

# Questions and Answers Regarding Hospital CAHPS (HCAHPS)

03/11//2004

**CMS, AHRQ and the CAHPS consortium have prepared these responses to questions that have emerged about the HCAHPS instrument, its development, testing and implementation. In developing HCAHPS, CMS and AHRQ are committed to the use of a transparent process, reliance on input from a variety of stakeholders and the use of data to the greatest extent possible to support all decisions. These practices will result in the most sensible and practical instrument possible to achieve the goals of disseminating valid and reliable information to consumers and assisting hospitals in their quality improvement efforts. These goals are at the heart of the National Voluntary Hospital Reporting Initiative, launched by the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, and supported by AHRQ and CMS and other organizations such as the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations, American Medical Association, Consumer-Purchaser Disclosure Project, AFL-CIO and AARP.**

## BACKGROUND

### **Q. What is the origin of HCAHPS?**

- A. Beginning in 1995, AHRQ and its grantees developed the Consumer Assessment of Health Plans Survey (CAHPS) to measure patients' experience of care in health plans. Key features of the CAHPS approach include: collaborative approach with the CAHPS team and with other organizations; development of reports of survey results in concert with the development of the questionnaire; inclusion of both reports and ratings of care; emphasis on testing and evaluation, including cognitive testing; reliance on user input; free and open access to standardized instruments; and technical assistance to users. CAHPS is currently used to assess the care provided by health plans covering over 123 million Americans across commercial, Medicaid and Medicare markets.

In 1999, AHRQ and its grantees began to expand the CAHPS effort to develop surveys to assess nursing homes, physician group practices, as well as for people with mobility impairments. At this time, AHRQ dropped the use of the 'Consumer Assessment of Health Plans Survey' title and now uses 'CAHPS' to identify this family of surveys.

The CAHPS approach is accepted as the standard for measuring consumers' experiences within the healthcare system. However, it had not addressed patient perspectives within the acute care setting. Thus, CMS partnered with the AHRQ to develop a hospital patients' perspectives on care instrument called HCAHPS.

**Q. How did AHRQ select the survey design team for HCAHPS?**

- A. The HCAHPS survey designers are members of the CAHPS II grantees from American Institutes for Research, RAND and the Harvard Medical School. These teams of researchers were awarded their grants through an open competitive process. Their experience includes extensive research into survey methods, in addition to vast practical experience in fielding surveys in a wide variety of health care settings. The members of the CAHPS team have developed a number of public domain surveys to evaluate several sectors of the healthcare systems as a consortium since 1995. In addition, these researchers have many years of experience in developing and implementing patient surveys prior to their involvement with CAHPS. Two of the CAHPS grantees – Susan Edgman-Levitan and Paul Cleary -- recused themselves from decisions about which measures should be included in the HCAHPS instrument due to their earlier involvement in the development of the Picker instrument that was sold to the National Research Corporation.

Other CAHPS products include surveys for health plans, medical groups, nursing homes, Medicare and Medicaid beneficiaries, disenrollment surveys, and ESRD services. The CAHPS health plan survey is considered the national standard for surveying health plans and is required by the National Committee for Quality Assurance for health plan accreditation.

**HCAHPS INSTRUMENT**

**Q. What are the similarities and differences among HCAHPS and patient surveys that hospitals currently use?**

- A. It is useful to think about the similarities and differences among HCAHPS and the patient surveys that hospitals are currently using in two areas: One relates to the purposes for which the surveys are used and the other to the domains that the surveys measure.

A detailed discussion follows, but in short:

- The surveys differ in that HCAHPS is designed to publicly report data to consumers, and vendor surveys are designed to report data internally to a hospital. The implications of these differences are elaborated on below.
- There is fair amount of overlap in the domains that the HCAHPS and vendor surveys measure.

**Purposes:**

HCAHPS and vendor surveys differ in terms of their purposes. The primary purpose of HCAHPS is to provide information to consumers about the quality of

care from the patients' perspective so that hospitals can be reliably compared. The purposes of the vendor surveys, as we understand them, are to provide hospitals with information to improve quality of care, contribute information for performance incentives, and gauge how well customers' expectations are being met.

To accomplish these purposes, survey designers have created three basic types of survey items. These are:

(1) Experience of care items such as:

How often did doctors explain things in a way that you could understand? (Never, Sometimes, Usually, Always)

(2) Rating items such as:

How well did doctors explain things in a way you could understand? (On a scale of 0-10 or a scale ranging from poor – excellent)

(3) Satisfaction items such as:

How satisfied were you with how well doctors explained things in a way you could understand? (Very dissatisfied to satisfied)

For the purposes that hospitals have been using vendor surveys, the satisfaction items and rating items have addressed their needs related to quality improvement and marketing. However, we know from extensive consumer testing that, for purposes of informing consumers, satisfaction items are limited in their usefulness. In addition, consumers have difficulty interpreting results from satisfaction items and they do not have the context of knowing what the level of expectation was for those who responded and in what way it may differ from their own expectations.

We chose to use experience of care items as a measure of the quality of care from the patient's perspective in combination with ratings of care.

### **Domains**

As early steps in the process of developing HCAHPS we conducted a literature review of hospitals patient surveys and had a call for measures, published in the Federal Register, asking those with existing surveys if they wished to offer their survey items as input to the HCAHPS questionnaire development process. We received seven sets of submissions, representing most of the major hospital survey vendors. A comparison of these surveys with one another and the resulting HCAHPS questionnaire shows differences, but there is also a fair amount of overlap among the surveys in terms of the domains covered.

Looking at questionnaires from these various sources it appears that nearly all of the questionnaire items fall in about 20 – 30 domains or categories of items. We chose to include eight of these domains in the HCAHPS questionnaire. These are:

- (1) Nurse Communication
- (2) Nursing Services
- (3) Doctor Communication
- (4) Physical Environment
- (5) Pain Control
- (6) Communication about medicines
- (7) Discharge Information
- (8) Overall rating of care/Recommendation of hospital to others

We chose these eight as HCAHPS domains for the following reasons:

- Focus groups indicated these particular domains were important to consumers
- Items in these domains performed well in our pilot test (i.e., were reliable and valid)
- They address areas CAHPS typically had dealt with previously, i.e., the personal aspects of health care delivery

Examples of domains we chose not to include are: billing, emergency room/department, emotional support, family, food, privacy, technical skills and convenience.

A content analysis of the items submitted by vendors and those in the current draft of HCAHPS indicates overlap between the domains represented in the items vendors' submitted and domains in HCAHPS. The degree of overlap ranges from 37.7% to 52.5%. Stated another way, when you compare the domains measured by HCAHPS with the domains measured by each of the vendor's questionnaires at a minimum, one-third of the items are in the same domains, and at a maximum, one-half are in the same domains. Therefore, we believe that vendors may be able to utilize some of the HCAHPS items to address issues covered by existing instruments. We are also interested in looking at how many of the items in vendor questionnaires submitted are not in domains covered by HCAHPS. The items in vendor questionnaires not covered by HCAHPS domains range from 14 -43.

We also compared the HCAHPS questionnaire with the vendors' surveys at the individual item level to determine what proportion of the items from each vendor questionnaire not only were in the same domain, but were similar in wording and influenced writing of the HCAHPS items. This measure requires greater similarity to be considered a match than the comparison of domains. This item by item comparison shows that between 9% and 15% of the items appearing on vendor questionnaires were close in content. No items were identical in wording primarily because HCAHPS uses the experience response set.

**Q. How did you arrive at the current version of HCAHPS?**

A. To develop the current version of the HCAHPS instrument, multiple strategies were employed: a call for measures; review of existing literature; cognitive interviews; testing of the draft instrument in a CMS three-state pilot in Arizona, Maryland, and New York; consumer focus groups; public input in response to Federal Register notices; and multiple opportunities for stakeholder input. The version of the questionnaire tested in the three-state pilot included 66 items. Based on the analysis of pilot data and other input received, the instrument has been reduced by half. The currently proposed version includes 24 core HCAHPS questions covering: “your care from nurses”, “your care from doctors”, “the hospital environment”, “your experiences in this hospital”, “when you left the hospital”, and an “overall rating of the hospital”. It also includes 8 additional items for adjusting for the mix of patients across hospitals and for analysis purposes.

The report describing the analyses from the three-state pilot can be found at [www.cms.hhs.gov/quality/hospital/3StatePilotAnalysisFinal.pdf](http://www.cms.hhs.gov/quality/hospital/3StatePilotAnalysisFinal.pdf).

A Federal Register notice was published on December 5, 2003 soliciting public comment on the revised version of HCAHPS along with the data collection protocol for national implementation. The sixty-day comment period ended early February 2004.

**Q. What is the empirical basis for the items that are included in HCAHPS?**

A. The HCAHPS survey was tested in the CMS Pilot Test with an overall sample of approximately 17,000 respondents. The best subset of items was selected based on extensive psychometric analyses including assessment of internal consistency and hospital-level reliability, factor analysis, item response theory and assessment of construct validity. Psychometric analyses from the test were used to help select items that should be included. In addition, the researchers reviewed the importance of the domains as reported by consumers in our qualitative research (e.g., patient focus groups) and the review of the literature. Researchers drew largely upon these sources of data. When the various data sources did not provide a clear cut choice, researchers used their experience and expertise in making consensus judgments about selection of items.

**Q. Why is it important to include more than just a few overall ratings of care questions on the HCAHPS survey?**

A. The current version of HCAHPS includes a combination of overall ratings questions and more detailed questions. Our research with consumers indicates that consumers want more detail about the specific components of care that are most important to them. Research on health plan CAHPS suggests that

consumers prefer the more detailed information over the overall ratings of care. We have conducted and will continue conducting research with consumers to find out what information is the most helpful to them in choosing a hospital. This research provides input into the selection and refinement of items in the survey.

**Q. What additional testing are you doing and what is the purpose?**

A. The AHRQ announced in the Federal Register on July 31, 2003, that it wished to offer the opportunity to conduct some additional testing of the survey. The issues that are being tested are:

- Impact of different modes of administration (telephone, mail and mixed).
- Effect of intervening stays in other facilities.
- Psychometric analyses to evaluate the equivalence of the English and the Spanish HCAHPS forms.
- Effect of length of time from discharge and completing the survey on HCAHPS scores.
- The co-variation of HCAHPS scores with clinical indicators of hospital performance.
- Further evaluation of HCAHPS psychometrically.

We also sought to study the processes for implementation of HCAHPS.

Topics include:

- How easily or readily can HCAHPS be integrated into a hospital’s existing sampling and survey operations.
- Sampling procedures that worked well or caused problems.
- Survey operations procedures that worked well or caused problems.

**Q. What steps did AHRQ and CMS follow in developing the HCAHPS survey?**

A. The HCAHPS development process includes several avenues for all the stakeholders involved to provide input. Below is a timeline that shows the development process:

	<u><b>Timeframe</b></u>
AHRQ publishes the call for measures in the Federal Register inviting all interested parties to submit survey instruments for consideration. Received 7 submissions from 9 organizations: Avatar, Edge Health Care Research, Healthcare Financial Management Association, Jackson Organization, Press Ganey Associates, National Research Corporation, Peace Health, Professional Research Consultants, and SSM Health Care.	July 2002
CAHPS II team reviews literature on patient assessment of hospital	Spt-Nov 2002

care related to survey content, sampling, data collection, and reporting.

AHRQ and CMS hold Webchat to answer questions about HCAHPS. Responses to Webchat posted on both CMS and AHRQ websites. Oct 2002

CAHPS II team provides CMS with draft domains for HCAHPS. Oct 2002

CAHPS II team reviews measures submitted in response to the call for measures, using standard criteria for reliability, validity, and breadth of use, ability to produce the type of data patients want to know, etc. Nov 2002

AHRQ and CMS hold Stakeholders Meeting at AHRQ. Participants include about 15 representatives from Federal government, Consumer groups, purchaser organizations, JCAHO, AHA, AAMC, AARP, and others. Purpose: Solicit suggestions and comments from a wide array of stakeholders on the content and implementation of the instrument. Nov 2002

CMS and AHRQ hold vendors meeting. About 20 survey vendors attended in person at CMS or by phone. Purpose: Solicit comments from vendors related to the questionnaire, sampling, data collection and analysis issues. Nov 2002

CAHPS II team delivers draft instrument to CMS for use in pilot test. Includes rationale for item and response option selection and administration instructions. Jan 2003

CAHPS instrument team: Jan-Feb 2003

- Continues conducting cognitive testing of questionnaire.
- Develops data collection and sampling methods.
- Develops analysis plan to evaluate the pilot test of the instrument, sampling and data collection strategies.
- Speaks with other sites that are willing to pilot test the draft instrument.

Federal Register Notice is published soliciting comments on the draft HCAHPS instrument for the CMS pilot. Feb 2003

CMS sends note to survey vendors announcing public comment period. Feb 2003

Hospital recruitment for pilot (through CMS Special Study) is completed. Mar 2003

Data collection begins for CMS 3-state pilot. June 2003

Federal Register Notice is published soliciting comments on draft HCAHPS survey and asking for input into implementation issues (60 day comment period).	June 2003
CAHPS II team analyzes data from CMS pilot.	Spt–Nov 2003
Review of instrument by CAHPS Cultural Comparability team.	Ongoing
Cognitive testing of Spanish version based on input from the Cultural Comparability team, feedback from the 3-state pilot test and input from HCAHPS Instrument team. Total of 12 interviews conducted.	Oct 2003
Six Consumer focus groups conducted in CA and MD to obtain consumer reaction to content and domains of HCAHPS Survey.	Oct 2003
HCAHPS Stakeholders’ Meeting at AHRQ. <u>Purpose:</u> To provide an update of the HCAHPS development process and to discuss implementation issues.	Nov 2003
CAHPS II team makes revisions to the HCAHPS instrument based on findings from the CMS 3-state pilot, consumer focus groups, and cognitive testing. Instrument contains 32 items—24 core items and 8 demographic items.	Nov 2003
Revised 32-items HCAHPS Instrument submitted to CMS.	Dec 2003
Sixty day public comment period on HCAHPS and implementation issues.	Dec ‘03- Feb ‘04
AHRQ conducts additional testing in 4 voluntary test sites.	Jan-May 2004

## NATIONAL IMPLEMENTATION

**Q. How will HCAHPS be implemented?**

**A.** The HCAHPS survey is intended to be part of the National Voluntary Hospital Reporting Initiative launched by AHA, FAH, and AAMC. This public/private partnership consists of the major hospital associations, governments, consumer groups, measurement and accrediting bodies, and other stakeholders interested in reporting on hospital quality. In the first phase of the project which is currently underway, hospitals are voluntarily reporting the results of their performance on

ten clinical quality measures for three medical conditions: acute myocardial infarction, heart failure, and pneumonia. It is expected that HCAHPS will comprise an additional and differently focused phase of quality of care measurement.

**Q. How will HCAHPS national implementation impact current hospital survey efforts?**

A. We anticipate that there will be multiple survey vendors, including the current survey vendors, who will be able to administer HCAHPS by following specific survey, sampling and administration specifications. HCAHPS can be seen as a core survey to which hospitals and survey vendors will be able to add a broader set of questions. HCAHPS is designed to gather only the necessary data that CMS needs for comparative public reporting and should complement, not replace, data that hospitals are currently collecting that support improvement in internal hospital customer services and related activities. Under the proposed design, hospitals/vendors can add up to 30 items of their choice to the end of the core HCAHPS questions. We expect that most hospitals will combine the HCAHPS module with items they currently use for internal improvement. However, hospitals have the flexibility to use the HCAHPS questionnaire as a stand-alone questionnaire if they want. We are currently reviewing comments from the December 5<sup>th</sup> Federal Register notice regarding the proposed design. There may be some changes to the implementation strategy to address the comments received.

**Q. Can the HCAHPS survey be combined with existing hospital surveys?**

A. The HCAHPS survey was designed to accommodate existing hospital patient surveys. With the current HCAHPS survey, hospitals could add up to 30 items and still be within the questionnaire length of the existing vendors' surveys. The only way to find out how well HCAHPS can be integrated with existing questionnaires is to conduct testing of an integrated questionnaire. In order to develop strategies for this approach, the CAHPS team has formally invited hospitals and vendors to work with us to test this approach and the survey administration process.

We are also initiating discussions directly with hospitals about issues that have been raised. Our goal is to develop practical, workable solutions in collaboration with hospitals and others who have an interest in using the HCAHPS data. Again, this is a very similar process to the one the CAHPS team used in the development and adoption process for the CAHPS plan surveys

**Q. Will hospitals need to switch from their current survey?**

- A. First, we are not asking anyone to switch surveys. We believe that the surveys currently in use and HCAHPS can be integrated into one. As indicated earlier, we are testing how to best integrate them. The primary purpose of HCAHPS is public reporting. In order to accomplish that objective, it is critical to have a uniform core set of items to make meaningful comparisons. Hospitals should continue to field items that provide additional information for their internal use, for example, for quality improvement purposes.

**Q. Will the survey be conducted using mail or telephone?**

- A. To accommodate the different modes used by hospitals/vendors in their current surveys, HCAHPS will allow flexibility in mode of survey administration. Hospitals/vendors will be able to choose among three different modes of administration: mail only, telephone only, and mixed mode. Thus, hospital/vendors that currently conduct their internal quality improvement surveys by mail can continue to do so, as can those who use telephone.

There is a recommended protocol within each mode of administration. For example, the recommended mail protocol calls for three waves of mailing. This is done to ensure adequate survey response. In our experience, one wave of mailing typically produces a 25%-35% response rate. We are proposing a 50% response rate for HCAHPS. To achieve this standard it has been our experience that three waves of mailing are required.

We will allow exceptions to the recommended mail, telephone, and mixed mode protocols, if the hospital/vendor can show that they can achieve the response rate standard. For example, if a hospital/vendor can show that they can achieve a 50% response rate with two mailings (rather than the recommended three mailings), they can use the reduced protocol.

Allowing different modes of survey administration can introduce bias in comparative reporting. Patient perspectives data collected through personal interaction (e.g., by telephone) often produces higher ratings on the average than data collected without personal interaction (e.g., by mail). To control for such effects, CMS will conduct a large-scale survey mode experiment, from which we will estimate the effects of mode of survey administration on HCAHPS scores. We will use the results of this study to adjust for mode effects in our HCAHPS estimates so that hospitals that use different modes of survey administration can be compared.

We are currently reviewing comments to the December 5<sup>th</sup> Federal Register notice. As a result of these comments, there may be some modifications to the current data collection strategy.

**Q. How will you handle trending issues?**

- A. Hospitals change vendors and surveys for a variety of reasons. When this occurs, vendors make adjustments and maintain trending data wherever possible. There is no difference between this normal business activity and the effort required to make adjustments where HCAHPS items differ from those of the surveys hospitals currently use.

Testing is currently underway that will answer a number of questions about trending, including how closely similar items from existing patient hospital surveys approximate those used in HCAHPS and what kinds of minor adjustments need to be made to maintain trending on the original, non HCAHPS items.

Vendors and hospitals have been invited to test their current items against the HCAHPS survey, allowing up to 40 of their current questions to be included in an administration of the survey.

The CAHPS team, NCQA, CMS and many sponsors of the CAHPS surveys for health plans have extensive experience in the resolution of such trending issues. The health plan CAHPS survey was tested against NCQA's instrument several years ago, and a convergence of the two instruments was completed, based on this testing. Similar work is now being undertaken with the Pacific Business Group on Health to harmonize versions of a patient experience instrument for assessment of individual providers and group practices. We are certain that the same kinds of processes can be employed to resolve trending issues with HCAHPS and other hospital surveys.

**Q. What will be the roles of hospitals/vendors and the government in the national implementation of HCAHPS?**

- A. There will be distinct roles for hospitals/vendors and the government in the national implementation of HCAHPS. Hospitals/vendors will be responsible for data collection, including: developing a sampling frame of relevant discharges, drawing the sample of discharges to be surveyed, collecting survey data from sampled discharges, and submitting HCAHPS data to CMS in a standard format. The government will be responsible for support and public reporting, including: providing technical assistance, ensuring the integrity of data collection, accumulating HCAHPS data from individual hospitals, producing case mix-adjusted hospital-level estimates, conducting research on the presentation of data for public reporting, and publicly reporting the comparative hospital data.

**Q. How much will the survey cost to administer?**

A. We do not have a final answer to that question, but we are collecting cost data during the additional testing that we are conducting.

**Q. How are concerns regarding the methodology for implementation going to be addressed?**

A. CMS is currently reviewing the public comments as a result of the December 5<sup>th</sup> Federal Register notice. AHRQ and CMS take very seriously the public comment process and will be addressing concerns raised regarding the current specifications for national implementation for HCAHPS. CMS is working with AHRQ to revise the current specifications. Since the validity and reliability of the data are critical when comparing hospitals for public reporting, CMS and AHRQ need to ensure that any modifications do not impact the ability to make reliable hospital-level comparisons. Additionally, AHRQ and CMS will be working with AHA to convene a group of hospitals to get their input into issues surrounding implementation.

**Q. Will the survey be conducted in languages other than English?**

A. Initially, the survey will be conducted in English and Spanish. Over time CMS will work with AHRQ to develop additional versions in different languages.

**Q. How will the HCAHPS data be reported?**

A. The HCAHPS data will be reported on CMS's [www.medicare.gov](http://www.medicare.gov) web site. The format of the reporting tool has not been determined. It likely will be fashioned after the tools for presenting comparative data in other health care sectors that are currently available on [www.medicare.gov](http://www.medicare.gov) (see Nursing Home Compare as an example). These tools present consumer-friendly descriptions of what the measure is, why it is important, and how to understand the data presented. The data (typically rates or percentages) for each provider identified by the user's search criteria are displayed in a horizontal bar graph, along with national and state averages.

AHRQ will conduct several rounds of research with consumers to identify the best way to describe the data in a clear, simple, and meaningful way.

**Q. Will hospital participation in HCAHPS be mandatory or voluntary?**

A. For now, and assuming that we see a very high degree of participation, this will be voluntary. When the HCAHPS instrument and survey administration protocol are finalized, we plan to include HCAHPS in a public/private collaboration on hospital measurement and reporting called, The National Voluntary Hospital

Reporting Initiative. This collaboration includes the major hospital associations, government, consumer groups, measurement and accrediting bodies, and other stakeholders interested in reporting on hospital quality.

**Q. What are the next steps for HCAHPS?**

- A. The first 60 day comment period for the revised survey and implementation procedures has just ended. This comment period is part of the OMB Paperwork Reduction Act process for national implementation of HCAHPS. CMS is in the process of reviewing all of the input received. AHRQ and CMS are working together to determine what changes need to be made in the instrument as well as the implementation procedures to address issues raised during the public comment period and input received from additional testing AHRQ is conducting.

In the development of the HCAHPS instrument, we conducted focus groups to obtain input into what is important from the perspective of consumers. We are planning to conduct additional focus groups over the next 3 to 4 weeks to build upon our current understanding of what is important from the consumer perspective. We will take into account this feedback as we make revisions to the instrument as a result of the public input. A second Federal Register notice will be published that includes the revised survey and implementation procedures; thus, there will be another opportunity for public input. Once the instrument is revised and all of the public input is received, OMB will review the instrument and implementation strategy. The instrument will not be finalized until OMB approves the instrument.

### **OTHER QUESTIONS**

**Q. Does submission of HCAHPS data to CMS impact the Medicare update for hospitals?**

- A. No. Hospitals that submit the initial 10 clinical measures related to heart attack, heart failure and pneumonia will get the full-inflation Medicare update in fiscal year 2005. Other hospitals that do not submit the clinical measures will get the full inflation minus 0.4 percentage points. The update is not tied to submission of HCAHPS data.

**Q. May I start using the instrument now?**

- A. Prior to national implementation, AHRQ is offering an opportunity for hospitals, vendors, and other interested parties to test the instrument. You must obtain permission from the Agency for Healthcare Research and Quality (AHRQ) to use the 32-item draft of the HCAHPS instrument prior to national implementation. In effect, this project provides an

occasion to test items that vendors and hospitals wish to add to HCAHPS as well as to evaluate the methods of data collection prior to reporting data for the Quality Initiative. To get more information about this opportunity, please see information on the CAHPS Survey Users Network web site at [www.cahps-sun.org](http://www.cahps-sun.org).

**Q. Will there be another public comment period through the Federal Register?**

A. Yes, a second Federal Register notice will be published once revisions are made to the current instrument and implementation strategy.

**Q. When were the opportunities for public input into the HCAHPS process and how can I provide comments?**

The HCAHPS process has been and will continue to be transparent. AHRQ and CMS actively sought input from the various stakeholders through a number of mechanisms such as public comment periods, public meetings or via letter, facsimile, or e-mail. The contact information for both AHRQ and CMS is provided below:

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The following table shows the forums available for public participation and the target audiences that each was directed to.

	<b>Audiences</b>					
	<b>Consumers</b>	<b>Purchasers</b>	<b>Hospitals</b>	<b>Vendors</b>	<b>Providers</b>	<b>Other*</b>
<b>Forums</b>				X		X
Call for Measures (Jul 2002)				X		X
Web chat (Oct 2002)	X	X	X	X	X	X
Stakeholder Meeting (Nov 2002)	X	X	X		X	X
Vendor Meeting (Nov 2002)				X		
CMS direct mailing-draft survey (Jan 2003)				X		
Public comment period (Feb 2003)	X	X	X	X	X	X
Open Door Forum (Mar 2003)			X	X		
Hospital Recruitment for Pilot (Mar 2003)			X			
Public comment period (Mar-May 2003)	X	X	X	X	X	X
Open Door Forum (Apr 2003)			X	X		
Open Door Forum (May 2003)			X	X		
Open Door Forum (June 2003)			X	X		
Public comment period (Jun-Aug 2003)	X	X	X	X	X	X
Request volunteers-additional testing (Jul 2003)			X	X		
Open Door Forum (Jul 2003)			X	X		
Open Door Forum (Aug 2003)			X	X		
Open Door Forum (Sept 2003)			X	X		
Focus groups-reaction to HCAHPS (Oct 2003)	X					
Open Door Forum (Oct 2003)			X	X		
Stakeholders Meeting (Nov 2003)	X	X	X		X	X
Open Door Forum (Nov 2003)			X	X		
Open Door Forum (Dec 2003)			X	X		
Public comment period (Dec 2003-Feb 2004)	X	X	X	X	X	X
Open Door Forum (Jan 2004)			X	X		
General test of HCAHPS opportunity (Jan 2004)			X	X		
Open Door Forum (Feb 2004)			X	X		

\* Category indicates researchers, quality improvement groups, accreditation bodies, etc.

**Q. How do the Institute of Medicine (IOM) dimensions compare to the HCAHPS dimensions as the survey evolved? Does the HCAHPS research either invalidate or validate the IOM dimensions?**

A. The dimensions used to guide the development of HCAHPS came from the Institute of Medicine (IOM). The dimensions in the revised version of HCAHPS overlap with the IOM dimensions. The HCAHPS survey development research neither invalidates nor validates the IOM dimensions; nor was it intended to.

The Centers for Medicare and Medicaid Services (CMS) asked the Agency for Healthcare Research and Quality (AHRQ) to develop a hospital patient survey, the results of which could be reported publicly to assist consumers in making choices among hospitals.

AHRQ, through its cooperative agreements with the CAHPS II consortia (a large group of experts in assessing patient care), implemented the development of HCAHPS. The CAHPS II consortia thought it was important to have a conceptual framework to guide the development process. Although several authors have proposed frameworks for assessing patient experiences, the consortia decided to use the dimensions of patient-centered care enumerated in the (IOM) report, Crossing the Quality Chasm, because of the rigorous process the IOM uses in developing its products.

The IOM is part of the National Academies of Science. IOM is widely regarded as one of the most independent and prestigious sources of information and evaluation for U.S. health care issues. The IOM has an elaborate process for reviewing and synthesizing the best available scientific evidence and writing reports that are meant to advise congress about pressing scientific issues. Typically, committees meet for more than a year and have members from throughout the country from various disciplines.

As part of their work in developing the conceptual framework and dimensions presented in the Chasm report, the IOM committee reviewed hundreds of articles and studies and interviewed experts throughout the country to develop their recommendations. CAHPS consortia members carefully reviewed the conceptual framework and dimensions proposed, concluded they were the best and most appropriate ones available, and decided to use them to guide the CAHPS work.<sup>1</sup>

The dimensions that the IOM specified are: respect for patients' values, preferences and expressed needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support; and involvement of family and friends. This framework was used to guide the CAHPS literature review, review of existing instruments, and develop initial items. It is important to note that

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<sup>1</sup> None of the members of the CAHPS consortia was a member of the committee that produced the Crossing the Quality Chasm Report.

the consortia was not limited by, but rather, was guided by, IOM's framework. Thus, some questions were selected for testing even though they did not fit neatly into the framework.

There have been efforts outside of the CAHPS consortia to create the perception that the CAHPS consortia completely rejected the IOM framework and dimensions. That is not the case. Rather, the IOM framework and dimensions were used as a starting point to further guide research in the development of HCAHPS.

The CAHPS Team conducted numerous psychometric analyses of the data from the CMS 3-state pilot study. These analyses included exploratory factor analyses used to indicate patterns of associations. Our factor analyses revealed that many items representing the same dimensions were often associated with one another precisely as we had hypothesized, but others were not.

The pilot study results in no way negate or reflect negatively on the conceptual framework and dimensions proposed by the IOM. Nor do they indicate that the HCAHPS draft items were not good and useful items. The exploratory factor analyses simply suggest that when analyzing patterns of variability among items, the most efficient statistical way of summarizing that variability might be to combine items differently than we had thought a priori. A rigorous scientific process was used to develop and select all items in the pilot instrument and subsequent revision. The process and the criteria for developing and selecting items are set forth clearly in the report of the pilot study.

The HCAHPS dimensions that resulted from the analyses are called: nurse communication; nursing services; doctor communication; physical environment; pain control; communication about medicines and discharge information. There is overlap in the IOM and HCAHPS dimensions, (e.g., information, communication and physical comfort/environment, and respect-- included in our communication dimension-- are common), but they are not identical.

In addition, because of the patterns of association among the items we developed, we decided to use slightly different terms to connote our dimensions than those that were used by the IOM. Such naming conventions are somewhat arbitrary. We could have stayed with the titles of the IOM dimensions, but thought that slightly different terms would be more descriptive.

The CAHPS Team members, and indeed all survey developers, have constraints on the number of questions that can be included in a survey. Thus, an efficient instrument might not cover all the dimensions proposed by the IOM or cover them equally, due to practical constraints.

In sum, our analyses do not invalidate the IOM framework or dimensions. Nor do they reflect negatively in any way on any existing surveys or the dimensions those

surveys employ. Other surveys cover very similar dimensions, but use different titles to describe them. The consortia, and indeed many experts in health care, health care quality, and quality improvement throughout the country think the IOM framework is the most complete and useful framework currently available. The CAHPS work is consistent with the IOM framework but because of practical constraints we did not explicitly try to cover all of the dimensions equally.