REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-17

Subject: Hospital Surveys and Health Care Disparities

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

At the American Medical Association's (AMA) 2016 Interim Meeting, the House of Delegates adopted Policy D-450.954, "A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities," which asked the AMA to study the impact of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) on Medicare payments to hospitals serving vulnerable populations and on potential health care disparities.

The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2017 Interim Meeting. This report provides background on the purpose and use of HCAHPS surveys and the role of safety net hospitals, explains the intersection of HCAHPS scores and safety net hospitals, explores how cultural competency influences patient satisfaction and HCAHPS scores, and outlines relevant legislation. The Council recommends policy to help shield safety net hospitals from the potentially negative financial impact that hospital quality program assessments may have on hospitals that serve a disproportionate share of patients with social risk factors and policy to recognize the importance of cultural competency in patient experience and treatment plan adherence.

BACKGROUND

The HCAHPS survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS has three goals.[1] First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to patients. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting of survey results serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

HCAHPS survey scores over a three-year period influence a portion of each hospital's value-based purchasing (VBP) incentive payment. The VBP adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care delivered. The VBP adjusts Medicare's payment rate to hospitals based on a set of defined process, outcome, and experience of care measures. The measures are represented in four different areas: Clinical Care (Process and Outcomes), Patient Experience of Care (HCAHPS), Efficiency, and Safety. As noted, the patient experience of care measure is based off of HCAHPS.

Safety net hospitals play a critical role in providing health care to vulnerable populations, and it is important to ensure that efforts to improve quality of care do not exacerbate existing health care disparities. Generally, safety net hospitals are financially stressed because they are chronically underfunded and payments are low. Because of these financial constraints, safety net hospitals may have fewer nurses and are more likely to be older buildings, which are factors largely beyond the hospital's immediate control.[2]

Safety net hospitals serve many patients without the ability to pay and generally have sicker patients and a more complex patient case mix than traditional hospitals.[3] Therefore, many safety net patients have conditions that require additional resources such as social work and behavioral health care; however, the hospitals often do not have the resources to devote to these services or the financial means to provide amenities that positively affect patient satisfaction.[4]

HCAHPS SCORES AND SAFETY NET HOSPITALS

According to one recent study published in the *Archives of Internal Medicine*, hospitals that serve a disproportionate share of low-income and Medicaid patients generally scored lower than other hospitals on the HCAHPS patient experience care survey and were 60 percent less likely to meet HCAHPS performance benchmarks under the Medicare VBP program.[5] Researchers compared HCAHPS performance and improvement for safety net hospitals with other hospitals from 2007 to 2010. While scores for both groups of hospitals improved over the four year period, the performance gap between them increased. Overall, 769 hospitals that treat the largest share of low-income patients scored 5.6 percentage points lower than their 2,327 non-safety net counterparts. It is worth noting that the HCAHPS survey is only available in six languages and therefore prohibits some patients from participating.[6]

The authors of the study surmised two explanations for the disparity between the two hospital groups. One explanation was that patients in safety net hospitals have different expectations than patients in other hospitals. The other explanation was that safety net hospitals have not done as good of a job focusing on the patient issues reflected in the survey.

Safety net hospitals have pointed out that they are at a disadvantage and that their scores should be adjusted to take into consideration the diverse case mix, poverty, language barriers, and cultural issues specific to safety net hospitals. They state that the Centers for Medicare & Medicaid Services (CMS) should design incentive programs that reward safety net hospitals prior to implementing financial penalties.

HCAHPS SCORES AND CULTURAL COMPENTENCY

Communication measures account for 50 percent of the HCAHPS patient experience index. As previously stated, patient characteristics such as race, ethnicity, and language preference may impact the perception of care provided.[7] Language and communication barriers may lead to patient dissatisfaction and poor comprehension and treatment adherence.[8] Patients and families who are non-white, speak a language other than English, and are on Medicaid report lower experience scores than those commercially insured, white, and English-speaking patients and families.[9] Therefore, demographic and cultural differences seem to be important considerations in improving communication.

The National Quality Forum (NQF) has defined cultural competency as the "ongoing capacity of health care systems, organizations, and professionals to provide for diverse patient

populations high-quality care that is safe, patient and family centered, evidence based, and equitable."[10] Cultural competency has been promoted as a strategy to enhance patient satisfaction and improve organizational performance.[11]
Patient centered care has been an ongoing focus of the health care community to facilitate quality improvement.[12] It follows that taking into account demographics and culture is necessary for aligning hospital services and patient preferences. For example, a study of California hospitals found that hospitals with greater cultural competency have better scores for doctor and nurse communication, staff responsiveness, hospital rating, and hospital recommendation.[13]

RELEVANT LEGISLATION AND REGULATORY ACTIVITY

Recent legislation has addressed how to account for social risk factors in Medicare payment. The 21st Century Cures Act requires Medicare to account for a patient's background when calculating reductions in payments to hospitals under the Hospital Readmissions Reduction Program.[14] In addition, the Hospital Inpatient Prospective Payment Systems (IPPS) rule requested feedback on how to account for social risk factors in the Inpatient Quality Reporting program. Also, in response to the IMPACT Act, the Assistant Secretary for Planning and Evaluation (ASPE) sponsored a committee of the National Academies of Sciences, Engineering and Medicine to specify criteria that could be used in determining which socioeconomic status factors should be accounted for in Medicare quality and payment systems. The committee released its report in December 2016.[15] Additionally, at the direction of the Department of Health and Human Services, the National Academy of Medicine (NAM) released a report on how social risk factors may influence health care use, outcomes, and costs in Medicare payment and quality programs.[16] Importantly, both the ASPE and NAM activities found that existing data sources used to capture social risk factors are insufficient for the purposes of developing better risk adjustment methodologies.

RELEVANT AMA ACTIVITY AND POLICY

Policy H-450.946 states that the AMA will advocate for effective quality management programs that incorporate substantial input by actively practicing physicians and physician organizations.

Policy H-450.966 states that the AMA will seek an active role in any efforts to develop national medical quality and performance standards and measures; emphasize the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; and advocate that principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts, including that standards and measures shall have demonstrated validity and reliability, shall reflect current professional knowledge and available medical technologies, shall be linked to health outcomes and/or access to care, shall be representative of the range of health care services commonly provided by those being measured, shall account for the range of settings and practitioners involved in health care delivery, shall recognize the informational needs of patients and physicians, shall recognize variations in the local and regional health care needs of different patient populations, shall recognize the importance and implications of patient choice and preference, and shall recognize and adjust for factors that are not within the direct control of those being measured.

The AMA has numerous policies on the appropriate use of patient satisfaction surveys. Policy D-450.960 directs the AMA to urge CMS to modify the HCAHPS scoring system so that it assigns a unique value for each rating option available to patients. Policy H-450.982 states that efforts should be continued to improve the measurement of patient satisfaction and to document its relationship to favorable outcomes and other accepted criteria of high quality care. Additionally, Policy D-385.958 directs the AMA to work with CMS and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment and to ensure that physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. Similarly, Policy H-406.991 states that patient satisfaction surveys should be used to help improve patient care and not be used for the purpose of determining physician payment.

Consistent with the AMA's continued efforts to refine risk adjustment, Policy H-155.957 encourages further study into the possible causes of geographic variation in health care delivery and spending, with particular attention to risk adjustment methodologies and the effects of demographic factors, differences in access to care, medical liability concerns, and insurance coverage options on demand for and delivery of health care services.

Policy H-295.897 promotes cultural competency training with the goal of emphasizing cultural competence as part of professional practice and encourages training opportunities for students and residents to learn cultural competency from community health workers.

In accordance with these policies, the AMA has advocated extensively for improvements to HCAHPS. The AMA always includes a section on improvements to HCAHPS in comments related to the Medicare physician fee schedule. The AMA successfully lobbied CMS to propose removing the pain questions from HCAHPS and clarifying that HCAHPS is a hospital level survey and that it is not appropriate to tie physician compensation or measure physicians based on HCAHPS scores.

Specifically, in the AMA's recent comments on the IPPS Proposed Rule, the AMA advocated for continued refinements to HCAHPS and refinements to the risk adjustment methodology used in program measurements. Further, the AMA advocated for CMS' consideration of measuring and accounting for social risk factors in Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs noting that the AMA continues to believe that in order to ensure the quality of care furnished by physicians and hospitals is assessed as fairly as possible, social risk factors must be taken into account.

DISCUSSION

Safety net hospitals play a critical role in providing needed health care to vulnerable populations. These hospitals provide a necessary function and often have more challenging patient populations and fewer resources to devote to patient care when compared to non-safety net hospitals. While patient satisfaction scores may provide an incentive for hospitals to devote more resources to the measure, safety net hospitals generally do not have the funding to do so. Although the Council believes that the goal of such patient satisfaction surveys should be to identify areas to improve patient outcomes and quality of care, the AMA must guard against efforts aimed at improving the quality of care that have the unintentional effect of stripping safety net hospitals of needed funding and thereby exacerbating health care disparities. Tying financial incentives to HCAHPS patient satisfaction scores may have the effect of financially penalizing such hospitals and unintentionally exacerbating existing inequalities in care.[17]

Further, numerous studies have found that patient satisfaction is not necessarily an objective measure of quality. In a nationally representative sample, higher patient satisfaction was associated with lower emergency department use but with greater use of inpatient care, higher overall health care and prescription drug expenditures, and increased mortality.[18] Therefore, the limitations of patient experience surveys should be recognized. Additionally, the Council notes that, at times, a statistically minimal number of surveys may have a material effect on overall scores. To that end, the Council recommends reaffirming numerous policies emphasizing that such quality assessments should adjust for factors outside of the physician's control and recognizing variation in different patient populations, policy stating that patient satisfaction surveys should not be a determinative measure of physician quality for payment purposes, and policy advocating for the continuation of efforts to improve patient satisfaction measurement.

Socioeconomic factors such as age, income, educational level, ethnicity and others have been identified as having a role in not only health care preferences but also health care outcomes. Such factors may present obstacles to successful outcomes and can widen health care disparities. Recognizing socioeconomic factors and focusing on cultural competency in care delivery may reduce racial and ethnic health care disparities and positively contribute to quality improvement. Therefore, the Council believes it is important not only to guard against patient satisfaction surveys unintentionally depriving safety net hospitals of needed funding but also to focus on ways to improve the patient experience. Accordingly, the Council recommends continuing to advocate for improved risk models that account for social risk factors in hospital quality program assessments. The Council notes that excluding a specific mention of HCAHPS from the recommendation and instead mentioning "hospital quality program assessments" makes the policy inclusive of the numerous hospital quality programs, including HCAHPS. Further, the Council recommends reaffirming policy promoting cultural competency training and recommends new policy recognizing the importance of cultural competency to patient experience and encouraging the implementation of such practices across health care settings.

While it may be difficult to determine whether patient satisfaction scores are a result of physician performance or demands and restrictions outside of the physician's control, the Council believes valuable information can be gleaned from patient surveys. There is evidence supporting the premise that when patients better understand treatment plans, they are more likely to adhere to recommendations and return for follow up care in the future.[19] The Joint Commission, which pools together best practices for HCAHPS scores, notes that positive patient perception of care may improve patient safety and staff retention. Additionally, patient experience of care quality and patient satisfaction are tied to the Triple Aim. Although experience may not necessarily be an indicator of quality, it is important for patient's perceptions of care to be positive. These perceptions reflect the physician-patient relationship and support patient retention and shared decision-making.

The Council believes improving the patient experience is a shared goal in health care. It also believes that ensuring the financial viability of safety net hospitals is vital to providing care to the most vulnerable and fighting to reduce health care disparities. Therefore, the Council recommends continuing to work with CMS and others, including America's Essential Hospitals, to address issues related to hospital quality program assessments.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-450.966 emphasizing that national medical quality and performance standards and measures should adjust for factors that are not within the direct control of those being measured and should recognize the variations in needs of different patient populations. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-385.958, which calls for the AMA to work with Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, should not be used as a determinative measure of physician quality for the purpose of physician payment and to ensure that physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-450.982 stating that efforts should be continued to improve the measurement of patient satisfaction and to document its relationship to favorable outcomes and other accepted criteria of high quality. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-295.897 promoting cultural competency training with the goal of emphasizing cultural competence as part of professional practice. (Reaffirm HOD Policy)

5. That our AMA support that the goal of hospital quality program assessments should be to identify areas to improve patient outcomes and quality of patient care. (New HOD Policy)

6. That our AMA recognize the importance of cultural competency to patient experience and treatment plan adherence and encourage the implementation of cultural competency practices across health care settings. (New HOD Policy)

7. That our AMA support that hospital quality program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and exacerbating health care disparities. (New HOD Policy)

8. That our AMA continue to advocate for better risk models that account for social risk factors in hospital quality program assessments. (New HOD Policy)

9. That our AMA continue to work with CMS and other stakeholders, including representatives of America's Essential Hospitals, to address issues related to hospital quality program assessments. (New HOD Policy)

10. That our AMA oppose hospital quality program assessments that have the effect of financially penalizing physicians, including those practicing in safety net hospitals. (New HOD Policy)

11. That our AMA rescind Policy D-450.954. (Rescind HOD Policy)

Fiscal Note: Less than $500.

REFERENCES

[1] Hospital Consumer Assessment of Healthcare Providers and Systems. Available at: http://www.hcahpsonline.org/home.aspx

[2] Paula Chatterjee, MPH; Karen E. Joynt, MD, MPH; E. John Orav, PhD; et al. Patient Experience in Safety-Net Hospitals. Journal of the American Medical Association. September 2012. Available at: http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1217207
[3] Cheryl Clark. Low HCAHPS Scores at Safety Net Hospitals Examined. Health Media Leaders. July 2012. Available at: http://www.healthleadersmedia.com/leadership/low-hcahps-scores-safety-net-hospitals-examined?page=0%2C4
[4] In Focus: Innovating Care Delivery in the Safety Net. The Commonwealth Fund. January 2015. Available at: http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/december-2014-january-2015/in-focus
[5]Paula Chatterjee, MPH, *supra* note 2.
[6] Hospital Consumer Assessment of Healthcare Providers and Systems. Survey Instruments. Available at: http://www.hcahpsonline.org/surveyinstrument.aspx
[7] Is Hospital Cultural Competency Associated with Better HCAHPS Scores? American Hospital Association. Available at: http://www.hpoe.org/resources/webinars/1367
[8] Cultural Competence in Health Care: Is It Important for People with Chronic Conditions? Georgetown University Health Policy Institute. February 2004. Available at: https://hpi.georgetown.edu/agingsociety/pubhtml/cultural/cultural.html
[9] Boris Kalanj. Cultural Diversity and the Patient Experience. Hospital Quality Institute. June 2014. Available at: https://www.nhfca.org/psf/Materials3/6-10-14/hasc_psf_keynote_june_10_2014[1].pdf
[10] Call for Measures: Healthcare Disparities and Cultural Competency Consensus Standards. National Quality Forum. October 2011. Available at: http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=68892
[11] Weech-Maldonado, Robert MBA, PhD; Elliott, Marc PhD; Pradhan, Rohit PhD; Schiller, Cameron MS; Hall, Allyson PhD; Hays, Ron D. PhD. Can Hospital Cultural Competency Reduce Disparities in Patient Experiences With Care? Medical Care Office Journal of the Medical Care Section, American Public Health Association. November 2012. Available at: http://journals.lww.com/lww-medicalcare/Fulltext/2012/11001/Can_Hospital_Cultural_Competency_Reduce.10.aspx
[12] The Relevance of Unconscious Bias in Cultural Competency. America's Essential Hospitals. May 2013. Available at: https://essentialhospitals.org/webinar/the-relevance-of-unconscious-bias-in-cultural-competency/
[13] Weech-Maldonado, *supra* note 11.
[14] Steven Ross Johnson. Will the 21st Century Cures Act Level the Playing Field on Hospital Readmissions? Modern Healthcare. December 2016. Available at: http://www.modernhealthcare.com/article/20161213/NEWS/161209902
[15] Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs. Office of the Assistant Secretary for Planning and Evaluation. December 2016. Available at: https://aspe.hhs.gov/pdf-report/report-congress-social-risk-factors-and-performance-under-medicares-value-based-purchasing-programs
[16] Maryellen Guinan. NAM Releases Final Report on Social Risk Factors and Medicare Payment. America's Essential Hospitals. January 2017. Available at: https://essentialhospitals.org/quality/nam-releases-final-report-on-social-risk-factors-and-medicare-payment/
[17] Shivan J. Mehta, MD, MBA. Patient Satisfaction Reporting and Its Implications for Patient Care. AMA Journal of Ethics. July 2015. Available at: http://journalofethics.ama-assn.org/2015/07/ecas3-1507.html
[18] Joshua J. Fenton, MD, MPH; Anthony F. Jerant, MD; Klea D. Bertakis, MD, MPH. The Cost of Satisfaction: A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality. Journal of the American Medical Association. March 2012. Available at: http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1108766
[19] Quyen Ngo-Metzger, Joseph Telfair, Dara H. Sorkin, Beverly Weidmer, Robert Weech-Maldonado, Margarita Hurtado, and Ron D. Hays. Cultural Competency and Quality of Care: Obtaining the Patient's Perspective. The Commonwealth Fund. October 2006. Available at: http://www.commonwealthfund.org/usr_doc/Ngo-Metzger_cultcompqualitycareobtainpatientperspect_963.pdf