between July and October 2018. Interviews were conducted by telephone, ranged from 30 to 60 minutes, and were recorded and transcribed. An initial set of themes was built from a literature review on patient experience measurement. A modified Grounded Theory<sup>5</sup> approach was used to develop codes building on the initial set of themes through iterative coding until reaching saturation. Related codes were grouped into corresponding encompassing themes.

By design, there was a wide representation of hospital types: 70% of PELs were leaders in not-for-profit hospitals and 30% in investor-owned hospitals. Broken down by teaching status, 44% of PELs were leaders in teaching hospitals and 56% in non-teaching hospitals.

In a follow-up to the initial interviews, a subset of PEL interviewees (nine out of 27) participated in a half-day roundtable held in December 2018 in Washington, DC. During this roundtable, preliminary analyses from the interviews were presented, highlighting areas that could benefit from further discussion and clarification.



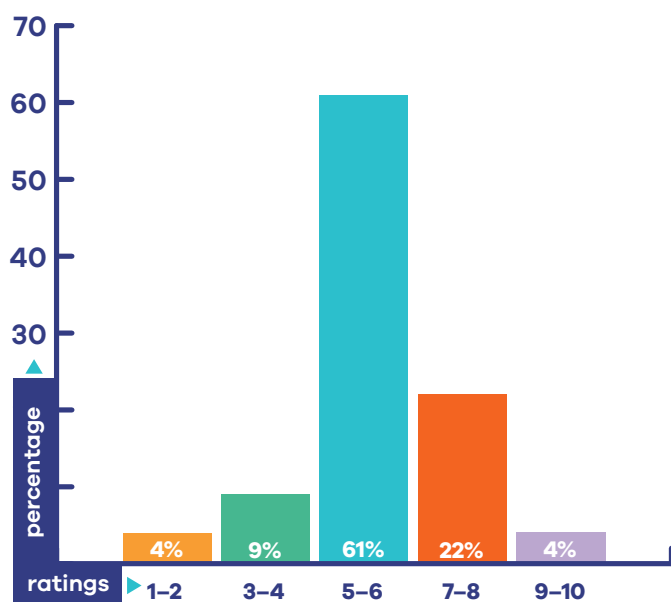
# Measuring the Success of the HCAHPS Survey

PELs were asked to rate CMS's progress toward two of its goals:

- To provide patients with useful information to make better informed decisions on hospital choice; and
- To give hospitals incentives to improve the quality of their care through public reporting.

The responses were on a scale of 1 to 10 with 1 being “not at all” and 10 being “completely.”

*Figure 3a. How well do you think the HCAHPS survey (and how CMS reports it) attains this goal on a scale of 1 to 10 with 1 “being not at all” and 10 being “completely”?*



*Figure 3b. How well do you think the HCAHPS survey (and how CMS reports it) attains this goal on a scale of 1 to 10 with 1 “being not at all” and 10 being “completely”?*

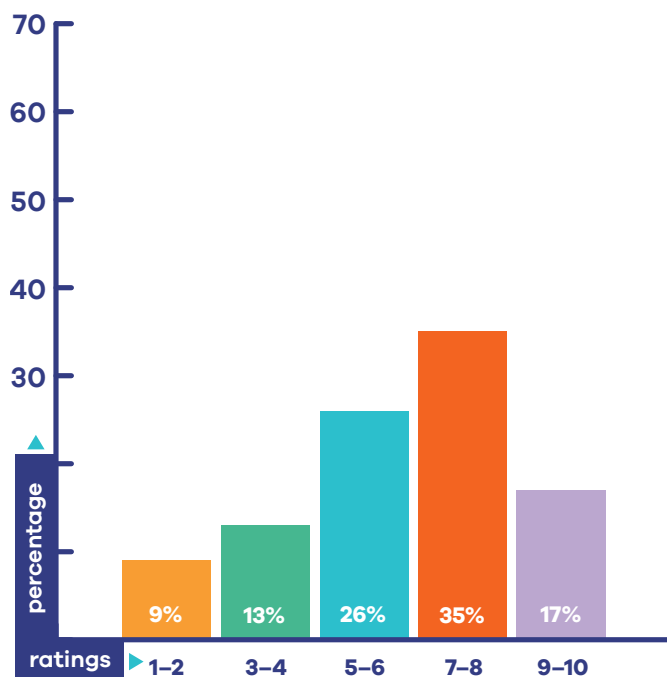


Figure 3a shows that 61% rated the first goal — to provide patients with the information necessary to make informed decisions on hospital choice — at a 5 or 6, and just 4% of PELs a 9 or a 10 in this area. In addition, as shown in Figure 3b, 17% of PELs rated CMS's second goal — to give hospitals incentives to improve quality of care — a 9 or a 10, with just over half of PELs rating CMS's performance on this goal at 7 or more.

Tables 1 and 2 list the strengths and opportunities for improvement identified by PELs as pertaining to these goals.



Table 1. *HCAHPS Survey Strengths*

Area		Strength
<b>Process</b>	<b>Survey Modes</b>	<ul style="list-style-type: none"> <li>Multiple modes: mail only, telephone only, mixed mode, Active/Interactive Voice Response</li> </ul>
	<b>Survey Deployment and Reporting Timelines</b>	<ul style="list-style-type: none"> <li>Established process to enable sampling with exclusions and quality control, survey administration, data and file specifications and coding</li> </ul>
	<b>Periodic Revalidation</b>	<ul style="list-style-type: none"> <li>Does not currently have one</li> </ul>
<b>Structure</b>	<b>Topics</b>	<ul style="list-style-type: none"> <li>Includes important domains such as "Care from Nurses" and "Care from Doctors"</li> </ul>
	<b>Questions</b>	<ul style="list-style-type: none"> <li>Includes critical questions such as "During this hospital stay, how often did nurses treat you with courtesy and respect?"</li> </ul>
	<b>Question Response Scales</b>	<ul style="list-style-type: none"> <li>Uses dichotomous and numerical rating scales</li> </ul>
	<b>Public Reporting</b>	<ul style="list-style-type: none"> <li>Standardization of questions makes national comparison possible</li> </ul>
	<b>Adjustment Factors</b>	<ul style="list-style-type: none"> <li>Adjusts for survey mode and a good set of patient-level factors</li> </ul>
	<b>Evidence-Based</b>	<ul style="list-style-type: none"> <li>There is currently no formal tie of questions to evidence-based solutions for improvement</li> </ul>

Table 2. *HCAHPS Survey Opportunities for Improvement*

Area		Opportunity for Improvement
<b>Process</b>	<b>Survey Modes</b>	<ul style="list-style-type: none"> <li>Incorporate an electronic mode to the available survey modes and meet patients where they are</li> </ul>
	<b>Survey Deployment and Reporting Timelines</b>	<ul style="list-style-type: none"> <li>Shorten time lags to reduce recall-bias and make public scores more relevant</li> </ul>
	<b>Periodic Revalidation</b>	<ul style="list-style-type: none"> <li>Implement a process for periodically revalidating the HCAHPS</li> </ul>
<b>Structure</b>	<b>Topics</b>	<ul style="list-style-type: none"> <li>Address any emerging gap areas that are important to measuring patient experience</li> <li>Re-evaluate patient's shifting attitudes over evolving domains that matter</li> </ul>
	<b>Questions</b>	<ul style="list-style-type: none"> <li>Investigate questions perceived as ambiguous or confusing by patients; reduce redundant questions</li> <li>Include open-ended questions for text narratives</li> <li>Re-evaluate cultural competency and appropriateness of literacy levels</li> <li>Reduce survey length</li> </ul>
	<b>Question Response Scales</b>	<ul style="list-style-type: none"> <li>Investigate how variety and changing of scales from question to question affects patient comprehension</li> <li>Investigate alternatives to the use of frequency (i.e., "always," "never") as a Likert scale</li> <li>Weigh out appropriateness of binary versus numerical rating scales for some questions to capture patient comprehension and reduce ambiguity</li> </ul>
	<b>Public Reporting</b>	<ul style="list-style-type: none"> <li>Increase patient awareness and education of HCAHPS and <i>Hospital Compare</i></li> <li>Improve data presentation and analysis, including evaluating the use or need for patient education on a) Top Box and other ways data is presented; b) how question ratings relate to percentile ranking</li> </ul>
	<b>Adjustment Factors</b>	<ul style="list-style-type: none"> <li>Explore emerging evidence for additional adjustment factors such as community-level factors and other social determinants of health, social support, and patient engagement</li> </ul>
	<b>Evidence-Based</b>	<ul style="list-style-type: none"> <li>Investigate how questions relate to evidence-based solutions</li> </ul>

Focusing exclusively on how well HCAHPS captures patient experience, respondents recognize the importance of the survey but feel there is room for improvement.

Figure 4a. How well do you think the current HCAHPS survey works to accurately assess patient experience?

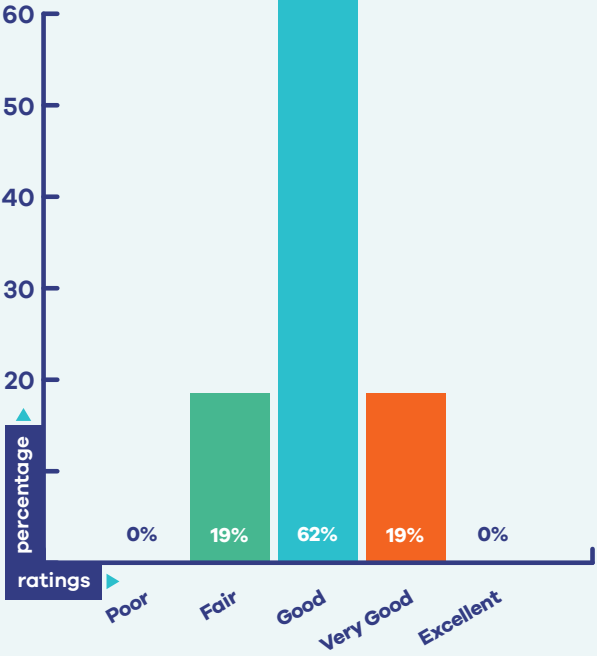
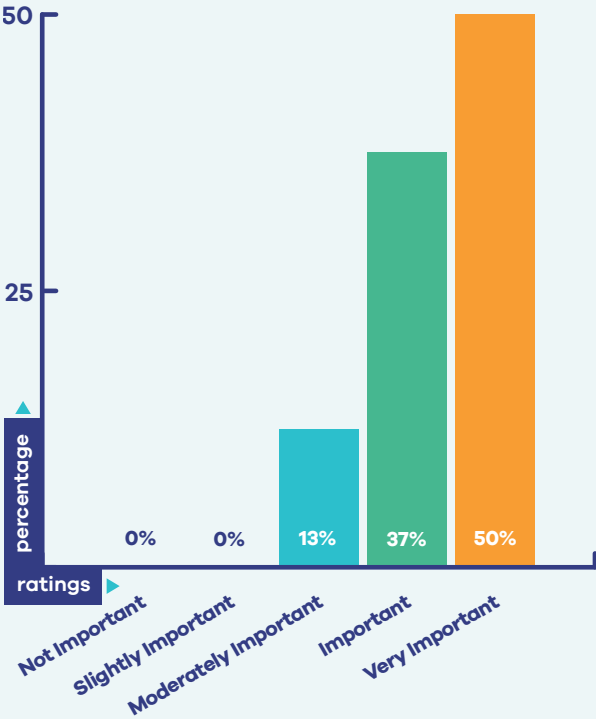


Figure 4b. How important is it to you that the HCAHPS survey be changed?





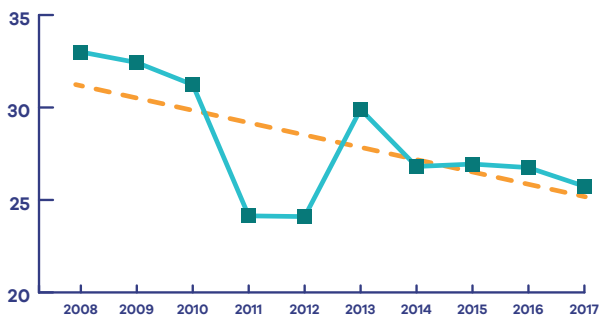
# Why is the HCAHPS Survey Response Rate Falling? Mode and Length

## Response Rates

PELs reported that their HCAHPS survey response rates are falling. Patients report frustration with the length of the survey, in both paper and phone modes, and the way questions are asked when the phone mode is used to deploy the survey. During the phone survey, patients may choose to exit the survey before completion (i.e., hang up).

In examining the national rates, we found that the rate of patient responses to the HCAHPS survey has fallen over time. Figure 5 illustrates response rates between 2008 (33%) and 2017 (26%), with a percentage change of -22% overall and an average 0.8 percentage point drop per year. Low response rates erode the validity of the survey.<sup>6</sup>

Figure 5. *The HCAHPS Survey Response Rates are Falling (2008–2017)*



Source: Author's analysis of data for 2008–2017 from the Medicare Hospital Compare "Patient Survey (HCAHPS) – Hospital" Annual Files.

## Digital Mode Helps

The absence of a digital option — that is, an option to administer the survey via email, the internet or a mobile application — has raised additional concern of biases and limitations in the capture of patient experience.

Without the option of a digital survey, hospitals are left to use the available modes (e.g., phone and mail) that are stated by PELs to be substantially more expensive to deploy and require more surveys to be deployed to ensure survey responses meet the threshold required for public reporting on *Hospital Compare*.

Further, it has been shown that when surveys are provided via tablets on the day of discharge, there is greater participation of hard-to-reach and minority populations whose response rates are usually very low, including black, Latino, and low-income populations.<sup>7,8</sup>

In addition, the absence of a digital mode raises a concern that the HCAHPS survey is not capturing the experiences of younger inpatients, such as millennials.

Improving response rates is important also for the reason that lower response rates are identified with lower overall HCAHPS survey scores.<sup>9,10</sup>

## Survey Length

PELs indicated concern over the length of the HCAHPS survey and number of core questions. As noted earlier, CMS allows hospitals to append supplemental questions following the HCAHPS survey core questions. This enables individual hospitals to survey hospital-specific patient experience issues.

Hospitals, therefore, must balance desire for collecting more information for internal quality improvement efforts with the length of the official survey. While CMS has expressed concern about the negative impact supplemental questions can have on response rates, these questions are considered important by PELs to inform hospital improvement efforts.<sup>11</sup> This is especially true for hospitals with limited resources to invest in additional analytics or parallel non-HCAHPS surveys developed by their vendor.

*"[after adding questions] we started suffering from very bad response rates that just kept dropping and dropping. We were sitting on a 10-page survey that was going out."*

PELs identified not only the addition of supplemental questions but also shifting patient expectations of technology and current available modes, and a general increase in the burden of surveying as reasons for the falling response rates.

Additionally, about half the PELs report using digital surveys to inform their quality improvement initiatives. These digital surveys do not count toward the number of completed surveys hospitals must collect to meet CMS requirements. However, these surveys are deployed by the same vendors used for the HCAHPS survey, and PELs receive the feedback more quickly than they do from CMS and generally report higher response rates.

While the incorporation of digital surveys was highlighted as being of highest priority, our study identified challenges related to digital surveying that are consistent with findings from other studies. One such challenge is capturing valid patient email addresses. These challenges come as a result of limitations of interoperability between electronic health records (EHR) and other databases, as well as limitations in implementing consistent and reliable processes to capture patient email addresses in the hospital. Prior studies have found challenges that include patients not providing an email address at admission, the use of filtering software to automatically redirect emails as spam, and the habit of ignoring unfamiliar emails.<sup>12</sup>



# Time Lag: The HCAHPS Survey Deployment and Reporting

The HCAHPS surveys are sent to patients between 48 hours and six weeks post-discharge. Once the responses to the survey are submitted to CMS, it takes nine to 21 months for those results to be reflected on *Hospital Compare*. The timelines for survey administration and reporting of results raises concerns. The time lag between inpatient discharge and survey receipt could introduce patient recall bias into the survey responses. PELs expressed a strong preference for being able to administer surveys to patients as soon as they are discharged, when the experience is still fresh in their mind, and when the information is most actionable by hospitals.

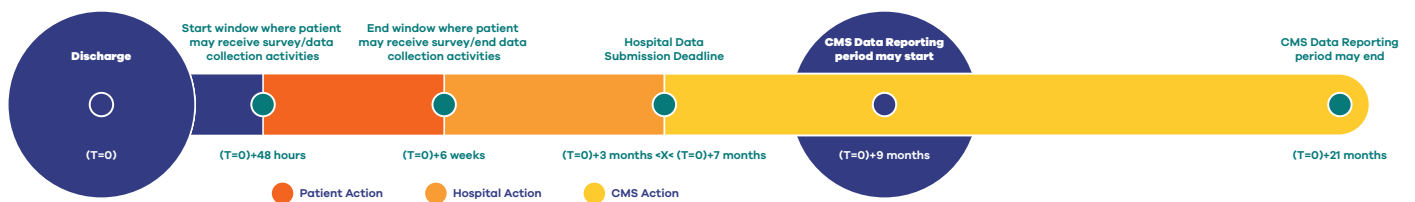
*"I think feedback timing would be much more beneficial for everyone if every patient were given a survey literally as they are walking out the door and that would be able to give us more real-time feedback about how well we did as well as increasing the number of respondents."*

The time lag between submission of the completed surveys and the public reporting of scores on *Hospital Compare* can be close to two years. This length of time weakens the utility of the results and could mislead consumers because it does not reflect the experience reported by current patients. Moving to a digital survey is expected not only to alleviate response rate decline but also to reduce the duration of these time lags.

*"Reduce the CMS mandate of waiting 42 days post-discharge before a candidate ... receive[s] the survey. [The time lag] is simply too long; patients [retain] a very vague kind of recollection of what actually happened. — let's start while they are actually still in the facility and let's reduce the amount of time post-discharge when they can get a survey."*

*"The lag time on reporting is nine months and the reporting period is 12 months. [The data] is almost two years old when [it is posted] on [Hospital Compare]. [This] makes it less relevant. If CMS can think through ways of improving the lag time for the information to be more real-time and relevant it would increase usefulness of [the] data."*

Figure 6. *Timeline from Hospital Discharge to Public Reporting*

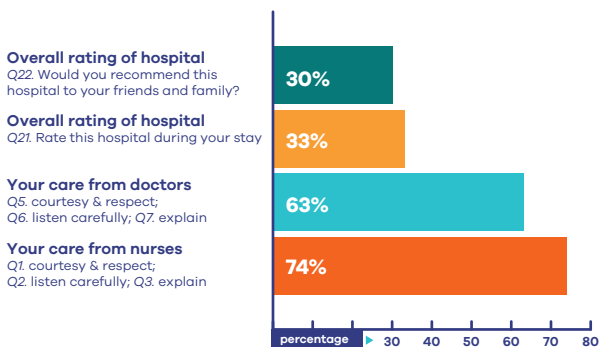


# The HCAHPS Survey Topics and Rating Scales

## Topics Covered are Important, But Incomplete

PELs considered many of the domains covered by the HCAHPS survey critical in capturing the patient experience. However, the survey was found to lack other domains considered important to patients. PELs identified existing HCAHPS survey questions that are important to retain as part of the core HCAHPS survey as well as questions that are important to add. 30% or more of PELs identified eight of 27 questions as important to keep (Figure 7).

Figure 7. Questions important to keep



PELs listed 14 topics as missing from the survey. However, when PELs were pressed to identify the most important topics(s) to add to the survey, a substantially smaller set of five emerged. (Table 3)

Table 3. Topics That are Important to Add

Critical Topics	Other Ideas for Topics
Care transitions and post-discharge experience	Billing
Efficiency and teamwork of care team	Compassion and courtesy
Fulfillment and comprehension of patient's care plan	Food and nutrition
Open-ended text	Ancillary labs and tests
Sense of emotional and physical safety	Quality and safety
	Registration process
	Support offered to family and caregivers
	Traffic and parking

Our findings suggest that there is a growing gap between what the HCAHPS survey currently captures and what PELs believe matters most to patients. A study conducted by Ranard et al found 12 domains covered in Yelp reviews about hospitals that are not covered in the HCAHPS survey.<sup>11</sup> There is a dearth of understanding regarding how the use of information technology in health care affects patient expectations or influences what matters to them. In addition, the aging of the population and rising burden of chronic illness, combined with the higher acuity of those treated at hospitals, suggests that what matters to the hospital patient population is changing over time. Shifting demographics, models of care, the incorporation of EHRs and other technology, biometric data and predictive analytics, and the increasing proclivity of the general population to use and act on information technology might be among

the factors that affect changes in what matters to patients during their inpatient admission.<sup>14</sup> The ability of patients to access and interpret the increasing volume and complexity of quality measurement information poses additional challenges.<sup>15,16</sup>

## Discharge Planning and Care Transitions Sections Are Not Achieving Their Intended Purpose

PELs generally agreed that it is critical to capture discharge planning and care transition experiences as is intended with the “*When You Left the Hospital*” and “*Understanding Your Care When You Left the Hospital*” sections. Commonly used shorthand titles to refer to these sections by PELs are *Discharge Planning* and *Care Transitions*. Both sections were identified as among the most difficult in which to sustain improvements, regardless of efforts to improve patient experience in care transitions. This difficulty was largely attributed to the perceived breadth of interpretation in these questions and patient recall bias. Some PELs raised concerns that these questions were particularly sensitive to variability in responses that can be directly tied to different patient socioeconomic backgrounds and engagement. Ambiguity of questions and variability in responses can lead to challenges in identifying root causes of poor performance in the HCAHPS survey scores. Additionally, some PELs were concerned that questions across these sections are redundant.

It became apparent that there was a gap between PELs’ recognition that capturing care transitions is important and the perceived clarity and effectiveness of the questions in the HCAHPS survey. The section titled “*Understanding Your Care When You Left the Hospital*” is composed of Care Transition Measures (CTM-3) and is intended to capture the extent to which hospitals prepare patients for self-care once discharged.<sup>15</sup> The CTM-3 assesses patients’ perspectives of the coordination of discharge care by focusing on aspects of the care experience that include understanding of the patient’s self-care and medication management role post-discharge, as well as the incorporation of the patient’s preferences into the care plan. The purpose

of the CTM-3 is to differentiate among health care facilities with differing levels of commitment to care coordination. Although the measure is endorsed by the National Quality Forum (NQF), some question its predictive ability and use as a basis for improving care transitions.<sup>18,19</sup>

As noted in Figure 1, PELs interact with patients to gain more clarity of the patient perceptions of their experiences of care and with the HCAHPS survey. They found that patients reported confusion with respect to what these questions were asking.

*“When we ask our patient and family advisory councils about this question, [‘During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left’ (Q23),] they shared they [were] not sure where it’s going. [As a result] we are at a bit of an impasse when we try to create education and training and auditing around that question.”*

There also was concern that patients misinterpret this question as asking about their choice in post-acute care, such as home health agencies and skilled nursing facilities, something outside a hospital’s control as hospitals may not direct patients to a particular provider.<sup>20</sup>

The section titled “*When You Left the Hospital*” asks questions regarding the discharge process. PELs observed that the content of the questions was insufficient and did not cover what they considered to be true preparedness for being at home. For example, Question 20 asks “During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?”

*“[‘Discharge planning’] really only evaluates whether or not the patient got a piece of paper that they took home with them. It does not evaluate if the patient actually knew who to follow up with and who to call after they left. Did they know important things that they needed to be watching for after discharge?”*



*Even though we score in the top decile for 'discharge [planning]' instructions, that is one of the areas that we really see opportunity for improvement [in what is captured]."*

*"The yes/no scale is the appropriate scale for questions that are binary like that...[however], we give written information to all our patients [so their answer is based on] whether or not they recall [receiving the information at discharge] when they are answering that item on the survey."*

## Ratings Scales and Public Reporting

The HCAHPS survey asks patients to rate hospitals using five different rating scales across the 21 core survey questions:

- 4-point frequency scale (on 15 questions); “never,” “sometimes,” “usually,” “always”; and
- 4-point agreement scale (on three questions); “strongly agree,” “disagree,” “agree,” “strongly agree”;
- Dichotomous scale (on one question); “yes,” “no”;
- 11-point rating scale (on one question); 0 to 10; and
- 4-point likelihood scale (on one question); “definitely no,” “probably no,” “probably yes,” “definitely yes.”

PELs offered differing perspectives on the appropriateness of the response scales. However, the large majority felt generally that the response scales had room for improvement.

Although there was general support for the use of response scales...

*"I like the scales that HCAHPS uses [as] it truly is seeing how often ... the right behavior [was executed]. I like the frequency scale that they use."*

...one of the concerns centered around the absence of questions focused on quality versus questions focused on frequency:

*"We are surveyed with [a vendor] and so we use the HCAHPS survey [with]... one open-ended question. I've been talking with our adviser lately about [the vendor's] integrated survey and I'm inclined to think that that might be a direction to go. I would like to see HCAHPS consider that because there are questions [out there] that address the quality of the behavior versus the frequency of the behavior, which is just as important as how often we're doing these kinds of things."*

The HCAHPS survey results reported on *Hospital Compare* include “top-box,” “middle-box,” “bottom-box,” 10 HCAHPS survey star ratings on certain composites and individual questions, and HCAHPS survey summary star rating and linear mean scores. Top-box is the frequency of the most positive response on a question or composite (i.e., patients who reported that their doctors “Always” communicated well). Middle-box is the frequency of the intermediate response (i.e., patients who reported that their doctors “Usually” communicated well). Bottom-box is the frequency of the most negative response on a question or composite (i.e., patients who reported that their doctors “Sometimes” or “Never” communicated well). Hospital-specific results are published along with national and state averages.

The main page on *Hospital Compare* for patient experience scores shows the top-box rates for the 10 selected composites and individual questions. Although other scores are available, it takes additional searching by the consumer to reach that information, making it less likely to be found. Some PELs indicated that the concept of “top-box” is not intuitive to most patients nor considered when patients fill out surveys.

*"I think somewhere where we lose a little bit is this top-box idea because it's kind of an all or none...it can be frustrating when you see how many ratings of 8 you have on a 0 to 10 scale, [but] if [the patients] don't give you a 9 or 10, you get nothing."*

*"The 'never, sometimes, usually, always' [scale]; I just think 'never' and 'always' are words that [indicate] extremes – I would say patients probably will not usually give you a 'never' or 'always.'"*

Another concern regarding the rating scale was how it translates into rates and percentile rankings.

*"I think they need to expand their rating scale. Right now it's very tight in there. You can have a lot of comparable places all running very closely. And when you look at their overall score and percentile ranking, we don't have a lot of wiggle room. We need to somehow figure out how to expand that to really be able to use it as a differentiator."*

*"Some of the rating scales do not allow for insight into true performance in that domain. For example, the discharge domain [has a] 'yes or no' rating scale. 82% of our patients mark yes, yet our performance ends up being in the 10th percentile. We would [need] to have 100% of patients saying 'yes' in order to achieve high performance. When patients are comparing for that section [looking at Hospital Compare], it looks like we're doing very poorly. But I just think there are flaws in some of the questions and especially some of the rating scales."*

*"It can be very discouraging to the staff because of the whole Top-Box...you report on Top-Box –but we're not explaining to the consumer what Top Box means. And they see one hospital is 50% and another hospital is*

*80%; the 50% hospital looks terrible, but they might have gotten 50% 9's and 10's, but the other 50% could be 8... I don't think the normal individual thinks in terms of Top Box... They think in terms of mean rating. I think that a huge part [of] where they can improve is to move to a mean score [as default view] for a clearer picture than just Top Box."*

## Time to Ask the Patient What is Meaningful

Throughout the discussion of survey content and responses, PELs referred to the importance of asking the patient what matters to them. Further, some PELs suggested asking patients about the best response scales to represent their experiences.

*"So, as far as coming back to what is the most important change we need to make with the HCAHPS, I truly believe we need to ask patients to help us redesign survey asking what matters most to them. Let's not ask the questions we think are most important. Let's ask them what matters to you and [then] ask those questions [they come up with in the survey]. We should also ask them "What should that scale be?"*



# Frontline Health Care Professional Engagement

The HCAHPS survey was designed for public reporting and comparison across hospitals. CMS and AHRQ dissuade hospitals from using the HCAHPS survey to compare performance across units or providers within a hospital.

Successful patient experience initiatives require provider engagement. Unit or provider attribution provides hospitals the opportunity to both target improvement activities and increase engagement of frontline clinicians. There is a gap in the awareness and importance placed on the HCAHPS survey by frontline clinical staff as compared to management and leadership.<sup>21</sup> PELs attempt to address this gap through cultural education about the HCAHPS survey, and benefit by drilling down to specific units and providers or by including open-ended text narratives from patients who will call out individual clinicians. In addition, PELs often choose to add targeted supplemental questions as part of structured plans to use patient feedback to engage and encourage clinicians to focus on improving patient experience.

*“When I think about [the HCAHPS], I talk with our frontline teams. That’s what they came into health care to do. When we can improve patient experience, when people can execute on their why, they are more satisfied in our environment. I link patient experience and employee experience because I think that is a driver that we have not recognized. There is a gap in understanding the importance of the HCAHPS.”*

*“Clinical staff just feel it’s a government-mandated survey to get the hospital more money. But a provider doesn’t feel that it’s something that helps them as a provider be a better provider.”*

*“We are addressing strategy and culture with our strategic imperative...and...holding our leaders accountable at a level for leading the patient experience...and also hold employees accountable to creating that extraordinary patient experience. It is a line-of-sight strategy to drive accountabilities and goals. There is also an incentive compensation tied to it here as well for every employee in our organization.”*

*“HCAHPS is now the main focus, but [the feedback we received from clinical staff is to] not have it in front of everyone and for every meeting, that it doesn’t have to be the kickoff point. People stated that they are here to care for and serve the patients. They are here to help people get better. They are very interested in quality and safety measures. They don’t want the slide that has just HCAHPS. That’s why our team internally has been very invested in tying HCAHPS and quality together so that we can help make that connection for them because they don’t see the connection at this moment.”*



# Social Determinants of Health: Disparities in the Capture of Patient Experience

PELs expressed concern that the HCAHPS survey also may inadvertently hinder efforts for hospitals to understand and address disparities in care among certain patient populations. PELs suggested several reasons why, including:

- Ambiguity in interpretation of certain questions; and
- Challenges in capturing patient populations with social risk factors such as housing instability.

PELs explained that this ambiguity can affect a hospital's success at improving aspects of the patient experience. According to PELs ambiguity can result from:

- Patient literacy levels that are lower than the literacy levels in which the questions are asked;
- The wording of a question that can lead to multiple interpretations; and
- Response scales that are narrow and lead to scores that do not provide sufficient information for isolating the root cause of poor performance (this is further explained in the Section titled "Response Scales").

*"While HCAHPS are written at a literacy level that is relatively understandable to most people, I think there are still literacy questions, and certainly in certain counties, that may be [negatively] impacted."*

The HCAHPS survey attempts to capture the experiences of English-speaking, non-English-speaking, and limited-English-proficiency patients across a range of literacy levels. However, non-English-speaking patients have been found to have disproportionately higher levels of low linguistic and

health literacy.<sup>13</sup> As a result, even with the use of the HCAHPS survey translations into other languages, this segment of the population risks being under-surveyed and not properly represented in the reported results.

In addition to the under- and misrepresentation of these populations, the absence of appropriate reading levels in non-English languages reduces the validity of the survey and introduces limitations on the use of the HCAHPS survey by language minorities.

*"CMS did...a good job...building a survey instrument that was mostly geared towards an English-speaking, relatively well-educated patient population. Half of our patients don't speak English [and] struggle with these survey instruments; they don't really understand some of the questions. There is a lack of [literacy in their own language]...that hinders them."*

*"The patient's language preference is a factor that impacts my ability to get a representative sample. The questions are not written at the level that we [need] in our organization because our [patient's] socio-demographic [characteristics are] at a fifth grade reading level."*

*"The proportion of patients who have English as a second language makes a difference because ...their perspective is generally not captured.[We get] a minuscule response rate for non-English-speaking patients through our vendor; I don't know if other vendors have better luck. We have [80% of our patients with English as a second language of which] 30% [are Spanish- speaking patients], and our response rate from [those patients] is 4%."*

Beyond the disparities in non-English-language patient experience surveying, additional factors play into disparities in the measurement and capture of vulnerable populations. Medically and socially complex, high-need, high-cost, and seriously ill individuals are highly heterogeneous populations whose acuity of illness, social needs, and disease trajectories differ substantially from those of other patient populations.<sup>22</sup> Seriously ill individuals, whose interaction with the health care system is higher in both quantity and frequency than that of less-clinically complex patients, will differ in priorities when it comes to experiences and expectations and the modalities of survey deployment to which they respond.<sup>23</sup> Prior studies have found that eliciting patient narratives into patient experience surveys helps explain variation in provider rating, particularly among sicker, more complex patients.<sup>24</sup>

Finally, the experience of care of homeless patients often goes uncaptured due to the absence of a mailing address or phone number. Deploying the survey immediately post-discharge in the hospital, as mentioned above, would help mitigate this challenge.

Differences in interpretation of questions by patients can pose substantial challenges to hospitals when performing root cause analyses. PELs identified factors that influence survey responses that are tied to patient- and county-level factors (i.e., percent homeless population, social support levels, insurance product).

*"If you are in a very affluent area, I think it is a little bit easier to do better on HCAHPS as patients are likely to be able to fill their prescriptions when they leave the hospital, and they are likely to have family and friends who are visiting them, who are likely to help them with their hospitalization, cheer them up, make them feel more welcome."*

There is a need to evaluate what matters to all patients, in particular the most vulnerable and high-need patients whose experiences are not always well represented. PELs are concerned the population of patients with clinical and social complexity might have been underrepresented in the focus groups that tested the HCAHPS survey design and what matters to patients.

*"We are the safety net hospital, and a lot of our patients have very difficult [life] circumstances, [and] a lot of comorbidities. [These patients contend with] both medical and social [issues]. [We have a] significant homeless patient population. A fair amount of [these patients] are not reachable by a mail survey due to their lifestyle. Those that are [reachable by mail] tend not to give us as high an experience rating. In reference to that, we would love to see more research put into patient mix adjustments and into how patients [with medical and social complexity and high need] answer these questions."*

*"Our inner city and critical access hospitals seem to serve a more complex population who may be less likely to rate highly regardless of the services that they receive. For example, we have about 10 safety net hospitals, and they serve patients that are in the most need of care. Their social determinants of health vary greatly, and they may have other issues impacting health care access such as immigration status, low English proficiency, and homelessness."*

*"Recognizing the differences in patient populations would be very valuable. The way [the HCAHPS] is structured now, we don't take into account what is meaningful for different patient populations."*

# Improving Patient Experience: Hospital Investments and Challenges

## Factors Beyond Hospital Influence

The adoption of the HCAHPS survey scores into hospital payment programs introduces further complexity and the need for a re-evaluation about whether measure performance is influenced by factors hospitals can modify to improve on lower performance areas. PELs stated that certain factors outside of the hospital's control should be considered in order to ensure a level playing field when comparing hospitals. These factors include unmodifiable hospital characteristics such as age and construction of the hospital, and environmental/community characteristics such as serving communities with higher concentrations of high-need patients, lower access to care, or higher concentrations of racial/ethnic minorities.

These findings are consistent with prior studies and a recent systematic review that identified patient- and hospital-level predictors associated with higher or lower patient experience scores (e.g., racial/ethnic minorities, higher numbers of primary care providers per capita).<sup>25,26</sup> Although the HCAHPS survey is adjusted for mode of survey administration and patient mix, it is important to evaluate additional characteristics beyond those that are currently adjusted for at the patient level, which may also not be under the control of the hospital but are related to survey responses.

Hospitals use the HCAHPS survey to guide patient experience improvement efforts and to track rates of improvement. PELs stressed the need for patient experience questions that are most meaningful for patients and that are actionable by hospitals.

Yet, even when hospitals perform their own analyses to identify root causes that drive performance, they can be limited in their response due to environmental and structural factors (i.e., age of hospital, size of rooms, materials used to build walls) outside their control. For instance, older hospitals with outdated soundproofing technology will be at baseline noisier than hospitals constructed more recently. Some hospitals have higher proportions of shared rooms, which influences a patient's experience.

*"We have one wing that's brand-new. We don't have any quietness issues in that wing. Our older wings [have] more issues with quietness; [they are] not as soundproof. Even though the noise level may not be any higher from one wing to the other, just the fact that one is more soundproof means that we get better scores in that particular wing for quietness. For responsiveness, if one wing is laid out in such a way that it takes a little longer for a nurse to get to each room, that can affect responsiveness."*

*"In some of our older hospitals, we [encounter] challenges with cleanliness and quietness. We have the same company cleaning all of our hospitals, but [when] a patient walks into a brand-new, shiny hospital versus a hospital that's been around for over 100 [years, the older hospital] just doesn't look as clean. The rooms [in the older hospital] are not as quiet just because of how they were built many years ago. In our newer facilities, we are able to insulate a little bit better and it helps with our quietness rating at night."*

## Hospital Direct Investment

Hospitals are committed to substantial investments in patient experience interventions and quality improvement efforts. These efforts tend to be broad in scope and highly heterogeneous across hospitals. For example, hospitals make use of patient improvement teams, broader enterprise-wide programs, or consulting services from their survey vendor and others to perform root cause analyses. These programs and teams attempt to address various aspects of patient experience by implementing interventions that span many areas of the hospital, including housekeeping; food services; nursing; education for doctors, nurses, and ancillary staff; rounding strategies; implementation of technology such as rounding tablets; and corporate patient experience boot camps. PELs also often collaborate with social media and service recovery teams on opportunities to address patient experience in real time and leverage social media patient experience input. Generally, PELs have great faith in these efforts, but see returns on investment as very slow to accrue and the effects widely vary across units and measures.

*"We have [made] a tremendous investment in our organization around improving the patient experience, and many times we don't necessarily feel as though our good intentions are being perceived by patients and we're not necessarily seeing the fruits of our labors in all the ways we would wish to on the HCAHPS tool."*

*"There's a lot of time, energy, and attention focused on this. Are we getting the full bang for our buck? I'm not sure. [That is] why studying HCAHPS – the current structure, refining it, but most importantly, understanding, what are the proven interventions that make a difference? That if we could all understand that, ideally, all boats would float higher because we'll all be implementing standard type of work that has a proven positive impact on patient experience. I'm not sure that we are working as smart as we might, given all the time and energy we put into this."*

Hospitals rely on certified survey vendors to deploy the HCAHPS survey with appropriately adjusted samples. In addition, vendors help guide PELs with deeper analytics to design and deploy internal surveys that focus on specific aspects of patient experience for internal measurement purposes.

*"We are spending north of seven figures [to have...our vendor] send out surveys in the mail to patients, and then less than 25% of the people we send the survey to complete the survey."*

*"It's not about the money. By the time we create a program, hire people to run it, and do all the surveys, we've lost all the money that we would get back on the incentives anyway... A lot of this came down to the vendors making more money. Between paying the vendor and then hiring a team or even a person or two to do it, you've lost whatever you might have been getting back."*



# Capturing Patient Experience Across the Care Continuum

The blending of the care continuum, when a patient's episode of care may span multiple care sites, has many benefits for patient care but introduces concerns with respect to patient experience surveying. PELs stated that patients are not always able to identify individual providers within the hospitalization or distinguish between the providers they interact with at varying points of care across the care continuum. For example, a pre-op appointment might be considered as part of the reported experience, especially if the encounter did not meet an expectation. The same might occur for post-discharge follow-up, which has become a growing component of the care hospitals provide as they seek to ensure that patients continue to heal.

*"[A] big disconnect in an experience can be, 'Okay. My doctor's office scheduled me to have surgery here. They told me to expect this, this, and this.' [But then] that's not the way things are done at the hospital. The hospital works very hard to [communicate] with the doctor, but you never bridge all gaps."*

*"[HCAHPS doesn't] take into account the experience of the doctor on the outpatient - in the clinics, the medical office. That absolutely impacts the patient experience and we run into trouble...It's so siloed...but in the mind of the patient, it's not."*

*"And what happens after the hospital visit is really important to the patient. If they're in pain or if they have blood... I think that affects people's impression of their inpatient hospital stay, but there's no way for us to assess how well we are staying in touch and supporting the patient in their healing experience after they've been discharged. And as we move into*

*a health care economy that's organized much more around the outpatient experience, [we need to] bridge [this gap and] create some kind of [experience measurement]."*

*"As people leave the hospital, that's not the end of their experience in an episode of care. How well that — the post-discharge work happens for them...that's a hard thing to measure because you want to get the timeliness of the survey. But we find that a lot of challenges we need to work on with respect to follow-up clinic appointments and anything that happens to a patient after they are discharged from an inpatient stay."*

It is important to capture patient experience across the care continuum. However, evaluations of patient experience should be actionable by the provider or entity being held accountable for patient experience. CMS's use of a suite of surveys to capture patient experience across other sites of care (e.g., emergency department, hospital, post-acute care) reflects its desire to create useful information for patients. However, patient care increasingly spans several sites of care during a single episode and brings with it concerns about patient survey burden and lowered response rates. Patients with higher illness burden who interact with the health care delivery system more frequently are considered to be more likely to experience survey burden.

# How Do Consumers use the HCAHPS Survey Results?

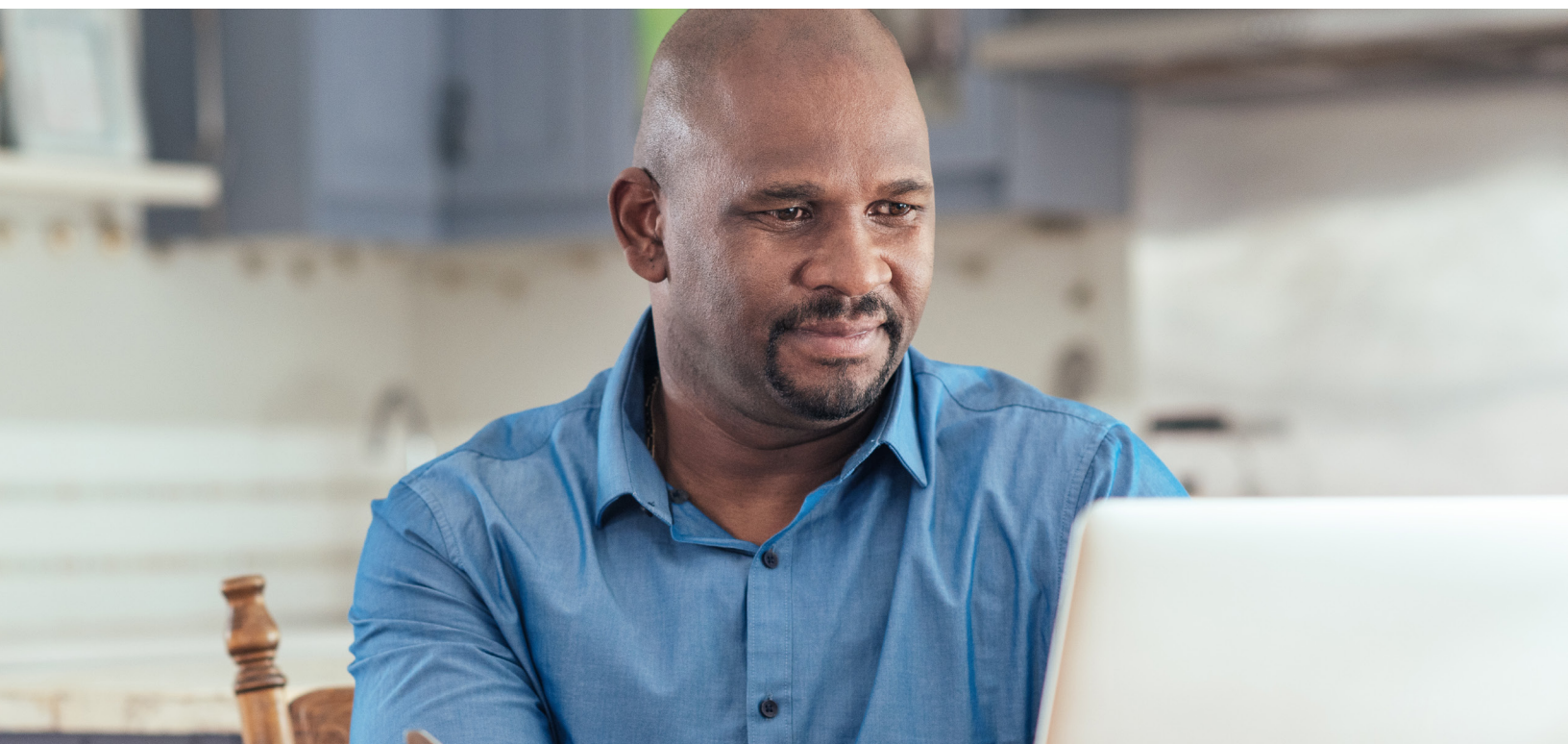
## Grow Consumer Awareness of Metrics to Guide Choices

PELs indicated concern with perceived limited consumer access of the HCAHPS survey scores through the *Hospital Compare* website. The absence of publicity was often cited as a reason why patients are unfamiliar with *Hospital Compare* and the HCAHPS survey, and instead rely on other more familiar sites for hospital reviews such as Yelp or Healthgrades. PELs also mentioned the age of the published data as too far removed to provide an accurate image of current patient experience, whereas other social media sites — although they may be biased, uncurated or have other limitations — offer more timely information, which consumers value.

*"I don't think patients are familiar with Hospital Compare. They use other more familiar sites to get information; they use Google and Yelp reviews."*

*"I don't think many consumers even know that Hospital Compare exists or how to use it or the data that is there. But, you know, promotion of the tool itself would be a big one."*

*"Create a more user-friendly website and to promote the availability of the data and the purpose of the data in — to more consumer platforms. Improving the web portal and the accessibility of the data and helping patients understand why it's important to use this source as a compare-and-contrast [is important]."*





# Recommendations

The findings of this study suggest that there are various areas of the HCAHPS survey that would benefit from a redesign or re-evaluation. PELs offer the following recommendations to inform future efforts to improve the HCAHPS survey:

- Add a digital mode;
- Reduce time lapse from survey submission to public posting of scores;
- Periodically re-evaluate the HCAHPS survey;
- Shorten survey;
- Re-evaluate patient priorities in today's hospital environment, including vulnerable and high-need populations;
- Reframe the “care transitions” and “discharge planning” sections;
- Assess patient literacy, question wording, response scales, and its interaction with non-English-language preferences;
- Assess the use and implementation of open-ended text and narratives;
- Assess patient- and community-level influences for risk adjustment; and
- Grow consumer awareness of the HCAHPS survey and *Hospital Compare*.



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# Appendix

## The HCAHPS Survey Core Questions (21) and Topics

Composite Topics (6)	
<b>Communication from nurses</b>	<p>Q1. During this hospital stay, how often did nurses treat you with courtesy and respect?</p> <p>Q2. During this hospital stay, how often did nurses listen carefully to you?</p> <p>Q3. During this hospital stay, how often did nurses explain things in a way you could understand?</p>
<b>Communication from doctors</b>	<p>Q5. During this hospital stay, how often did doctors treat you with courtesy and respect?</p> <p>Q6. During this hospital stay, how often did doctors listen carefully to you?</p> <p>Q7. During this hospital stay, how often did doctors explain things in a way you could understand?</p>
<b>Responsiveness of hospital staff</b>	<p>Q4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?</p> <p>Q11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?</p>
<b>Pain communication</b> <i>(to be removed effective October 1, 2018)</i>	<p>Q13. During this hospital stay, how often did hospital staff talk with you about how much pain you had?</p> <p>Q14. During this hospital stay, how often did hospital staff talk with you about how to treat your pain?</p>
<b>Communication on medicines</b>	<p>Q16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?</p> <p>Q17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?</p>
<b>Discharge information</b>	<p>Q19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?</p> <p>Q20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?</p>
<b>Understanding your care when you left the hospital</b>	<p>Q23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.</p> <p>Q24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.</p> <p>Q25. When I left the hospital, I clearly understood the purpose of taking each of my medications.</p>
Individual Topics (2)	
<b>The hospital environment</b>	<p>Q8. During this hospital stay, how often were your room and bathroom kept clean?</p> <p>Q9. During this hospital stay, how often was the area around your room quiet at night?</p>
Global Topics (2)	
<b>Overall rating of hospital</b>	<p>Q21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?</p> <p>Q22. Would you recommend this hospital to your friends and family?</p>

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# Associations



The Federation of American Hospitals (FAH), founded in 1966, is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care, and cancer hospitals. Investor-owned hospitals serve their communities proudly while providing high-quality health care to their patients. For more information, visit [FAH.org](http://FAH.org).



America's Essential Hospitals is the leading champion for hospitals and health systems dedicated to high-quality care for all, including the most vulnerable. We support our more than 300 members with advocacy, policy development, research, and education. Communities depend on essential hospitals for specialized, lifesaving services; health care workforce training; public health and health equity; and care coordination. Essential hospitals innovate and adapt to lead effective and efficient care. Visit [essentialhospitals.org](http://essentialhospitals.org).



The AHA is a not-for-profit association of health care provider organizations and individuals that are committed to the improvement of health in their communities. The AHA is the national advocate for its members, which include nearly 5,000 hospitals, health care systems, networks and other providers of care. Founded in 1898, the AHA provides education for health care leaders and is a source of information on health care issues and trends. For more information, visit the website at [www.aha.org](http://www.aha.org).



The AAMC (Association of American Medical Colleges) is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals. [aamc.org](http://aamc.org)



The Catholic Health Association of the United States is the national leadership organization of the Catholic health ministry, representing the largest nonprofit provider of health care services in the nation. One in seven patients in the U.S. is cared for in a Catholic hospital each day. Catholic health care, which includes more than 2,200 hospitals, nursing homes, long-term care facilities, systems, sponsors, and related organizations, serves the full continuum of health care across our nation.







