# PATIENT EXPERIENCE AND HCAHPS AT ESSENTIAL HOSPITALS

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## KEY FINDINGS

- Members of America's Essential Hospitals, as well as nonmembers, improved their performance on measures of patient experience from 2008 to 2018.
- Member hospital scores lagged nonmember scores in 2008, and that remains the case in 2018.
- Patient and hospital characteristics, as well as the market within which a hospital operates, influence patient experience.

As part of the federal government's Hospital Quality Initiative, which seeks to improve health care quality through accountability and public disclosure, the Centers for Medicare & Medicaid Services (CMS) began developing the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in 2002 and implemented it in 2006.[1] CMS detailed three goals for the survey: to produce data on patients' perspectives of care that allow consumers to make meaningful comparisons between hospitals; to give hospitals incentives through public reporting to improve care quality; and to increase accountability and transparency for the quality of care hospitals provide.[2,3]

## OVERVIEW

In the three years after the start of the HCAHPS survey, scores among hospitals showed an overall improvement, with a 2.8 percentage point increase from 2008 to 2011 in the most positive response categories across each score.[4] Improvements to scores have continued overall since 2011, with aggregate improvements across the board from 2015 to 2016.[5] However, analyses of HCAHPS score trends have shown that despite overall improvements, not every hospital made gains.

The HCAHPS survey results currently are a component of the Hospital Value-Based Purchasing (VBP) Program, which rewards hospitals based on the quality of care provided to Medicare patients, including patients' experiences of care during hospital stays.[6] Over time, researchers have considered how well patient experience scores, as captured by the HCAHPS survey, measure quality. Several studies have demonstrated that patient experience measured through HCAHPS is associated with quality indicators, including length of stay following a surgical procedure, lower surgical readmissions, lower complications, and lower mortality.[7–9]

## HCAHPS METHODOLOGY

The current version of the HCAHPS survey includes 25 questions to determine patient perspectives in these key areas: communication with doctors, communication with nurses, responsiveness of hospital staff, communication about pain (to be removed in October 2019), communication about medicines, discharge information, transition of care, cleanliness of the hospital environment, quietness of the hospital environment, overall hospital rating, and likeliness to recommend.[10] The survey also includes questions about demographics and to determine whether patients should skip sections unrelated to them, for a total of 32 questions. In addition to core items, hospital-specific questions also can be included to supplement data the hospital already collects for internal quality improvement programs.[11] To participate in HCAHPS, patients must be older than 18, have stayed one or more nights in the hospital as an inpatient, have a nonpsychiatric MS-DRG/principal diagnosis, and be alive at the time of discharge.

Patients are sampled randomly from eligible discharges monthly and are surveyed between 48 hours and six weeks after hospitalization. Surveys are collected by mail only, telephone only, mixed (mail first,

then telephone), or through Active Interactive Voice Response. To account for the differences in these methods, CMS conducted testing to determine the effects of the survey completion mode, response lag, and service line, and HCAHPS scores are adjusted to reflect these effects. Then, the agency aggregates the data quarterly and makes the most recent four quarters publicly available.[11]

Certain patient characteristics also might affect HCAHPS survey responses. To provide meaningful results of true patient experience and quality of hospital care, regardless of these factors, CMS led early research on the effect of patient demographic factors on HCAHPS scores to create patient-mix adjustments.[12,13] These adjustments include patient age, education level, self-reported health status, primary language, and the interactions between service line and age and service line and gender.

## ESSENTIAL HOSPITAL PERFORMANCE

To analyze performance among essential hospitals, we examined hospital-level HCAHPS scores for each calendar year from 2008 to 2018. Overall, HCAHPS scores improved over this time. The largest increase for both member and nonmember hospitals was in the percentage of hospitals rated overall 9 or 10, which improved by 8 percentage points. There were no score decreases, although communication with doctors showed the smallest gains, improving by 1 percentage point for nonmembers and 2 percentage points for members. Two composites do not have year-to-year scores for comparison. The first is the pain management composite, which was replaced by a composite on communications about pain in January 2018 and then removed from public reporting altogether in July 2018. Further, the communications about pain composite never was publicly reported and will be removed from the survey entirely in October 2019. The second is the care transition composite, for which public reporting began in 2017.[10] Member hospital scores lagged nonmember scores for each measure in 2008, and that remains the case in 2018.

Despite having overall lower scores, there were several high performers among our members. University of Texas (UT) Health North Campus Tyler, University of California San Francisco Medical Center at Mount Zion, Saint Joseph's Hospital, and Oregon Health & Science University Hospital were in the top 10 of our members for seven or more metrics. Essential hospitals ranking in the top 10 for patient likeliness to recommend all had substantially higher scores than the national average, as did the top 10 essential hospitals for overall ratings. UT Health North Campus Tyler also had standout scores for patients always receiving help as soon as they wanted (78 percent) and doctors always communicating well (89 percent).

## FACTORS ASSOCIATED WITH BETTER PERFORMANCE

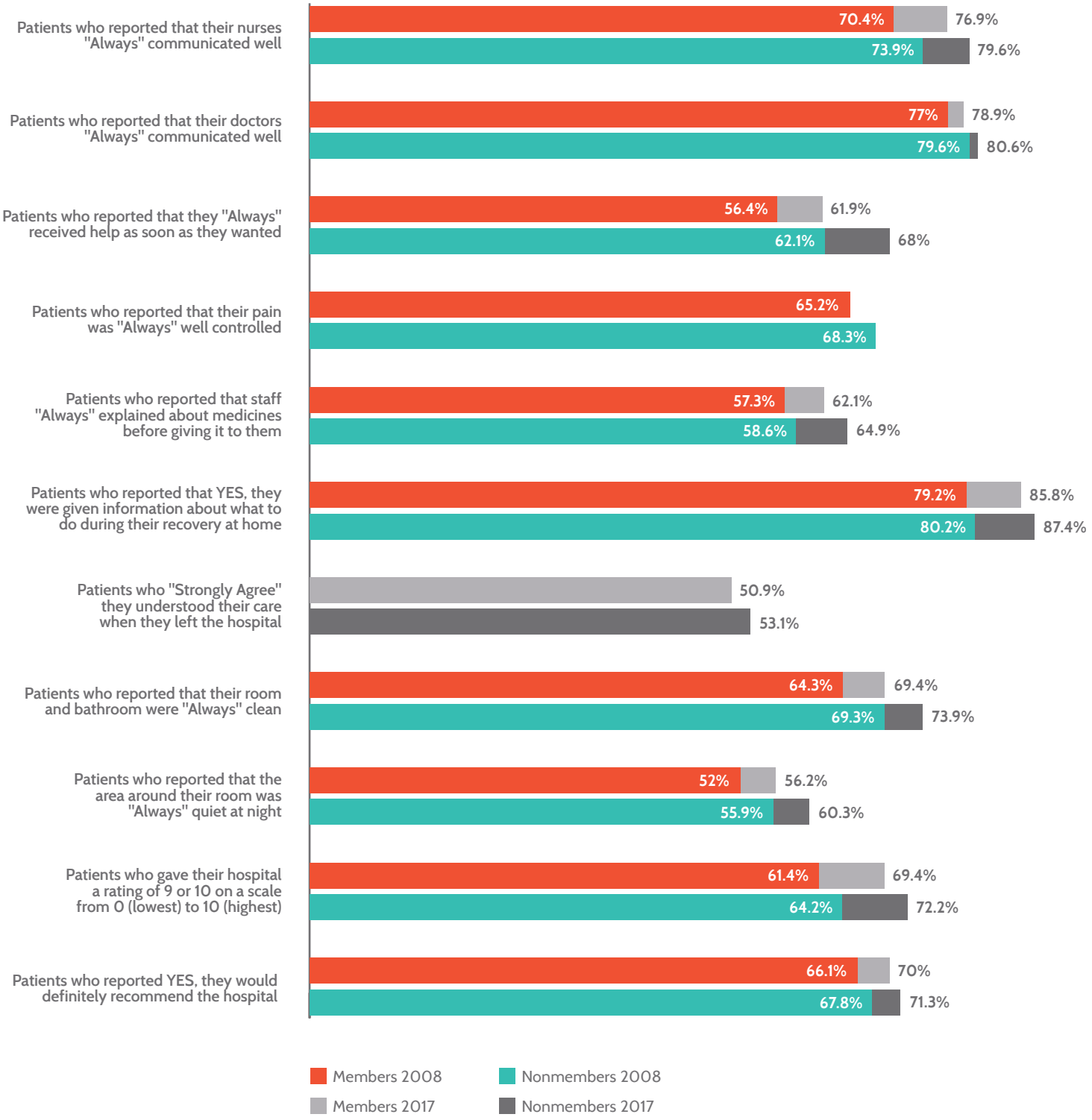
Since the inception of HCAHPS, researchers have sought clarity on the factors that lead to better performance measures. Research has focused on three groupings of such factors: patient characteristics, hospital characteristics, and the characteristics of the hospital's market.[14] Findings from these studies can help hospitals identify changes that might improve patient experience scores, as well as guide policymakers to understand how structural factors influence scores. Further, gaining insight into which key factors lie within a hospital's control is critical to designing equitable programs and policies.

### *Patient Characteristics*

Race and ethnicity, gender, age, and self-reported health status are patient-level factors that have been explored with regard to how they impact HCAHPS measures. In general, those who self report as African American or Hispanic report experience scores more positive or not meaningfully different compared with non-Hispanic whites.[15–17] However, those who self report as Asian American or Native American report lower experience scores.[17,18] Some have argued that differing expectations of care among racial and ethnic groups might partly explain these differences. In their 2010 study, Goldstein et al. point out that minority patients reporting quieter rooms compared with other patients within the hospital constitutes evidence of a difference in perception rather than an objective difference in care, as it is unlikely these patients are systematically placed in quieter rooms at night.

There also is evidence of differences in scores by age and gender. Females tend to rate their experience more poorly than males, and this trend grows more pronounced among older patients. To account for these differences, CMS began stratifying its adjustment methodology by gender, beginning with data collected after the first quarter of 2017.[1] Researchers also have established a significant relationship between self-reported poor health status and lower HCAHPS scores.[17,19] This might reflect lower scores by patients with more severe conditions, chronic illness, or multiple comorbidities.

## MEMBER VS. NONMEMBER HCAHPS SCORES, 2008 TO 2017



### *Hospital Characteristics*

In addition to patient-level factors, studies also have demonstrated a relationship between hospital characteristics and patient experience. For-profit hospitals tend to receive lower HCAHPS patient experience scores than either nonprofit or publicly owned hospitals.[7,20–22] There also is evidence that larger hospital bed size is associated with lower HCAHPS scores, although Tsai et al. 2015 found that hospitals with the highest HCAHPS scores tended to be larger.[21–24] The evidence for performance differences between teaching and nonteaching institutions is mixed. Jha et al., 2008, and Ford et al., 2013, present nonsignificant findings, while Johnston et al., 2015, reported higher scores at nonteaching hospitals. However, Tsai et al., 2015; Liu et al., 2016; Kazley et al., 2012; and Lehrman et al., 2010, found higher scores among teaching hospitals.

Hospitals that fill a safety-net role in their community are more likely to receive lower HCAHPS scores.[25,26] These essential hospitals treat a large proportion of Medicaid patients, who tend to report lower patient experience scores.[7,22,27,28] Essential hospitals also treat the sickest and most vulnerable patients. As discussed above, such patients are more likely to rate their experience poorly. As such, hospitals with a high case-mix index—a metric CMS uses to measure a hospital's average patient severity of illness—tend to receive lower HCAHPS scores.[29] Johnston et al. found similar results in a 2015 study that measured patient severity using a patient's number of diagnoses, procedures, and chronic conditions. In 2016, Thiels et al. reported that complex cases tend to have lower scores, concluding that hospitals that provide high levels of complex care might have artificially lower scores.

### *Market Characteristics*

Few studies have examined the market characteristics associated with high performance on patient experience measures.[14] However, market- and regional-level factors are important to understanding the drivers of HCAHPS performance. In fact, a 2018 study by Herrin et al. found that county-level characteristics—including sociodemographic makeup, cultural differences, and access to care—accounted for more than a quarter of the variation in HCAHPS scores.[30] Hospitals in urban areas tend to have lower HCAHPS scores, as do those treating larger proportions of non–English speaking patients.[28,31,32] Also, hospitals in markets with higher levels of competition tend to have higher scores.[32]

There is mixed evidence regarding how the number of primary care or specialty care physicians in a market impacts patient experience. A 2015 study found that more primary care physicians (PCPs) is associated with worse reported patient experience.[32] This study suggests "as the number of general practitioners goes up, patient satisfaction significantly decreases for each measure, suggesting that patients that have access to more practitioners have higher expectations of care in the hospital."[32] This study also found that an increased number of specialists in a market results in higher experience scores.[32] However, Herrin et al.'s 2018 study provided conflicting evidence, finding that higher PCPs per 100,000 in a county was associated with higher HCAHPS patient experience scores, while a higher number of specialists per 100,000 was negatively associated. They concluded that counties with many PCPs and fewer specialists performed better in measures of patient experience.[32]

### *Implications for Essential Hospitals*

Continuing to build knowledge of the factors associated with performance on measures of patient experience is important for essential hospitals to improve care for all patients. It also is important to understand if the current system of hospital performance measurement and corresponding incentives disproportionately penalizes hospitals that treat vulnerable patients due to factors outside the hospital's control.

Evidence has emerged suggesting that while patient experience scores have improved somewhat since CMS' VBP Program began, the program might not have been responsible for creating that improvement.[33,34] Trends in HCAHPS scores also show that improvement has plateaued in recent years, indicating hospitals might have reached a point of diminishing returns on their efforts to improve patient experience. Essential hospitals have followed this trend, plateauing at scores lower than other hospitals, on average.[25–27] This suggests that factors not within hospitals' control might be more responsible for the distribution and allocation of penalties under the VBP program than factors within their control.

Essential hospitals treat patients who face more acute challenges, both in their health care and in their communities. Policymakers should structure incentives in a way that accounts for factors that affect the measurement of patient experience, promote equity, and reward continued improvement.

## *Notes*

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