NATIONAL QUALITY FORUM

Moderator: Nicole McElveen
March 16, 2012
1:00 pm CT

Operator: Good day everyone and welcome to today's Healthcare Disparities conference. Just as a reminder, today's call is being recorded.

At this time, I would like to turn the conference over to our host for today, Ms. Nicole McElveen, please go ahead ma'am.

Nicole McElveen: Hi everyone. This is Nicole from HUS. Thank you for so much for joining us for our call today. This is the Healthcare Disparities and Cultural Competencies Steering Committee conference call, just so you're aware if you dialed-in. As traditional with most of our conference calls, we do also have the webinar platform that has a few slides that I'll be projecting as we talk through the measure.

So feel free to join Webinar if you do have the capabilities. If not, you can very easily follow along with the material that was sent to committee last week. So what we circulated to the group in preparation for this call was the preliminary reviews of the measure. So the entire committee was invited to review the measure in-depth and provide their ratings and rationale.

And so the summary from that output has been provided to the group along with some supporting documents around our discussion for related and competing measures. We will be discussing

some of the other two measures that have been recommended for endorsement that also address cultural competency a little bit later on in the call.

So our goal then for today's call specifically will be to evaluate the cultural competency implementation measure against the NQF evaluation criteria. And then as I mentioned, we'll also discuss any related measures that are also focused on cultural competency.

The format for this call will be similar to the discussion format that we had during the input meeting. So the measure developer which is (Rand) is here on the call with us and will first provide a brief introduction to the measure. And she will be available throughout the duration of the call for any questions that the committee may have during the discussion process.

For this measure, again, the entire committee was invited to do the preliminary review and ratings. Since we haven't selected a lead discussant, we're just expecting the group to sort of jump in with comments or if someone wants to volunteer when we get to that point to lead us off, that would be great.

One thing that will be different is we will not vote on this measure during the conference call. What will happen is immediately following the call, I will send out a link to an online survey that will allow the committee to provide their vote for the criteria as well as your vote on overall recommendation for endorsement.

And finally, just so the group is aware, our co-chairs, (Dennis and Denise) both unfortunately were not available for the call today. But Dr. Kevin Fiscella has willingly accepted the temporary assignment of co-chair for the day. So he will be assisting to moderate the discussion throughout the call when we go through the measure.

Were there any quick comments or questions?

Female: We know your time is valuable and we appreciate your patience.

Male: Nicole, the web link is in the materials you sent out, right, for those who want to...

Nicole McElveen: Yes, that's correct.

Male: At the bottom of the page.

Nicole McElveen: That link can be found in the agenda. And it was also provided in the email that I sent out to the committee last week.

Male: At the very bottom.

Nicole McElveen: So again, briefly, what I wanted to do was also just provide a quick overview of our evaluations criteria. You know, this is probably very fresh in many people's minds. But for those who were not at the meeting, I just want to review this again.

Again, on this slide, you can see that those four major criteria shown in hierarchy. The first being importance to measure and report. One of the key components that you'll talk through under importance is the evidence to support the measure focus. And the importance criteria is a must-pass criteria.

The second is scientific acceptability of the measure properties. This is where the committee will consider the testing around reliability and validity. Next is usability. So this is focusing on how useful the measure is for the intended audiences that it has been designed for. And finally feasibility which looks more at aspects related to implementation of the measure.

And I just want to mention to those on the phone, if you're not speaking, if you could place your line on mute. We just had a little bit of static coming through.

And finally before we begin the discussion of the measure, the committee should be aware that this measure that we're going to be discussing today it was derived from the NQF endorsed cultural competency preferred processes. This set of processes was reviewed by our previous NQF steering committee and that group evaluated and recommended these set of processes based on evidence, scientific acceptability, usability and feasibility. And subsequently they were endorsed.

For this measure, there were 13 of those 45 endorsed processes that were used to comprise the (Rand) measure. The selection of those 13 processes was done by an NQF expert panel convened specifically for that purpose. We recognize there may be some specific questions about the processes.

But because of the conflicts since those processes are an NQF English products. We feel it would be best to limit our comments during the discussion, other than the statement that was just made. And just again, just so you know that the practices are NQF endorsed and have been included the measure. The ((inaudible)) discussion should really focus on the measure itself as it's been constructed, tested and presented in the submission form.

So I will now turn it over to Kevin who will be leading the discussion. Just as we did for the in-person meetings, we have the ratings, the preliminary ratings, around the criteria shown on the screen here. And you can obviously refer to the summary document that provides a little more verbiage around different comments from committee members who reviewed the measure previously during the discussion.

So Kevin, I'll turn it over to you to lead us off and get the ball rolling.

Dr. Kevin Fiscella: Thanks Nicole. So why don't we just go through the ratings that were sent out and start out with the first one which was importance to measure and report.

Beverly Weidmer: I'm sorry, this is Beverly with Rand; can I interject for just a minute?

Dr. Kevin Fiscella: Sure.

Beverly Weidmer: Nicole, I don't know if you still want me to provide a five minute overview of the measure?

Nicole McElveen: Yes, absolutely. I'm so sorry, Beverly, I didn't mean to skip you.

Beverly Weidmer: Oh sorry and I apologize, Kevin for interrupting.

Dr. Kevin Fiscella: No, I appreciate it.

Beverly Weidmer: So this is Beverly Weidmer from the Rand Corporation. And we were the lead in developing this survey measure. And in brief, I'm going to provide you with an overview for the process for developing and testing the measure.

So as Nicole mentioned, we developed this survey measure to closely align with the cultural competency framework and preferred processes that are included in the NQF report on preferred practices for measuring and reporting on cultural competency. And that document along with recommendations made by the NQF expert panel were the foundation for the development of the survey measure as Nicole explained.

The primary goal of the survey measure is to assist healthcare organizations in identifying the degree to which they're providing culturally competent care and addressing the needs of diverse populations as well as their adherence to 12 of the 45 NQF endorsed cultural competency practices prioritized for the survey. As Nicole mentioned, 13 of those were indentified by an expert panel in the process of testing.

In consultation with NQF, we agreed to drop one of the practices from the survey. And so the survey itself focuses on 12 of the 45 practices that were endorsed NQF. In developing the survey, we not only reviewed the practices in detail and looked at existing measures that are out in the public domain that we could consult and perhaps adapt. But we also conducted two rounds of cognitive testing with healthcare organizations to try to understand how they are understanding the measures.

And to make sure that the measures are, you know, easily understandable as well as valid in terms of we collected extensive information on the types of things that they do and how they really constructed their responses to each of the survey measures. So we conducted two rounds of cognitive testing. We also sough input from the same expert panel that identified and prioritized the measures to include in the survey on the survey measure itself.

They provided us feedback. And based on that feedback, we made significant revisions to the survey. And then finally, the main testing process was to conduct a web-based field test of the survey measure that included 269 different organizations.

One of the main goals in developing the survey measure was to understand and test whether the survey measure can actually be used across healthcare setting as well, of course, to understand whether organizations understand the measures in the same way, whether it can be administered without the assistance of an interviewer.

Whether the information that's collected from the survey is actionable, is not subject to varied interpretation. And also, you know, to assess the degree of burden on organizations that complete the survey. So the field test was conducted in the fall of 2011. Again, it was a web-based field test in which we survey 269 different organizations that included hospitals, dialysis centers, federal-qualified health centers, health plans, and integrated health systems.

The field test was successful in that we were able to collect enough information to conduct the psychometric analyses that we wanted to conduct to evaluate the measure. But admittedly we did only achieve a fairly low response rate of 18%.

Let me think, what else can I tell you about the survey measure? Let's see. Following the field test, we did provide the participating organizations their score. The scores, we looked at them to ensure there were no ceiling effects. And we did find that the max score was 97.5 on the, you know, total survey score.

The minimum score was 17.2, the mean score was 65, and the median score was 68.5. So there were, you know, a range of scores across the, you know, 50 or so organizations that actually completed the survey. And we were pleased to see that, you know, overall there weren't overly high scores to the survey indicating, you know, kind of ceiling effect.

And I think I'm passed my five minutes. So I'm going to stop here. And Kevin, I'll let you go on and I'll answer any questions that the committee has as the discussion progresses.

Dr. Kevin Fiscella: Well thank you Beverly. I think that's very helpful. So why don't we walk through the or go through the different categories and just organize the questions based on those. You know, we have a limited amount of time here.

Beginning with the first section, if it's okay with you, Beverly, you have the scoring sheet in front of you, don't you?

Beverly Weidmer: I do have it in front of me, thank you.

Dr. Kevin Fiscella: So there were a number of comments about importance to measure and report here that were brought up so I'll open it up to the committee for people who want to pose those questions now.

(Lou): Kevin, this is (Lou). I'm actually in my car. Right now, I'm going to end up actually in my office fairly shortly. But it might be helpful if you maybe review some of those comments.

Dr. Kevin Fiscella: Sure.

(Lou): I really can't see them right now, thank you.

Dr. Kevin Fiscella: So there was, in terms of importance, there was eight yeses and two nos. Similarly for impact, ten rated it highly. Some of the comments related to links between the questionnaire under consideration and differences in processes or outcomes of care.

There was also a question perhaps you could address Beverly is that is how great the variability was and if this variability was believed to be clinically relevant and how one might even think about that question.

Beverly Weidmer: So variability in terms of...

Dr. Kevin Fiscella: Yes in terms of responses between these different groups, the scores by the organizations who were responding.

Beverly Weidmer: There was variability in the responses as I mentioned, both in the overall survey score as well as in, we provided individual scores for each of the preferred practices. And there was, you know, quite a bit of variability.

However, I don't know that we have enough data to make a statement about whether the variability can be linked to outcomes. Admittedly again, the field test was a relatively small field test. And we were not able to obtain sufficient numbers of completed surveys by type of healthcare organization to be able to look at that adequately. I don't know if that answers your question.

Dr. Kevin Fiscella: Yes, I think it does; so questions from the committee on the first section here. So let's go on hearing none, to the second part where there was a little more divergence of opinion. So I think, you know, reading through this, it sounds like there was a consensus that this is important and potentially impactful even though the evidence is at this point indirect.

So going onto the second criteria, scientific acceptability of the measure based on decision logic. So here the committee was split with five yeses and six nos. And similarly in terms of reliability, three highs, three mediums, two lows. And with validity, one high, five mediums, two lows and looks like one insufficient, or four insufficient, I'm sorry.

So again, let's open it up to the thoughts that people have in terms of this issue, scientific acceptability.

Ed Havranek: Yes, this Ed Havranek from Denver. I'm really concerned here. I mean 18% is a very poor response rate. And going beyond that 18%, the response rate was not uniform across the types of organizations. I think, if I'm remembering this correctly from when I reviewed this last week, more than half came from FQHCs which is half the responses.

And very few came from hospitals, from other source of healthcare settings. So what we're really getting is information from a very small sample of organizations that are presumably quite predisposed to have an interest in this area. And, you know, to me that was a huge red flag.

Elizabeth Jacobs: Yes, this is Liz Jacobs. I totally agree with that comment. That was also one of my concerns.

Dr. Kevin Fiscella: Beverly, did you want to respond or did you have any thoughts on that?

Beverly Weidmer: Yes, no. And I understand the concerns and I think, you know, we recognize that the field test, as I said, not only included a fairly small sample but also that the response rate was extremely low.

Although it was low, it's not - it is a low response rate but it's not an unusual response rate for surveys of organizations also. I mean I think, you know, going forward, we are actively going to be looking for additional funding to be able to field the survey with a much larger sample.

And again evaluate the psychometric properties and really be able to look at the data by type of organization as well as across organizations.

Male: There was a really interesting question someone raised by inter-rater reliability. It wasn't clear to me who at organizations answered this survey and what their qualifications were, what their knowledge were. I mean I could answer this survey about my organization and I'm sure I would be wrong about half the time.

Beverly Weidmer: Yes. And we did collect information on who actually completed the survey at each of the participating organizations. And it varied across organizations. At large organizations, it

tended to be either the person who was responsible for cultural competency issues or quality improvement. Or in some cases, it was the person who was responsible for, you know, hospital surveys, for example.

In smaller organizations, it tended to be the medical director. In medium-sized organizations, it sometimes was the medical director. It was sometimes someone that the medical director designated, usually someone who was primarily tasked with quality improvement activities at the organization.

So it did vary from organization to organization. We did provide instructions that person who completed the survey should be someone who was knowledgeable about the practices that were going to be discussed as part of the survey.

Particularly for large organizations, we also found that it was not possible for one person to complete the survey on their own. So oftentimes they had to consult with different departments and collect information in order to complete the full measure. So for example, it might be the person who was responsible for quality improvement when it came time to answering the questions about language access and interpreter services, they consulted with the head of that department.

Grace Ting: And this is Grace Ting. You know, I definitely seem to have recalled getting the survey and maybe it was this survey and maybe it was another field test or survey. But did you have some sort of language in there asking the CEO to be involved in some way, shape or form? Or am I mis-remembering this?

Beverly Weidmer: The CEO or the director of the organization, we did send the survey to them. And they designated the person who should complete the survey.

Grace Ting: Okay because I remember there was one survey that asked, they could designate but then still had to signoff. And I know that was a barrier in our company because, you know, they could designate. But I mean ultimately if there was some sort of sign-off requirement or had to be entered by the CEO's office that was just not going to happen. And I think that's why we did not respond.

Beverly Weidmer: Yes. We did request that the person completing the survey attest to the accuracy of the information that was submitted.

Romona Hasnin-Wynia: This is Romona. I think that, you know, the issue of inter-rater reliability is important in general. But I think we have to also - I'm going to take kind of a different take on this within the context of kind of who responded to this particular survey. I agree the response rate was very low and that's a concern.

But that said, even if you had a great response rate, the variation in the size of the organization, so the larger the organization, you know, that's where the concern around inter-rater reliability will become most dominant.

With the smaller organizations then it looks like, you know, your response rate was dominated by FQHCs and I don't know, you know, FQHCs vary in size. But the smaller the organization, the less of an issue it is for the inter-rater reliability within that organization.

Now across the organization, that's a different, you know, that's a different question. But I don't know that that's relevant. I mean what we're, you know, trying to get at is kind of organizational cultural competence here. So I just kind of want to throw that out there that the smaller the organization, to a certain extent, you know, depending on who answered for the organization, the likelihood of that, another person answering for that same organization will likely have similar responses.

That will vary more in larger organizations. You know, we definitely, when I was back in the day when I was still at the hospital, America Hospital Association and at HRET, we definitely sent a lot of surveys out into the field to hospitals. And it was always an issue about who responded to the survey in the hospital.

Even if it was targeted to the CEO, it was rare that the CEO would respond. It would often me a variety of, you know, midlevel managers with the assumption that the person who was responding would respond to the best of his or her knowledge. And if they didn't have the information, they would seek it out from others in the larger organization.

So I think this is an issue. I think the response rate is a bigger issue than the inter-rater reliability because of the variation and the types of organizations that you're seeking information from.

Beverly Weidmer: This is Beverly again. I think, you know, looking at inter-rater reliability and also doing additional validity testing is that something that we are going to actively pursue going forward.

Male: So in other words...

Male: But right now you can't tell us if there are systematic differences in response to this survey based on who at an organization responded to it. Is that what you're saying?

Beverly Weidmer: We're not able to look at that, exactly.

Male: Thank you.

Beverly Weidmer: As part of the cognitive testing, we did collect information not only on how responding organizations understood a particular survey item but also collected information on the context or

the information that they drew on to answer that item. So for example, if we were asking about training, we asked them to talk to us, you know, extensively about the type of training that they offer at their organization.

If we were asking about interpreter services, we followed up with probes to try to understand what exactly they do in terms of interpreter services. How they communicate to their patients that interpreter services are available.

Male: And Beverly, are you able to share a little bit of what your plans are in terms of inter-rater reliability and validity testing?

Beverly Weidmer: Well I think going forward, again, we hope to be able to obtain additional funding to field the survey with a larger sample, particularly including larger organizations like hospitals. And specifically asking whether we might be able to test the survey with more than one individual within the organization to then be able to compare responses and ensure that the response is not only - are valid but also reliable across respondents.

So we haven't obtained funding yet. This is still in the works but it's one of the things that we plan on doing going forward.

Dr. Kevin Fiscella: Are there other questions regarding the scientific acceptability here? So let's move onto the usability question. And here again, it was split. Two members rated it as high, six medium, one low and two insufficient. Some of the comments included, "not ready for public reporting", "not clear whether scores would prompt action". "Need better data on sampling, administration, and the response burden".

"The 4-A adoption framework is full for focusing QI activities of healthcare organizations". And "the only information regarding meaningful interpretation are (1) there is a theoretical framework

underlying its construction. And their expert panel seemed to like it". "There's no data showing its been used by anyone to produce meaningful, quality improvements in any organization".

Beverly Weidmer: And if I could address that last comment. It is true but I mean this was a survey that was just only recently, you know, developed and made publicly available. And so, you know, it is kind of hot off the presses, as it were. And, you know, other than this first field test, to my knowledge and I don't know probably to NQF's knowledge, no one else has used the survey as of yet.

Dr. Kevin Fiscella: Comments from the committee on the usability, questions?

Male: You know, it's just, it's really hard. I mean it's hard to assess usability for something that hasn't really been used very much, you know?

Elizabeth Jacobs: This is Liz. One comment I have about that is given that it's so variable on who actually responded and actually gave the answers, I mean that raises a question in my own mind about usability. But if you can't actually identify who's completed it necessarily, in a way it would be hard for organizations to - on some level it may reflect that it's hard for them to actually complete the survey.

Beverly Weidmer: Could you repeat that last part again, Liz?

Elizabeth Jacobs: Oh I was just saying that, you know, I wonder if this reflects some issue around usability, excuse me feasibility and usability if like you couldn't - it's not clear exactly who would be the person to fill it out and so different people are filling it out at different institutions.

And I understand there's some size issues. And (Phil Monocan) I know made a good comment about that, how people got that information. It just raises that question in my own mind.

Robyn Nishimi: This is Robyn. I just want to clarify something. Usability, the criteria, is meaningful and understandable to the intended audience. Feasibility goes to the issue, I think, that you're addressing, Liz.

Elizabeth Jacobs: Oh you're right; you're right.

Robyn Nishimi: I just want people to be clear about what we're talking about here.

Male: And it sounds like the usability was largely addressed through the covenant of interviewing, that was the approach, Beverly?

Beverly Weidmer: Through the covenant of interviewing. And we also did follow-up interviews with a small sample of organizations that actually completed the survey to collect additional information on, you know, their experience in completing it. How much of a burden it was, whether they experienced any issues.

You know, how many people that had to consult within the organization in order to complete it, et cetera. And, you know, overwhelming, among the organizations that completed the survey and provided comments, they were able to provide kind of open-ended comments at the end of each section of the survey and then at the very end, as well as the feedback that we obtained through the cognitive interviews and these post-survey interviews.

Was that, the survey was easy to understand and complete. It is a little long but it's a web-based survey that is easy to complete. They get their survey score at the end of the survey so they like that part. And the information that we got is other than, you know, the length which for some organizations was a bit long and, you know, for the larger organizations the fact that at times they

had to consult with different departments that the survey was easy to understand and to complete.

Male: And remind us again of what the estimated time was; what was that, how did it come out to?

Beverly Weidmer: It really it ranged from 15 minutes to a maximum of 180 minutes. And I think the average time was close to an hour to complete.

Dr. Kevin Fiscella: So this is really a nice segue into the feasibility issue. Again the responses were similarly distributed, most clustering in the middle there. Do you have information on the non-responders and why the response rate was so low?

Was this due to lack of engagement of the CEO? Or did you get high rates of CEOs agreeing to do it and then the organizations did not, in turn, submit a response. Can you perhaps shed some light on that piece?

Beverly Weidmer: We did follow-up with non-respondents and collect information on reasons for non-participation and it varied. One of the things that well there were several issues that affected the response rate.

The first was the timing of the survey. And unfortunately, you know, we had a specific window during which we could field the survey. And it conflicted with other surveys that were going into the field at the same time. Particularly, here in California, we approached the Primary Care Association and they reported to us that they just finished a survey and were about to start another one.

We did hear from a lot of organizations that they are over-surveyed and under staffed. And, you know, also they were very interested in the survey and interested in the content of the survey and thought that it might be useful that they just didn't have the resources.

And that for some organizations, unless they see a real compelling reason to participate or mandate it to complete the survey, then they just don't do it. So that was, you know, that was some of the responses that we got. In other organizations we did find that the survey was sitting in the CEO's in-boxes at work. So they received the information and they just had not designated someone to complete it.

So it kind of stalled there not so much that they were not interested in participating, they're just incredibly busy and we had a fairly short turnaround time for completing the survey. So one of the recommendations that we have going forward is to extend the field period to allow, you know, CEOs to review the survey, designate someone and then follow through.

In other organizations, again, I think it was Grace Ting I think you mentioned that for larger organizations, they have to get different levels of approval to submit that information. And then the requirement to attest to the accuracy of the information was possibly a holdup.

So it was a mix of reasons. And we have recommendations going forward. I mean I think one of the things that would go a long way to increasing a response rate to a survey like that is to careful looking at the timing. And then to seek the endorsement from different organizations so primary care organizations, or the American Hospital Association, you know, the American Health Plans Organization.

And we did approach some of these organizations and they were both very interested in the survey and would be willing to help promote it going forward.

Dr. Kevin Fiscella: Well that's helpful; other questions on the feasibility before we go onto the next topic

of related competing measures? Well thank you Beverly, this has been very helpful.

Beverly Weidmer: Okay.

Dr. Kevin Fiscella: Nicole, do you want to introduce the related competing measures for the committee's

consideration?

Nicole McElveen: Sure. So going through the related measures, and we're basing this discussion under

the assumption that this cultural competency implementation measure will be moving forward so

think of it in that light. But there were two measures that the committee had recommended

previously for endorsement that sort of address or have a similar measure focus around cultural

competency and that is the (Caps) item set for culture competence as well as the cross-cultural

domain of the (C-CAT) which is that communication assessment toolkit submitted by the AMA.

So this first slide again just highlights that these measures have the same measure focus. Much

of the similarities between these measures were specifically between that the cultural

competency implementation measure and the cross-cultural measure. So some of the questions

listed out within the specification of those two measures address similar concepts.

The other piece to that is that while the measures may be related in focus, they, again, don't all

target the same populations so remembering that Taps is more focused towards questions for the

patient. The C-CAT looks at questions for patients and staff, their hospital staff.

And then the cultural competency implementation measure focuses on questions addressing

more towards the senior-level staff at hospitals, health plans, community clinics, and dialysis

organizations. So we wanted to bring that to your attention.

The next few slides or the next few slides I have here are just some of the questions. Again, these are only between the C-CAT and this cultural competency measure here, the implementation measures, these, the question comparison here. And looking at your screen, you'll some of the questions we kind of pulled out.

The first one just looks at whether the organization has an action plan or has made the environment welcoming for patients, diverse populations of patients. The second question looks at training. So for example, the question asks if their staff cover receives specific or adequate training to address diverse or cultural backgrounds for patients.

And then the last question looks at whether the patients have received materials that asks questions around their healthcare values, or their beliefs, or their cultural beliefs, or their needs. So the next slide also has some questions.

Again, these conceptually these questions are similar but they're not identical. So I won't, you know, we're kind of short on time and I won't go through the details of all of the questions. But we did want to get feedback from the committee first on whether you agree that the measures have a similar focus.

And if they do, if you feel that the cultural competency implementation measure should still remain as a recommendation for endorsement along with the other two that you previously recommended, so...

Robyn Nishimi: This is Robyn. This is a hypothetical argument in terms of the (Rand) measure because you have to vote on that but because we have you together, we're asking for that. So assume that it's advancing and then comment based on that.

Grace Ting: So this is Grace Ting from WellPoint. And I have to say that I, I definitely see similarities but I would also very strongly advocate that the CCIM should be included for precisely the target audience pieces. I mean one of the reasons that at the in-person meeting I endorses the CCAT and the CAPS, one, those two measures, were because there was an absence of a measure that really reflected other care settings, you know, outside of the ambulatory and inpatient hospital setting.

And so those measurements, I'm like, yes, I know we're focused on the hospital but I guess it could work for a virtual health plan. So in the absence of nothing, I voted for them. But I have to say that the (Rand) tested, you know, CCIM does take a more global language. And so it would be a lot easier to adapt and sell to a non-care giving, you know, point of care, basically setting. So I would so vote for endorsement.

Nicole McElveen: Any other comments from the group on that?

Donna Washington: This is Donna Washington. I just have a question to clarify. I agree that probably the most relevant point here is that all three measures have somewhat different audiences. So I think that that's a strong consideration. But the question has to do but then what is the burden on the healthcare organization?

Does it mean that in the theoretical case that all three measures are endorsed, would the expectation be that they would then field all three measures?

Grace Ting: And I would like to know too; this is Grace. That's a good point.

Male: Did Nicole or Robyn want to respond to that?

Robyn Nishimi: I mean all of these right now are optional, you know, add-ons. So it really would be up to

the implementing organization as to which they, you know, would like to add-on to. It's not like

these are mandatory and someone is saying that you have to use them.

Male: But it would be conceivable that organizations would receive responses to - reply to all three of

these. Is that true?

Robyn Nishimi: Well if a purchaser in your community, if you had three purchasers in your community

let's say and they wanted to assess cultural competency of your organization. It is conceivable

that they could each choose a different one.

From a national perspective, I have a hard time believing that, you know, CMS is ultimately going

to choose all three. I mean let's say five years down the road, it would seem to me, if CMS and

that's obviously a hypothetical, wanted to assess this, they would probably pick one.

Grace Ting: I think that a final NQF, you know, endorsement document, there is a paragraph, you know,

saying that we recognize some of these measures may be overlapping. And that organizations

adapting the measures should review and implement what makes sense to them I think that

would be okay.

Robyn Nishimi: Yes, I mean we could obviously do that. The other thing, this is not uncommon in a new

measurement field. And this is, measuring cultural competency is frankly at the cutting edge of

medicine right now. So it is not uncommon.

You know, back in the day when I was in the first days of NQF to have competing, you know, beta

blocker use after AMI measures because they were based on different sources, et cetera so. And

it's, you know, evolved towards a much tighter set of measures so.

I'm not troubled so much that there be multiple ones because the implementing organizations tend to use what's best for them. And then the field evolves towards a standard.

Nicole McElveen: So is there a general consensus amongst the group that you would be okay with moving forward with all three or is there anyone who, I guess is opposed to that or?

Robyn Nishimi: I think the question is assuming that there are going to be multiple measures, related measures. And we know that there's at least two and there may be three depending on the outcome with the (Rand) measure. Is there a sense from the group that given the different populations and the slightly different questions that at this time there's no need to choose one measure from amongst them?

Male: Or again, putting it the other direction, are there other members who think that all three of these measures should not proceed forward at this point?

Grace Ting: Well we already voted on the other two, correct?

Male: That's right.

Grace Ting: And, you know, I think that the reason the other two passed and the reason that perhaps you're saying to pick acceptability were higher because of that new or target audience for administering the survey right. So, you know, I, again, I don't want this particular measure to be deemed for this, what is the field testing problem where the organizations skewed one, you know, towards smaller federally-qualified health centers and, you know, found that the sample size was low.

Actually for a survey, 18% response rate is actually not bad at all. You know, and I think that's the reason that it's what it is. It's very, you know, spread out, smaller sample sizes because it tried to

be more inclusive. And I think that there's a role for that because I know that I can sit there and extrapolate and say, oh yes, the other measures will work for me.

But then I would have to adapt. And then they are toying with the instrument and that's not so good either. But if there is an instrument, maybe a little bit less tested and maybe a less scientifically valid but if I don't have to adapt and its endorsed, I would just go with that.

And it's an easier sell for me internally if it were. And I think to other non-points of care organizations to adapt to this particular measure.

Male: I mean that sounds like an argument against this really to me. I mean if you have something that's not perhaps scientifically valid but is, you know, attractive on some face level it's going to attract attention to this. It seems to me something that we should be much more cautious about.

Grace Ting: Okay so I always approach this on a very tactical, you know, sort of corporate perspective right. And the downside of having what I deem a very scientifically tested but not as widely applicable measure like the other two that were tested in care setting is that when I take these measures to the other approved measures to management, they'll look at it and say, yes, but that's geared towards hospitals and medical centers. And we're not going to do that.

And then what's going to happen is that we will not implement anything right. But whereas if there is this - it's not as if this isn't tested; I actually think that's what it is for a survey, with a broader audience, the scientific acceptability is good.

So that's a different standard. You know, it's not as academically rigorous or clean as the other two, true. But then you have to look at it's trying to be more inclusive so of course it's going to be more fuzzy. But for what it is, it's actually pretty good for what it is.

I can take this and say look, this is applies to us. And leadership will likely say, well, you know, you're right, okay. We'll implement it. So it's just, you know, if you have something that doesn't quite fit then it's easier for leadership who's again bombarded by all sorts of, you know, requirements, they'll just say it doesn't apply to us therefore we don't do it.

And then therefore you won't get the measurement and you won't advance.

Male: Keep in mind, this is not a vote on this measure. Really the question is there's so much duplication here that this measure should not be pushed forward at this point. We're not voting on the measure and the other two have been endorsed.

So the question really is, is overlap here.

Male: I mean I guess I would say I don't think that the overlap is clear and obvious enough that it should be disqualified on that basis.

Nicole McElveen: And this is Nicole. Since we're kind of nearing to the top of the hour, I think what the best approach is, once we get the final vote on the (Rand) measure, we'll be able to obviously assess this discussion we've had around the related concepts a little bit better.

But for now, I think that the conversation and the points that the committee has raised will suffice for us to move forward.

Grace Ting: Nicole, would you mind commenting on the voting process if there is to be one to the work group or committee?

Nicole McElveen: Yes. I mentioned that at the beginning and that will lead us to go offsite is on the next steps and timelines. But so what will happen is immediately following the call, I will circulate an email that has a link in it to access an online tool which is where you'll doing your voting.

So again, the voting will be on the criteria that we discussed during the call. So looking at importance, you know, specifically impact, performance gap evidence. Under the scientific acceptability of the measure properties, you're going to be expected to vote on the reliability and validity and usability, feasibility and then finally your overall recommendation for endorsement.

There's also a section to provide verbiage around a rationale for your ratings that you've included. Once we have those results in, we'll be able to, you know, tell the committee definitely if this measure will be moving forward.

We're asking for the turnaround time on those, on your vote, pretty quickly. We're asking to receive those votes by Wednesday, March 21. We will be sending a summary from this conference call on Monday to the group if you'd like to wait until you get the summary.

But while it's fresh in your mind, I did want to circulate the link to allow folks who participated on the call to vote immediately if they wanted to do that. And then, you know, our timeline moving forward, we're going out for public ((inaudible)) will comment in April.

So another thing to keep an eye for is the draft report which we'll be circulating to the group next week to get your feedback and comments on that as well before we move forward with the rest of the consensus process.

Operator, this is Nicole. We've kind of ran out of time a little bit but can you just tell me if we had anyone from the public dial-in on the line?

Operator: Let me check here, one moment. It doesn't appear we've had anyone from the public dial in though.

Nicole McElveen: Okay. Are there anymore questions from the committee about the process going forward, or voting, or? All right, thank you Kevin for leading the discussion, Beverly we appreciate your participation on the call as well and the committee members.

So you'll be getting an email from me in just a second for the voting. And we'll be in touch on next steps. Thank you guys.

Male: Thank you.

Female: Thank you.

Robyn Nishimi: Nicole?

Nicole McElveen: Yes?

Robyn Nishimi: This is Robyn. Can I talk to you just for a sec?

Nicole McElveen: Yes.

Robyn Nishimi: Do you want me to call you on your cell?

Nicole McElveen: Yes, just ((inaudible))...

(Delone): Hey Nicole?

Nicole McElveen: ...in just one minute.

(Delone): This is (Delone). I'm going to get off.

Nicole McElveen: Okay.

(Delone): All right, bye.

Robyn Nishimi: I'll call you on your cell, the NQF cell?

Nicole McElveen: Yes, that's fine.

Robyn Nishimi: Okay.

Nicole McElveen: Okay.

<div align="center">END</div>