American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

March 25, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, S.W., Room 445-G
Washington, DC 20201

RE: CMS-4171-NC, Request for Information to Aid in the Design and Development of a Survey Regarding Patient Experiences With Hospital Outpatient Surgery Departments / Ambulatory Surgical Centers, and Patient-Reported Outcomes from Surgeries and Procedures Performed in These Settings

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) request for information (RFI) regarding the development of a patient experience survey for use in hospital outpatient surgical departments (HOSDs) and ambulatory surgical centers (ASCs). CMS plans to add this proposed survey to its Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, which also includes other surveys for hospitals, physicians, nursing homes and home health agencies.

The AHA has long favored the use of patient experience surveys as tools to help hospitals improve the engagement and satisfaction of patients and families. Indeed, the AHA supported the development and public reporting of data from one of the early surveys in the CAHPS family, the Hospital CAHPS (HCAHPS). Patient experience surveys provide concrete data for hospitals and other providers to identify problem areas, set quantitative improvement targets and track performance.

However, the AHA urges CMS to reconsider the necessity of a new, separate survey tool for ASCs and HOSDs. We are concerned that the CAHPS program already includes multiple overlapping survey tools creating confusion about how to assess the patient experience across multiple care settings, as well as excessive survey administration burden. Instead of a separate survey, CMS should incorporate a small number of supplemental survey questions targeted at facility-level issues for ASCs into an existing CAHPS survey.

We also recommend that CMS allow lower cost survey administration options to mitigate the financial burden of surveying. Finally, CMS should enhance its existing CAHPS surveys by reassessing how it adjusts scores for the severity of patient illness.

THE CONFUSION AND BURDEN OF MULTIPLE CAHPS SURVEYS

The AHA is concerned that the proliferation of CAHPS surveys makes it difficult for patients to accurately assess their care experience. A patient's course of care often crosses multiple care settings and providers within a given period, and the CAHPS program has surveys for nearly every setting. As noted above, CAHPS includes surveys for physicians, hospitals, nursing homes, dialysis facilities and home health agencies. In addition to the proposed survey for HOSDs and ASCs, CMS is developing new surveys for emergency departments and hospice. Patients who receive care in two or more of these settings could receive multiple surveys. Typically, surveys are not distributed until days or weeks after a patient has received their care. This may create confusion about which provider or facility is actually being assessed. A patient may inadvertently attribute a positive or negative experience to the wrong organization.

Correct attribution of performance results could be especially problematic if a new survey for ASCs and HOSDs is implemented because two existing CAHPS surveys – the Clinician/Group CAHPS (CG-CAPHS) and the Surgical CAHPS – capture closely related information. In the RFI, CMS indicates existing CAHPS surveys that could be used for ASCs and HOSDs are focused on individual physicians rather than the facility. However, we believe the content of both CG-CAHPS and Surgical CAHPS already include information highly relevant to assessing experience of care in ASCs and HOSDs. The CG-CAHPS survey evaluates practices and individual providers on several issues, including access to appointments, physician communication with patients, courtesy of office staff and follow up on testing results. The Surgical CAHPS survey captures similar information, but with a focus on surgical care in both the inpatient and outpatient settings. Patients rate the quality of pre-and-post procedure information provided to them, the helpfulness of office staff, and communication with surgeons and anesthesiologists before and after the procedure. If CMS implements yet another survey relevant to ambulatory surgical patients, then patients would receive three separate but similar surveys for exactly the same care episode.

Given the content of the existing CG-CAHPS and Surgical CAHPS surveys, we do not believe an entirely new survey for ASCs and HOSDs is necessary. **Instead, we encourage CMS to develop a brief list of supplemental, optional survey questions that capture any facility issues related to ambulatory surgical care that could be added to one of the existing surveys.** Supplemental questions have been gradually added over time to several CAHPS surveys. For example, a three-item Care Transition Measure (CTM-3) was developed for the HCAHPS survey. It was endorsed by the National Quality Forum (NQF) and has been recently included for reporting in the hospital Inpatient Quality Reporting Program. Instead of taking an entirely new survey through the development and NQF review process, survey development efforts were targeted at addressing a limited, specific gap in a proven survey tool.

We believe this targeted development model would fit the needs of ASCs and HOSDs. The CG-CAHPS and Surgical CAHPS instruments have been reviewed and endorsed by the NQF and are in use by many organizations to assess the ambulatory care patient experience. Building off of

those proven instruments would be less costly and time consuming than developing a brand new, entirely separate survey. Moreover, we believe that using an existing survey tool would avoid unnecessary duplication of survey activities and result in less patient confusion about what part of their care is actually being assessed.

The AHA also believes that leveraging an existing CAHPS survey for ASCs and HOSDs would alleviate the substantial cost burden of administering surveys. While the CAHPS survey instruments are available free of charge, hospitals usually have to pay vendors to administer the surveys. Those vendors also provide hospitals with a performance report for internal use and facilitate data reporting to external agencies like CMS. Large hospitals and health systems often include an array of inpatient and outpatient services, each of which uses a different CAHPS survey tool. Typically, hospitals seek to obtain as much data as possible from these surveys. While this additional data adds rigor to patient experience performance improvement efforts, hospitals must pay vendors higher fees to obtain a larger sample of responses. The resources available for conducting all patient experience surveys within an organization are finite and usually come from a single budget. An additional, separate survey adds to the pressure on that budget making it even more challenging to balance the desire for additional data with the breadth of survey activity.

The burden of survey administration does not come from only the number of different surveys an organization uses, but also from CMS's survey administration protocols. **Thus, we also urge CMS to allow less expensive survey administration modes, such as emailed or web-based surveys, as an additional means of alleviating burden.** Hospitals are permitted to use only two survey administration modes – mailed surveys and telephone surveys. The cost of administering these surveys means that hospitals often cannot increase the sample size of their surveys to obtain more rigorous data about patient experience. Electronic survey distribution modes, such as email and web-based portals, make survey data collection and aggregation less expensive, and may allow hospitals to increase sample size without greatly increasing costs.

CAHPS SCORE ADJUSTMENTS FOR PATIENT SEVERITY OF ILLNESS

Regardless of the survey instrument or set of questions implemented for ASCs and HOSDs, CMS must ensure that survey performance scores are adequately adjusted for patient characteristics beyond the control of hospitals so that accurate, meaningful comparisons of measure results can be made. Accurate measure results are especially important as CAHPS survey performance becomes a greater part of federal quality reporting and payment programs.

Therefore, the AHA continues to urge CMS to reassess how it adjusts CAHPS survey scores for the severity of patient illness. As we previously noted with respect to the HCAHPS survey, emerging research suggests that patient characteristics may impact scores more than previously thought. For example, an analysis by the Cleveland Clinic has shown that as patients' severity of illness worsens, HCAHPS scores decline in a statistically significant manner. The same relationship was observed when the researchers examined the relationship between patients' symptoms of depression and responses to HCAHPS – as symptoms of depression worsened, HCAHPS scores declined. These findings indicate that hospitals that treat the most severely ill patients may have systematically lower scores. We believe this trend also may affect scores for other surveys in the CAHPS family. We encourage CMS to conduct an analysis that

assesses the extent of the issue, and identifies potential mechanisms for enhancing how CAHPS scores are adjusted for patient factors.

Thank you for the opportunity to comment. If you have questions, please contact me or Akin Demehin, AHA senior associate director for policy, at (202) 626-2365 or ademehin@aha.org.

Sincerely,

/s/

Ashley Thompson
Vice President and Deputy Director, Policy