NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
June 25, 2019
8:35 am CT

Suzanne Theberge: All right. Good afternoon everyone. Thank you for joining us today. Welcome to the Patient Experience and Function's Spring 2019 Measure Evaluation Web Meeting, the first of several that we'll be having over the next few days.

This is Suzanne Theberge, the Senior Project Manager on the team. I'm joined by the rest of the project team. I'll let them introduce themselves.

Sam Stolpe: Hi everybody, Sam Stolpe, Senior Director on this project. And I just wanted to briefly say thank you so much for coming out to DC and spending the time with us. We were able to accomplish a lot in the time that we had together. Got our - a couple of more boxes to check and appreciate everybody's continued effort.

Oroma Igwe: Good afternoon everyone. This is Oroma Igwe, Project Manager and thank you for your time today.

Jordan Hirsch: Hi everyone. This is Jordan Hirsch, the Project Analyst and I also want to thank everyone for coming up today as well as joining us in DC last week.

Suzanne Theberge: All right. We will do a quick roll call, go over the agenda and then we'll get right into the measure evaluation portion of the meeting. So Lee Partridge?

Lee Partridge: I'm here.

Suzanne Theberge: Thank you. Chris, have you joined us yet? Chris let us know he was going to be a few minutes late, so he'll be joining us shortly. Beth Averback?

Beth Averback: Here.

Suzanne Theberge: Thank you. Don Casey?

Don Casey: Present.

Suzanne Theberge: Thank you. Ryan Coller?

Ryan Coller: Good afternoon, here.

Suzanne Theberge: Thank you. Sharon Cross? Chris Dezii? Shari Erickson?

Shari Erickson: I'm here.

Suzanne Theberge: Thank you. Dawn Hohl? Dawn will be joining us a bit later also. Stephen Hoy? Sherrie Kaplan?

Sherrie Kaplan: Here.

Suzanne Theberge: Thank you. Brenda Leath?

Brenda Leath: Good afternoon. I'm present.

Suzanne Theberge: Thank you. Brian Lindberg?

Brian Lindberg: Here.

Suzanne Theberge: Thank you. Linda Melillo?

Linda Melillo: Hello, I'm here.

Suzanne Theberge: Thank you. Ann Monroe? Lisa Morrisse?

Lisa Morrisse: I'm here.

Suzanne Theberge: Thank you. Terry O'Malley? Deb Saliba?

Deb Saliba: Here.

Suzanne Theberge: Thank you. Ellen Schultz? Lisa Suter?

Lisa Suter: Here.

Suzanne Theberge: And Peter Thomas?

Peter Thomas: Present.

Suzanne Theberge: Great, thank you. So once Chris joins us, we should have forum, so we should be good to vote and we will proceed into the call. Just a few brief housekeeping items before we get started.

As I think you probably all know, please mute your lines if you're not speaking and also turn off your computer speakers. You do need to be dialed into both the phone and connected to the webinar to see the slides. And then we also need you to vote via poll everywhere. So committee members should have that link in their invitation, please connect to that as well. It's the same platform we used last week at the meeting.

So with that, any questions before we start measure evaluation?

Peter Thomas: Yes, this is Peter Thomas. Just quickly, I - we had dropped two of the final measures I believe if I'm not mistaken and I kind of as expected that I'll be talking about those today. It doesn't look like that's on the agenda. So will we be doing those two last measures some other time?

Suzanne Theberge: I think we are looking at doing those next week, July 1, sorry. We didn't think we will get through all of the remaining capped measures in two hours. But I guess we'll see how it goes.

Peter Thomas: Okay, very good, thank you.

Suzanne Theberge: And - okay.

Sam Stolpe: Does anybody joined the call while we're - since we've done row call?

Stephen Hoy: Yes, hello. This is Stephen Hoy. I just saw the row call slide as I logged on, so…

((Crosstalk))

Sam Stolpe: That's all right. Glad to hear Stephen.

Suzanne Theberge: Great, thank you. Well, I will turn it over to Lee to begin the discussion which is CAHPS Clinician & Group Surveys, Measure 0005.

Lee Partridge: Good afternoon everybody and welcome back to the continuation of our meeting of the spring 2019. I hope that the northeastern thunderstorms didn't destroy too many people's travel plans to get home last Thursday. It was something of a delusion in New York.

First measure today is CAHPS Clinician & Group and according to my notes, I'll be discussing just that. So I will turn it over to…

((Crosstalk))

Lee Partridge: …am I right?

Suzanne Theberge: Yes, I have my notes here. So we'll actually start with the developer introduction. Okay, so I believe that's Paul Cleary. Sorry about that. Paul, are you on the line.

Paul Cleary: I am.

Lee Partridge: Yes. Dr. Cleary, go ahead.

Paul Cleary: Hi everyone. Thanks for all your time and all the attention you've given to CAHPS. I'm going to be leading the discussion and clinical group CAHPS and health plan CAHPS. And I'll be brief to allow the maximum time for discussion. I think most of you know that the Clinician & Group CAHPS of this survey that's focused on experience of patients with primary specialty

care received from providers, nurse staff and it's ambulatory care survey and it covers six months.

CAHPS - CG-CAHPS Version 1 was endorsed by NQF in 2007 and Version 2 received maintenance endorsement in early 2015 and Version 3 was released in 2015. I think basically the only difference in the CAHPS Survey between the earlier releases is the, you know, addition of a composite on coordination of care. And I had some comments on the review, but maybe - it sounds like maybe Beth would like to lead that and I'll fill in. Where there any questions or emphasis?

Beth Averback: Sure. And do you - Lee, do you want me to go through this kind of what like we did in-person kind of talk, do evidence and then the reliability validity or do you want me to do a summary of all of it?

Lee Partridge: I think a very brief summary Beth and then we'll proceed section-by-section and voting.

Beth Averback: Sure, okay. So thank you. So yes, as Dr. Cleary mentioned we've got the third version here looking at six month look back instead of a 12 month. Some of the changes were to consolidate some of the questions, decrease the number of questions and then move some of the medical home questions to another survey.

I can say not only from the standpoint I mean we discussed into that organization, we used the survey, so I'm very familiar with it from the standpoint of being a leader that works with it.

As we walk through and I think the developer did a nice job talking about the evidence we know that patients have better outcomes are more likely to take

their medications as prescribed, lower utilization of unnecessary services in ED when they've got that connection and great experience with their clinician.

There are opportunities as far as gap and some deviation from the mean as far as the breadth of performance. When we look at some of the disparities, we know that older patients tend to be a little bit happier. The - that will (unintelligible) to analysis by race just based on the volume and the number of returns.

For reliability and validity that was passed by the scientific methods panel with a comment that the care coordination section had less reliability and might be interested from the developer to have some comments related to that and the three questions in care coordination were around following up on test results knowing medical history and then I'm talking about all medications that are prescribed.

Very few data points we're missing, missing data was present in less than 5% of the surveys. Feasibility, there was a comment about the recommendation was low feasibility though I know a number of medical groups do this as part of infrastructure and view it as an operating cost. And so my make of recommendation that we consider that is moderate instead of low. Same with usability, as far as being able to use the surveys to make a difference that's being used in public reporting in the number of places in addition to internal process improvement.

And then I think the other comment is there were some comments in the review around it being process versus an outcome measure I think to go along with the discussion we had in-person. Most of us would view this as an outcome measure, because its outcome based on the patient's perception. So - and the survey is also available in English and Spanish.

So with that, that's pretty much my summary.

Suzanne Theberge: Okay. Dr. Cleary, you want to respond?

Paul Cleary: Sure. Terrific summary, thank you. The issue about reliability did come up. I think everyone is very, very aware of the kind of data that we presented. We typically presented two things and this goes throughout the CAHPS Survey. We presented internal consistency measures, calling back Alpha and we do inter-unit reliability.

In terms of CAHPS and the way it's used, we consider inter-unit reliability really the most important criterion, because the ultimate goal is to distinguish among provider groups and so on. And that's actually quite good for CG-CAHPS. The observation was correct that Alpha was relatively low.

We look at it's important that Alpha can be very, very informative in terms of concepts that related and response patterns that are related as almost everyone on the call this knows it was derived to indicate the extent through which items reflect the single latent construct and that's not always in the CAHPS. So as it was mentioned, the coordination maybe tests in medical history and medications and although those are units we consider a unitary concept and testing as some of the consumers understand it as reflecting coordination functions, it's not critical that they'll be highly correlated within individuals. And so even though Alpha is low, the inter-unit reliability was good and we view that as the most important criteria.

And feasibility I believe was raised on every CAHPS Survey and CMS responded in writing to HCAHPS and I won't repeat that. But we - I

appreciate the comments. We - you know, the broad use and the way in which it's used, we saw reflected feasibility.

We don't - someone commented that we should have included vendor class, it's a little sensitive, because as people know there is a heterogeneity in vendor cost. Some of those costs are proprietary, they differ and anyone who's done bidding for surveys as I do frequently, you know, it's very hard to compare apples and oranges. But - so it's just very hard to present. We thought meaningful cost data, but - you know, people felt strong there, but we can do try and do a better job out in the future. I think those are the main issues.

Lee Partridge: Thank you. Our fellow (commenters) here were Deb, Lisa Morrisse and Ryan. So any one of the three of you?

Deb Saliba: So this is Deb. Beth did an excellent job of summarizing and I don't have much to add. I do agree with her that I would rate usability and feasibility as moderate, not as low.

And I think, you know, we need to bear in mind that any measure that we're going to do that's going to be patient reported is going to require actually going to the individual patient, the individuals that are affected and that they're always better done is done by - not by the immediate care provider in order to get an objective and honest answer from the respondent.

So given that these are very important measures and they're wide used and that initial approaches can be mailed, I would move usability and feasibility to moderate. And I appreciate Dr. Cleary's comments as well.

Ryan Coller: This is Ryan. I agree with what's been said and it sounds like this particular thread will be consistent across most of the CAHPS measures. So I don't know if anyone - NQF had any other comments about the pre-review rating that was assigned to it that we're not considering, but I agree with the idea that move it to moderate.

Sam Stolpe: Hi. This is Sam with NQF and I can give some commentary on the staff rating. So our one task is staff, it's just to consider the actual criteria and then to hold the submission up against the criteria with - I mean we do take context into consideration and we're happy to hear the committee thus far is reflecting that the moderate rating might be more appropriate. But we just have to hold things accountable.

And given that the developers just didn't have the data related to the vendor cost and the burden associated with implementation that that's fine if they can provide some context around feasibility then - for their committee to consider then absolutely you may arrive at a totally different conclusion. So we don't think that it's inappropriate that the conversation is taking the direction that it has.

Lisa Morrisse: This is Lisa Morrisse. I think it's also important to note that one of the reviewers that may have contributed to that score did not feel like this was an outcome measure that leans toward it being a process measure which I disagree with. I think it is an outcome measure and we've covered that.

Also it would have been good to get for (looking at) feasibility and usability data on electronics submission and other options then the telephone calls which I believe is what we have. But we don't have that. So that's where we add.

The other thing is there were some dialogue how this has been used to - for improvement, but there hasn't been as much improvement as we'd like to see especially with patients. And hopefully more will come out on how one can use this data to help drive improvement in there and delivery of a better patient experience.

Paul Cleary: Yes. Thanks for…

Beth Averback: Yes. Lisa, this is Beck. I might make just a couple of comments more from just experience with organizations using it. So our organization uses the electronic version as, as another major medical group in our community. And so I know that the electronic email version is in use. I've been to a number of conferences were groups have presented their patient experience data and have shown what they've done to make an improvement. I just don't think that it's been published. It's been more in the quality improvement and kind of group practice sharing forms where I'm seeing that information presented.

Paul Cleary: So, this is Paul. Can I make one or two comments?

Beth Averback: Please.

Paul Cleary: Yes, I appreciate all those comments. They were spot on. A lot of people are doing electronic administration. We're constantly doing experiments of electronic administration as, as CMS and, you know, we hope to have much more information as we go forward. So those are really good points to rise.

I think people now, the consortium develops the surveys and tries to create resources for people and we don't really have a mandate and don't collect data. There is a CAHPS database and the CAHPS database information that we presented didn't show improvement. But I think everyone in this

committee would understand, it's not cohort data. The different years as new people come into the database, new entrants may bring the scores down. So there is a lot of reasons why that wouldn't necessarily show improvement.

And we do hear many of the stories of anecdotal improvement. We have published data from HCAHPS and Medicare CAHPS showing improvement overtime. We think it's pretty compelling and there is a lot of literature on the way these surveys in general can be used. But I agree with others. We'd hope there will be even more data in the future about specific initiatives and the impact that's had on improvement.

Sherrie Kaplan: This is Sherrie. Could I make a couple of comments?

Lee Partridge: Go ahead.

Sherrie Kaplan: Thank you. And I want to start off by saying how this is valuable I think this measure is and how important it is that we continue to push forward and better understanding the experiences of patients and being able to have practices in systems and clinicians, you know, make changes directly based on that. I just think it's extremely important.

I want to just - I guess maybe I'm playing devil's advocate a little bit, but I just - I really do have some concern about it being labeled an outcome measure. I understand what the others are saying on the call that I do think that, you know, this - the way what an outcome measure means in terms of a value based program puts it in the category that's quite different.

And maybe - you know, and I agree that we need to move towards more experience of care for patients, but this really does I believe technically involve measuring their experiences based on the care processes. So I guess I

just want to push back on that a little bit and I understand where that - you know, we're not really voting on that I guess, but I just wanted to mention that.

And I do think - I understand what this would - was being said with regard to the challenges with - in terms of listing vendor cost and time, et cetera. But I don't know that I find that fully acceptable. I think that we ask practices and I understand systems are larger groups who have the capacity to do this in a much more efficient manner. But there are many out there who just can't or find it extremely burdensome and costly. And even if they really, really want and they don't really do actually want to get the feedback from their patients. But it's quite challenging to administer for some of them and the costs are not readily available.

And I just think in this era of moving toward transparency, we really do need to push that issue and, you know, as much as possible to not just accept that it's okay that we can't help our practices understand that.

Don Casey: May I - this is Don. May I follow that?

Lee Partridge: Go ahead Don.

Don Casey: Sure. Well, let me help, because frankly I mean again I'll say it again in '06 I chaired the first committee and the NQF had actually approved that family of CAHPS, the CNG was still sort of coming out of box, but certainly we had HCAHPS and other CAHPS projects that were in the family.

And to be honest, I've never actually ever in my life heard of it until now as an outcome measure. And if you look on our Web site, I don't see that we're

in a outcome. But let's not argue about it. But the generic dictionary definition of outcome is something that happens and that's the end of it.

I think what Sherrie is trying to say from a physician standpoint and what I would say from a health delivery standpoint is when I heard the word outcome in terms of care delivery, I think very specifically about a health outcome that can be measurably assessed relative to the health status of an individual. So in that sense, we'll leave it at that. But I do think that is very confusing right now even though people in this room seem to agree on things. So I'll just state that, but let's not get into it. I think Sherrie would agree that's the way her advocacy group views outcome when we use the term. So I'll leave it at that.

Secondly, I think the usability from the standpoint of actually administering the CAHPS Survey as well fought out, it's well designed, it's done with the sample. It turns out that when you get the data, it's not usable, because A, you don't know who responded and B, it's a sample. So from the standpoint of the information it's good information and certainly confidentiality is important, so I'm not criticizing that, I'm just saying that because of relatively small numbers physicians take this and can use it sometimes and sometimes, because there is volatility in the results from point-to-point see - not necessarily see clear trends.

Thirdly, I think it's a comp out to say we can't provide at least a range of what the costs are and I agree with Sherrie, that's an important consideration especially if we're talking about burden from the standpoint of the end user.

And lastly, I know it wasn't brought up, but I did look up the CAHPS Clinician & Group Surveys chart book in '17 and I'm looking at the graph on page 9 which shows actually that the five measures that are in the survey, the

communicating, reading, other provider office staff care coordination and access have even been flatter or gone down between ‘15 and ‘17 which is disturbing to me, because again these things are used for payment, but, you know, the assumption is because they’re publicly reported and they’re used for payment means that they’re going to make improvements.

I just don’t see it in the data, maybe we should wait end of the three years, but that’s important for people to recognize and this comes directly from the CAHPS output, not I think the other study. So I just point that in there to be a question mark in my mind about the importance of this measure. So I’ll leave it at that.

Lee Partridge: Thank you Don. I would point to the fact that Dr. Cleary has I think mentioned a couple of minutes ago that the database is a voluntary one and that some participants change from year-to-year and that can contribute to the kind of problem that you saw. I’m not saying that’s the reason, but I just wanted to remind our fellow committee members that Dr. Clearly did address that issue a couple of minutes ago.

Don Casey: Yes. Let me just say to that point Lee that there were 3,443 practice sites in ‘17 and the number of respondents totaled was 366, almost 367. And that average is up to about 122 patients per site, but the numbers are in this report and worth looking at it.

Lee Partridge: Okay.

Brian Lindberg: This is Brian. I had a comment.

Lee Partridge: Go ahead.

Brian Lindberg: Yes, thank you. Yes, this relates to the type of measure discussion. I just wanted to - you know, from the consumer's perspective, way back we used to talk about the outcome measures, the process measures and then a separate category which was really the patient perception. And that was valuable from our point of view, patient perception measures were important on their own regardless of whether they, you know, could be labeled somehow linked to an outcome or a process.

So my view is that I - you know, I'm not as concerned about what NQF labels them although I do appreciate the comments that have been made. But, you know, when we were first started NQF and we were working on all of this, we were fighting for more outcome measures. But frankly, we weren't talking about these kinds of measures at the outcome measures that consumers need them to make better decisions. We still in my mind are patient perception measure is very important, but different from what, you know, we want as consumers to be able to make decisions.

Lee Partridge: Okay. Further comments from the committee in general and then I think since time is ticking, if we're ready we should go on to take the votes. Anybody else?

(Chris): Hi. This is Chris. I just joined.

Lee Partridge: Welcome Chris.

(Chris): Thank you. Do I get to vote or not?

Lee Partridge: Yes.

(Chris): Okay.

Terry O'Malley: And hi. This is Terry O'Malley. I've been on for most of the discussion. I did have a question…

Lee Partridge: Excellent. Go ahead.

Terry O'Malley: And that is - trying to get to the sort of the usability of sort of how can this data help us do work in approved care? Does the (helper) they have a sense of sort of how many years you need to be engaged in collecting this data and what's the minimum sample size that you need to be comfortable with the results?

Lee Partridge: Dr. Cleary?

Paul Cleary: It's a good question. It's a big question. I don't know that there is a timeline. But I think, you know, people have shown improvements in being able to use CAHPS over relatively short periods. My sense and people on the committee may disagree, but we've tried to create protocols and procedures and transparency in terms of recommendations and so on that are relatively straightforward to follow and it's used pretty widely. So, you know, we have a lot of information about a lot of systems, clinicians and groups that come onboard pretty quickly and can use the data, you know, the points well taken and it could provide ranges of costs and so on.

Samples vary widely depending on the variability of units. We routinely publish data on variability of the units being compared often for example, 300 to 400 patients is a number that's used to get pretty good unit level reliability for CG-CAHPS and most of the other ones being compared today I believe there are publications that show the number of respondents that are needed to

achieve different levels of unit level reliability that one sort of rules. I think the entity requirement is 410.

Often reliability gets fairly robust at about 300 respondents, but again it varies by measure and by survey depending on the amount of unit and the amount of within unit variability.

Lee Partridge: Any further comments? If not.

Stephen Hoy: This is Stephen. I was just curious from the developer and the committee if any of the issues with reliability could potentially be tied to the patients and families not necessarily understanding the context in which they're supposed to be responding. For example, which of my doctors am I responding to right now? We see a lot of these surveys. So could that be part of the issue tied to reliability that's out to the committee and all to help me understand?

Paul Cleary: I could - it absolutely could. The - when you say - when we say reliability, because we're talking about Clinician & Group CAHPS, really what we're talking about is how well can we distinguish patient experiences in group-A from the other groups in our comparison sample and that's function of two things. How much those groups vary in general? Are they different? And then how much within group variability there is.

So to the extent for example that a person is responding about one physician versus another physician unless one is doing a physician attribution, it won't make as much difference. But there is confusion about the group and people may misunderstand what the entity we're asking about is and that could affect - could reduce your ability to distinguish that group from other groups.

To counter that and what we call things, what we call groups, what we call entities, what we call the people who care for us does vary overtime and there has been, you know, fairly considerable - there has been a considerable amount of work looking at the wording people use and what they understand, we routinely do focus groups and cognitive testing and have made various small changes over time to try and use language that conveys in the best way possible to individuals what experience they're being asked about.

That having been said, it's never perfect. Any time we do a cognitive testing, your focus groups, there is some misunderstanding. We just try and minimize that to the extent we can. The same is true across, you know, for example, languages and so on. So the answer to your question is yes, it could affect reliability and we worry about that a lot and try to address it by the methods I have mentioned.

Stephen Hoy: I can see where that's a challenge. You know, my - if we're truly a patient family centered health system, we'd have one experience score, because my experience across as all those - all these different silos or entities as you call them of healthcare and so I see it being a challenge when you - for my latest example, I was frustrated with my clinician group, because they didn't send my EHR records over to my hospital. So where does that land on which survey for me has always kind of been a (subwaying) point for me and I just wonder where that fits in with the map of the framework and reliability, so thank you.

Lee Partridge: Any further comments or questions? If not, Suzanne you want to tee us up for voting?

Suzanne Theberge: Sure. Go ahead.

Lee Partridge: Go ahead.

Suzanne Theberge: Okay. So everyone should log in to the link that is attached to the committee member invitation and you should see the voting for evidence. Just like at the meeting and we are voting on the evidence to measure and report on Measure 0005: CAHPS Clinician & Group Surveys. A is Pass, B is No Pass.

Peter Thomas: Sorry, I'm…

Deb Saliba: I'm on the - I can see the slide, but I don't see where to vote, slide down.

Suzanne Theberge: So the voting link is a separate link from the webinar. It is in the committee member invitation, calendar invitation and we can chat that to you. Sorry, who is that that just requested it?

Deb Saliba: I found it.

Peter Thomas: Peter Thomas.

Suzanne Theberge: Okay. Peter, we will chat you that. Give us a moment.

Peter Thomas: Okay. I mean I'm on a Web site right now that says in the upper left hand corner NQF 5 CAHPS. So I think I'm close, but I don't see any ability to go…

Suzanne Theberge: Hang on. We're going to send you that link Peter. We're just pulling that up to share with you.

Peter Thomas: Not by email - by email or some other way?

Suzanne Theberge: We'll - we're going to send it to you via the chat function on the webinar. I don't see - we'll email it to you.

Peter Thomas: Okay. Sorry everyone.

Suzanne Theberge: Anyone else need the voting link, any other committee members? And so we're looking for 15 votes on this. So we're just waiting for that last vote.

Sherrie Kaplan: This is Sherrie Kaplan. I have a - remember I have a conflict on this, so did you subtract out of that?

Suzanne Theberge: Yes, we did. Yes, thank you Sherrie. All right, we're good. Voting has closed for evidence with 12 pass and three no pass. The measure passes evidence.

Lee Partridge: All right, 1B.

Paul Cleary: This is Health Plan CAHPS. Health Plan CAHPS as can…

((Crosstalk))

Lee Partridge: No.

Paul Cleary: Sorry.

Lee Partridge: I'm sorry Dr. Cleary.

Suzanne Theberge: Paul we've voted a lot of different questions.

((Crosstalk))

Paul Cleary: I knew that from the last meeting, my…

((Crosstalk))

Lee Partridge: All right. Suzanne?

Suzanne Theberge: Okay. The committee is ready to vote on performance gap. Yes, okay. Voting is now open on 1B, performance gap. A, high, B, moderate, C, low, D, insufficient. Okay, we have an extra vote here. But we will sort that out on the back end. In any case the measure passes performance gap, that's two high - with two high, 10 moderate, three low and one insufficient.

Peter Thomas: Well, I voted this time and I think the vote was closed the first time, the first question when I cast my vote, so maybe that's why.

Suzanne Theberge: Okay.

Peter Thomas: This is Peter.

Suzanne Theberge: Great, thanks. I think we'll - yes, I think we're good. Okay. Would the committee like to vote on reliability?

Lee Partridge: Yes.

Suzanne Theberge: Or is there any further - yes, okay. We'll just pull that vote up. So the committee has the option here to take the scientific methods panel rating for reliability for Measure 0005 and that rating is a moderate for reliability. Your options are yes or no.

Okay, well the vote is unanimous with 15 votes, yes and we will now go on to the same - does the committee wish to accept the scientific method panel rating for validity which is also moderate. And the options are yes and no. And again, unanimous, 15 votes yes for accepting the methods panel rating of validity as moderate and now on to feasibility.

Is there any discussion for feasibility or has the committee sufficiently covered that?

Man 1: Sufficient.

Suzanne Theberge: All right. We will…

((Crosstalk))

Suzanne Theberge: Now, just give us a moment to pull that vote up. All right, now we are voting on feasibility. Options are A, high, B, moderate, C, low and D, insufficient. We're looking for a couple of votes here. And here we go. The measure of passage at moderate with 13 votes for moderate, zero votes for high, three votes for low and zero votes for insufficient.

And we will now move on to Use. Any discussion? The committee is now voting on 4A, Use. Your options are A, pass or B, no pass. Just waiting for a couple of more votes here. All right, and the measure passes Use with 13 pass and three no pass. And now, we will go on to 4B, Usability. Your options are A, high, B, moderate, C, low and D, insufficient for 0005. Just waiting for a few more votes. All right, and the measure passes Usability with two high, nine moderate, four low and one insufficient.

Any final discussion before we open it for the overall vote for recommendation for endorsement? All right, voting is now open for overall usability for endorsement. Recommendation for maintenance 0005, CAHPS Clinician & Group Survey. Options are A for yes and B for no. Still waiting for just one more vote, there it is, all right. The measure is recommended for maintenance of endorsement by the committee with 14 votes yes and two votes no.

Okay, I think we're ready to move on to the next measure.

Lee Partridge: Thank you everyone. The next - according to my list, the next measure is now CAHPS Health Plan. Our lead discussion is Sherrie Kaplan. I - Ann Monroe I know couldn't join us unexpectedly at the last minute. I don't think Chris…

(Chris): Yes, I'm here.

Lee Partridge: Are you here? Okay, good.

(Chris): Yes.

Lee Partridge: Then Dr. Cleary, the floor is yours to talk about HCAHPS.

Paul Cleary: Well, I'll just say that it's different and that the focus of the survey is on all experiences with the health plan with six months or longer for the Medicaid version and 12 months or longer for the commercial version.

The Health Plan CAHPS Version 4 was endorsed by NQF in 2007 and 5 received maintenance endorsements in 2015 and I'll just defer to Sherrie to make the comments, because I think many of the issues that will come up maybe are comparable.

(Chris): Yes.

Lee Partridge: All right. Sherrie?

Sherrie Kaplan: Hi Paul.

Paul Cleary: Hi Sherrie.

Sherrie Kaplan: Not a conflict of interest. But Dr. Cleary and I have known each other for an unspecified number of decades and we've had a long experience with patient reported outcomes and patient reported experience measures. So my concerns and these are probably going forward, not for this particular measure and I was - I'm on the scientific advisory or scientific methods panel, but I did not review this measure on that panel.

My questions are going to be rounded on the - or I have a couple of concerns about this measure. It's being used at the plan level and there are plan level data reported in 1B. It's been around for a long time. And I have a little bit of a concern that about half of the evidence cited is over 10 years old and since this has been around for such a long time, it starts to get more of the - more recent evidence could have strengthened the case there. But that doesn't necessarily make the body of evidence.

So that's one thing. And the data that are reported are at the plan level for 100 - sort of for 152 Medicaid health plans and 169 I believe commercial health plans. So there are plan level data reported and there is some degree of difference between the top and the bottom. Again, the top box scores are a little bit right - just a right sort of feeling. Some of these top box scores look - have a better feeling, but that's still not a problem for the gap.

Lee, do you want me to just go through a few more issues with reliability and validity and then turn back to Dr. Cleary? Or do you want me to stop…

Lee Partridge: Well, unless anybody objects that worked I think fairly well on the previous measure. So go ahead and then Dr. Cleary can respond and then we'll open it up.

Sherrie Kaplan: Absolutely. Okay, so there is a couple of issues about the data that were presented. One, Paul, is the confounding of plan we state for at least three of the 34 states and I was concerned about how that was handled on page - paragraph 2 on page 52 of the application. The second thing I'm rather concerned about is the interclass correlation coefficient at the plan level and it's pretty low. How - the problem with that disturbing finding, you said if you see the standard care of measurement at the plan level, my concern is there is going to be a lot of noise in that variable which - you know, where that measure which causes me concern about the ability to discriminate between plans.

Another thing is that the variability and response rates by vendors although you - the recommended numbers are like 40% to 50%, in my experience with vendors, it often approximates about 15% which can really mess you up in terms of generalizability and response by, you know, in both favorable and unfavorable.

And then two more quick things. I have a concern of Table 2A23C on page 52. The ICCs are as I said pretty low. Table 2B3.6C needs some help on the units there, because it looks like the plan level, but I wasn't exactly sure. And if those mean differences between adjusted and unadjusted scores are in

percentages and the standard deviation is 5%, then some of these are approximating the same and some of them are not.

Could you comment on those couple of issues? Unless you want to go lead, are we're supposed to (unintelligible) everybody else's comments first?

Lee Partridge: No. Let Dr. Cleary respond.

Paul Cleary: I'm just catching up to page 52. Lots of good points raised. We certainly could include more recent evidence. And I'll go back and look at the issue of confounding plan with state. I don't think we presented. But we do have a (unintelligible) couple where we take components of variation and we looked at components of variation both by region, states within region, markets within states and plans within markets.

And then I think that seems a little detailed for this application, but that we have looked in great detail at that kind of variation plans or you can't - you do differentiate well between plans taken into account the fact that they're nested not just in states, but within markets and so on.

And as I mentioned before, that - those analysis were done with Medicare advantage data and often we don't - since we're not collected, this consortium is not collecting the data. We try and compile the data that we have available where your point is well made and I can provide that data later or certainly we could address that in subsequent submissions.

The response rate issue is a very important one. In fact, the consortium in arc are sponsored a national meeting this year and representativeness and response rates looking at not just response rates which everyone knows becoming problematic for all surveys, but representativeness is this committee

now is you can actually have a reasonable response that's less representative and a lower response rate. So we're trying to address both of those issues by making the surveys easier to complete, administer, helping people think through how to assess their denominator population.

And I don't know what else to say about that except that nationally rates have been going down as you know Sherrie for the last decade and we've been just trying to do a lot of research to ameliorate that trend or mitigate that trend and emphasize the need to assess representativeness.

And now I'm turning to I think page 52 and what was the table number you're referring? Was it Table 2A…

Sherrie Kaplan: 2.3C, 2A2.3C.

Paul Cleary: Yes. So the - yes, the plan level reliability is there. Again, the real issue is the extent to which you can differentiate plans and those are actually I think pretty reasonable, it varies from like 0.67 to 0.88.

Sherrie Kaplan: I'm looking at the ICCs Paul.

Paul Cleary: Yes.

Sherrie Kaplan: And so the ICCs allow - the between versus - over between plus within plan variation, but the problem is that with the ICCs where they're calculating and again this is like evolving, so NQF is beginning to - you know, we're discussing these kinds of issues with NQF, because the standards, it wouldn't be fair to hold the developer accountable for standards that may change. But included in the denominator should have been or should be going forward the patient across items. So you have patients across items as an firm, you have

patients within plan, so patients within plan variation and then you have between plan variations and the denominator.

So in fact, the ICCs right now are all under except for - yes, they're all under 0.05 which doesn't give you a lot of confidence that there is ability to detect between plan differences unless for those 152 plan you gave us (spline) that said here is the between plan - here is the within plan variation that included the patient level variation in addition. And then the main differences between plan so that we could actually see how much of that variation - what's the standard there of the measurement at the plan level. Do you by the way have the standard air measurement at the plan level?

Paul Cleary: Yes. We - I just make several comments. We actually considered the (spline) approach and because this would apply to all the CAHPS Surveys and it was not traditional, we had, you know, a discussion of it and thought it was reasonable not to include it and we decided not to go there. We're actually preparing a description of the various ways in which unit level reliability is calculated. And in fact, there is a project with CMS ongoing now, but because it has been to be frank inconsistent across different surveys depending on the time of the development, the group that was developing it and so on.

Our - one of the variations that we'll say is the assumption of link units that you're going to have common within plan variation, we've kind of proposed it. We look at units specific within plan, within unit variation as a more accurate way to get it basically this reliability for each unit. I mean we - yes, we have lot of data. We could present many variations of this and just this we thought was the most parsimonious and reasonable representation that the - you do get differentiation among plans.

Sherrie Kaplan: So well, you know, we can - Ellen (unintelligible) and I have had - was sharing lease back and forth about the right way to do this. And so this is not the appropriate for that discussion. But it still is a little disconcerting that the ICCs are not bigger than they are. But the - can you also clarify at table - if you turn to page 61, the 2B3.4B, is that table giving us information at the patient or the plan level?

Paul Cleary: Hang on. I'm getting up there. Page 61 and what were the numbers again?

Sherrie Kaplan: 2B3.4B.

Paul Cleary: .4B, sorry. And I'm sorry, your question is?

Sherrie Kaplan: Are those data at the plan or the patient level?

Paul Cleary: You were talking about the case mix adjustments?

Sherrie Kaplan: The effects of health status and education, yes.

Paul Cleary: Yes. So it's basically a model where you look at the between plan differences controlling for within plan coefficient. So it's a patient level analysis and the adjustment coefficient is the coefficient of general health status on doctor communication for example, absorbingly between unit differences.

Sherrie Kaplan: Okay.

Paul Cleary: So it's essentially a within unit coefficient. So for everyone else on the committee in general, we look at the relationship between a person's reported health status and the persons reported by their doctor communication whether they explained listened, et cetera, et cetera, taking out the effect of the fact

that plans differ on communication and on health status. So you're basically saying the purpose of this is to say how does plan-A compared to plan-B if those two plans had a comparable distribution of general health status, because we know that people in better health tend to report fewer problems with communication.

Sherrie Kaplan: Okay. Thank you Dr. Cleary, that helps. For those of us who didn't have page 62 up on our screens.

Lee Partridge: Thanks Paul.

Paul Cleary: Thank you.

Chris Dezii: This is Chris, Chris Dezii. I was one of the other discussions that (unintelligible) did a very nice job. I've nothing to add. She covered everything. I just wanted - I think I heard her say or maybe not in the performance gap, there is a moderate opportunity for improvement and it has been improving over time, but in light of everything we said. Nothing more.

Lee Partridge: Now, Dawn was the other discussion and I know she was joining us late. Are you on Dawn or not with us yet?

Suzanne Theberge: Dawn was expected right around three or shortly after and nothing on yet.

Lee Partridge: Okay. Well then we open it up for general questions in discussion.

Paul Cleary: So just when I think I'm just retracing what I said and I think there is prior to Sherrie's question I didn't answer, but Sherrie, you're essentially correct. Although ICC does indicate there is a lot of variation in individual experiences, you know, and/or interpretation of the items, but that doesn't

negate the fact that the item may still differentiate among unit A, B, C and D, because there is still…

((Crosstalk))

Paul Carey: …that variability.

Sherrie Kaplan: Yes. That's why we kind of like the - you know, and I'm partial to the actual graphing of the standard measurement around the plan means and so that, you know - because then you can kind of get a visual picture for people who are trying to say how much that is who are not. You know, I think it is helpful to kind of see that picture, but if there is other reasons not to - and since you've already done it, you've - it's probably not a big pain to kind of deliver. But in future maybe that would help with the argument that there is more between and within plan variation.

Paul Cleary: Yes, that's fair.

Lee Partridge: General discussion.

Don Casey: This is Don. Paul, I have a couple of questions. One is of course I pulled up the 2018 chart book and I'm looking at the four different plans. I didn't - I'm not a statistician in the sense that you guys are down in the weeds with ICC differences. But, you know, it clears that the trends - thank god, the trends are obviously pretty flat especially in the Medicaid subpopulations and of course not all states participate at the Medicaid level.

So we have - you know, it looks like there were significant changes between about '08 to '13 in aggregate, but you would agree overall trends, I understand the importance of distinguishing game plans with the overall trends for the

four subpopulations have been pretty marginally flat - marginally improved or flat. And I guess the question is, are you seeing year-on-year statistically significant differences at the aggregate state and plan level between each of these categories that don't Medicaid - child Medicaid chip and Medicare?

Paul Cleary: We have seen and I actually published a couple of articles about hospital CAHPS and there has been a couple of articles that isn't - that wasn't in articles, the chart book. If you look at the aggregate Medicaid data, there have been improvements. I won't say dramatic, but I will say pretty consistent and pretty regular improvements overtime. I'm obviously a partisan in this discussion, but I've actually been pleased giving how hard it is to change certain aspects of healthcare systems that there is I believe a substantially more profound awareness of the importance of patient experiences sand that systems and states and provider groups have been doing things to improve and it has shown up an aggregate data.

Don Casey: I can see some of it, but I kind of…

Paul Cleary: That's more an aspirational statement than a hard data statement. But, you know, we do have a lot of individual reports, sorry to interrupt you.

Don Casey: Yes, I know. That's okay. I can see some of it, but of course you - the reporters are using the truncated way to access trick. So the difference is look, I think bigger. But certainly in some of these aspects like getting needed care for chip, you know, that actually looks the same between '14 and '18 by my eyeball. So that the - you know, the top box scores in some cases do show some early on trends and made chip looks better, but if you look at getting needed care from Medicare for example, that's decline steadily since '18. So I'm just saying that we ought to - in my opinion we ought to be looking at these chart books. Would you agree?

Paul Cleary: Well we - yes, we think the database is very, very useful. One of the difficulties of the chart books is their cross sectional voluntary data. So I think - I don't know the chip data, I don't have that in front of me. And I don't - I didn't recall that. And I can't - I'm trying to think, I don't think I'm aware of other chip data. So I don't have anything to say to that. But yes, you do have to be cautious with the chart books because of the fact that the - it's sequential cross sections and that can differ.

And, you know, in some cases - and I don't want to sound defensive, because I'd like to improve more than they have. But in some cases, you know, you get late entrants and they're the people who have the most problems. We just did three years of statewide surveys and Connecticut is part of one of our (SIM) projects and we're seeing actually quite nice improvement in both Medicaid and commercial. Unfortunately they're not publicly available, so I couldn't enclose them. Our data don't include chip data though.

Lee Partridge: Okay. Further discussion? Okay, Suzanne…

Dawn Hohl: I just wanted to introduce myself. This is Dawn Hohl, just dialed in.

Lee Partridge: Dawn, I'm sorry. We got moved a little quickly here. So we had a good bit of discussion about the measure which you were looking at which is the Health Plan CAHPS measures.

Dawn Hohl: Okay. I'm so sorry, okay.

Lee Partridge: That's all right. I think you know them very well. And if you have any overall comment, you want to share, I think we talked a considerable length about…

Dawn Hohl: I do not.

Lee Partridge: Okay, all right. Are we ready to proceed to voting?

Suzanne Theberge: Yes, give us a moment to pull that up and we will begin voting on 0006. All right. Voting is now open for evidence on 0006 CAHPS health plan survey importance to measure and report. A, pass; B, no pass. I believe we are looking for 18 votes. Sorry, 17 votes. Okay. And here we have 17 votes. So, 16 votes pass, one vote for no pass. The measure passes as evidence.

And any discussion before we move to voting on gap? Okay. It's - voting is now open for performance gap on 0006 CAHPS health plan survey. A, high; B, moderate; C, low; D, insufficient.

((Crosstalk))

Suzanne Theberge: Okay voting is now closed. We have two voting for high, 15 voting for moderate and one voting for low. The measure passes gap. Moving on to reliability. The committee has the option to take the methods panel recommendations of…

(Chris): Moderate for a liability and moderate for validity for the next one.

Suzanne Theberge: Thank you. Voting is now open. Yes or no. Okay. Voting is now closed. Everyone has voted yes. Eighteen votes for accepting the Scientific Methods Panel rating of validity. We will now move on to - reliability, sorry. We will now move on to validity. Same question. The committee has the option yes or no to accept the methods panel rating of validity for 0006.

Hang on while we pull up that correct vote. That vote is now open. Your options are yes or no. All right. Again, unanimous vote to recommend the Scientific Methods Panel rating of moderate for validity with 18 votes for yes. Now moving on to feasibility. Any further comments before we vote?

(Chris): No.

Suzanne Theberge: All right. We will be opening that vote in just a moment. Voting is now open for three, feasibility for 0006 CAHPS health plan survey. Options are A, high; B, moderate; C, low; and D, insufficient. Waiting for a couple more votes here. All right. Voting is now closed. It's zero votes for high, 15 votes for moderate, two votes for low and zero votes for insufficient. The measure passes feasibility.

Next vote is for use. We are pulling that up now. Voting is now open for criteria four A, use for 0006 CAHPS health plan survey. Your options are A, pass and B, no pass. And voting is now closed. We have again unanimous 18 votes for pass. No votes for no pass. And criteria four B, usability. Voting is now open. A, high; B, moderate; C, low; D, insufficient on 0006 CAHPS health plan survey.

Waiting for one more - there it is. Okay, we have four votes for high, 12 votes for moderate, and two votes for low, zero votes for insufficient. The measure passes usability. Any further discussion items before we move on to the vote for overall recommendations for endorsement?

All right. Hearing none, the voting is now open for an overall recommendation for endorsement on 0006 CAHPS health plan survey. Options are A, yes or B, no. All right. And the committee has unanimously

recommended measure 0006 for maintenance of endorsement with 18 votes for yes. And that concludes this discussion for 0006.

Lee Partridge: Thank you. Thank you Doctor Cleary. And (Chris) do you want to take over?

(Chris): Sure. That is fine. Okay. So, the next one I believe is the 0166H CAHPS if I'm not mistaken. I don't have who are the lead discussants for that but while we're figuring that out…

Lee Partridge: (Unintelligible).

Brian Lindberg: Brian Lindberg.

(Chris): Brian. Okay.

Man 1: Hey Brian.

(Chris): So Brian you'll be up - should we have the developer just do a quick intro, you know, maybe one minute or so and then Brian you can talk about what you saw.

Lee Partridge: Yes.

Brian Lindberg: That'd be great.

(Chris): Okay.

(Phil Erman): Hi, this is (Phil Erman) from CMS. I'll be introducing the HCAHPS measure. Also, on the line with me are (Liz Goldstein) from CMS and Professor (Ellen Tzozosky) from the Harvard Medical School. I just want to set the context a

bit for the HCAHPS measure by quoting from a letter from Ken Kizer, president of NQF to Mark McClellan, administrator of CMS.

And in this letter from October of 2005 Doctor (Kizer) mentions that it's pass is particularly important because it addresses the critical gap in performance measures for public reporting. As noted in 2003 NQF consensus report, there's been no standardized open source measure that pays perspectives of their experiences in hospital care which is necessary for valid widespread public reporting in this important aspect of quality hospital care.

It's kept instrument in the specifications were carefully and methodically researched and tested before being submitted to NQF for consideration. During NQF consideration, it underwent further scrutiny and review. The overwhelming support for it came only after many discussions and some changes to specifications recommendations.

Like all NQF voluntary consistent standards the current HCAHPS measure will no doubt evolve and improve with use. It stands today however as a strong, well developed and thoroughly vetted measure that addresses a critical need in public reporting of health care quality. And like other NQF endorsed measures, there's literally no other mechanism for consumers, providers and others to get the information the HCAHPS will publicly provide.

HCAHPS has withstood the rigors of the NQF process and has widespread report - support. HCAHPS must take precedence in the federal government's efforts to promote public reporting of hospital performance. Therefore, the NQF Board of Directors strongly urges you to immediately implement HCAHPS.

As far as context, just a few facts about HCAHPS. As you all know it's a 32-item survey of patient experience of care. Currently over 4500 hospitals participate. Of those, some 1300 participate voluntarily, that is they are not required by CMS to do so but they do so of their own volition. Currently we public reported HCAHPS measures are based on about 3 million HCAHP surveys which means about 8000 surveys are completed every day.

In terms of burden which I know the committee was interested in we estimate that a basic no frills cost for HCAHPS to hospitals will be about $4000 per year. Of course, that will vary depending upon the vendor and the mode used, etcetera. And we estimate that it takes patients about eight minutes to complete the HCAHPS core items on the HCAHPS survey. Thank you.

(Chris): Great. Great. Thanks very much and thanks for the quick thing about burden. I know that's a concern so great. Brian, go ahead.

Brian Lindberg: Thank you. Let me - before I dive into the evidence let me just ask if you could -- CMS whomever would be appropriate could -- provide just a little more on the issue of the three items related to pain that had been taken out of the HCAHPS.

(Phil Erman): Sure, I can do that. The three pain items will be removed from the survey beginning with patients discharged October first of this year. This is a direct result of the Support Act which was passed overwhelmingly in Congress last year. It's based upon the perception that the three items - three pain related items in the survey were incentivizing hospitals to pressure physicians to prescribe more drugs to get better scores.

We never saw any evidence of that -- at least no scientific evidence of that -- yet there was a growing concerning Congress that this was in fact the case.

So, we were mandated by Congress to remove those items pretty much as soon as possible.

Brian Lindberg: Okay. Thank you. Well let me - the quick comment on that is that on its face, it stands out as a -- from a consumer perspective -- pretty negative change. And given that Congress doesn't spend the time that we do looking at these measures and these patient perception tools it's from my point of view a very disappointing occurrence and I'm wondering down the road -- and we can talk about this maybe later -- how we're going to find out the information that we were getting from that data.

But though let me just add to what - the quote about - from Ken you know that Ken Kizer didn't mention the good, the bad, and the ugly of all that process. But the fact is that this is - this measure has long been very important to consumer groups who have supported it, helped in playing a role in its development and modifications to it. And it's just critical that consumers have these patient perceptions of hospital experience and further that the public reporting I think and shown to push hospitals to do better.

So, I was happy to draw this straw. And I will dive into the evidence which is generally very positive based on votes, patient feedback that was solicited and focus groups that were done. I think there's evidence as well that hospitals have improved their services tied to the information they receive from HCAHPS. There's, I think, the developer has provided information that was helpful in terms of hospital managers sharing best practices and other evidence showing the value here along with the updates they have provided.

I think on the performance gap, the analysis shows that there - the performance variation in a number of areas is significant enough to be valuable including on variation based on race and on seven different language

offerings and the responses there. Let me see what else we've got here. There was one response that the gap - there is a gap analysis provided by the developer and I don't think that clinicians and facilities can use the data to improve their processes.

Others on the call may want to chime in on that when we're through this. On reliability, the measure was reviewed by the Scientific Methods Panel and passed with high reliability and validity ratings. There was one reviewer concerned that the overall variance was not showing two difference in performance. I guess from what I read the - primarily the reviewer was referring to the ICC results which fell below a threshold that was needed for meaningful differences.

But on the other results, Spearman Brown Formula, it met the threshold. So, we may want to discuss that. Let's see. So, my view was on the reliability that it did both the Scientific Methods Panel and my review of the information is that it did reach that important threshold for us on validity. Generally, the SMP agrees with the submitters conclusion that the studies support for the construct and prove validity.

One SMP member noted that quote, "I didn't understand why the Hospice Nursing Home, etcetera patients are excluded for valuation of hospital stay. " We may want to talk a little bit about that. It certainly is from a consumer point of view interesting because those individuals one, could make an assumption are going into a facility for a higher level of care potentially in some areas and that might be interesting to see what their viewpoint was on the hospital care. The Hospice population versus the nursing home population might be viewed differently.

On reviews comments, there -- let's see. On reviewer talked about - they said, "There's no evidence presented linking measure scores to an independent measure of quality of care at the clinical level." And I think that's an interesting point and maybe is mute in the sense that we're talking about a patient's perceptions. But none the less a couple reviewers talked in those terms.

And again, the issue of whether this was a true outcome measure came up from a reviewer and I think we've covered that pretty well. But feel free to bring that up in our discussion as well. On feasibility, I think that the preliminary rating although was low I think that the - I mean, I think the case has been made that it's feasible. It's been used. We continue to, I think, improve our ability to follow up on the use of the survey and provide other technologies to get more input.

So, I'm not sure that we want to go deeply into that. The biggest point I guess came from one of the committee comments that there is - they said, "This is where my biggest concerns lie. This is measure is simply too prudence in for patients, facilities and clinicians slash staff to administer, interpret and then act upon."

And then under usability and use I think that it's - obviously it's publicly reported. It's used in accountability. It's used in hospital compare and hospital inpatient quality reporting program which are very important, and with hospital value-based purchasing. Generally, the committee comments were positive and basically regurgitate what I think was provided by the developer and CMS.

So that's my summary. Again, I do find it disturbing that an area that I think over the years we've learned is so overlooked and often mismanaged - that is

pain management. From the consumer perspective it's a shame that we don't have the information, the tools to lead to making sure that individuals are not suffering. But that's my summary. Thank you.

(Chris): Great. Okay. Thanks Brian. Sorry. The preliminary rating for feasibility from the (unintelligible) was low and I think that's because there was not a description of burden. But it seems to me that the developers provided that description. Does that make sense to the staff at this point?

Man 1: Sorry. I'm not certain that we actually saw a description of it other than a brief write up. But if the developer would like to…

(Chris): Oh, it was just what they said verbally.

Man 1: Okay. Yeah, yeah, sure. Okay. Right. Thanks (Chris).

(Chris): Okay.

Man 1: That is what we had in mind is just a verbal description…

(Chris): Okay. Okay.

Man 1: …of what burden looks like and that's appropriate.

(Chris): Okay, right. And then, yeah, as Brian described there was another concern that may have been related to that. Okay. So, we've got some other discussions. (Lisa), Brenda and Sherrie, would any of you like to add anything else to Brian's very comprehensive discussion?

(Lisa): This is (Lisa) and I will concur with your assessment. I thought Brian's summary was excellent. I don't disagree with any of it. I will say that there was a question about the use of construct validity as for empiric's validity testing, but the Scientific Methods Committee determined that that was acceptable and the rating, I think, was moderate from the SMP.

And I think in terms of Hospice exclusions I think when you're that - like, a reasonable exclusion to me given the challenges with quality of life for that particular patient population although I can absolutely recognize that it may be something that the developer wants to track over time to determine if there are - they're losing a particular high proportion of patients to that exclusion over time or if that's changing over time in ways that might suggest that patient care is being impacted.

I'll echo Brian's comment about the concern over removing the pain questions. Although I know clearly it was done in response to the concern about unintended consequences and I'm just wondering if with CMS on the call if there might be opportunities for thinking creatively about collecting the data but not using the data in calculating the measure results so that CMS or hospitals could track that information for their own information but not have it used for payment purposes so that there could be transparency for providers and for CMS about pain control even if - but yet, they're avoiding the unintended consequences of potentially incentivizing opiate overuse. And that was all I had to add.

(Liz Goldstein): This is (Liz Goldstein) from CMS. For the pain one we're actually - Congress passed a law so we cannot collect it unless we're just asking about whether a hospital told a patient about the side effects of opioids. So (unintelligible)…

(Chris): Wow.

(Liz Goldstein): …unfortunately.

(Bill): Yes, this is (Bill) at CMS. Just to add to that our first step was just to remove pain from the payment formula that is hospital BVP but that wasn't enough. And then we revised the measure. We reworded it to make it more about - totally about communication about pain and that still wasn't sufficient. And so, the last step was that we had to remove it entirely. So, we didn't go into it willingly. We resisted as much as we could.

((Crosstalk))

(Chris): Okay. Well thank you for that.

((Crosstalk))

(Chris): Go ahead Brenda.

Brenda Leath: I concur with what others are saying particularly Brian. I was pleased that you spent time talking more about the issue of the removal of the questions related to pain. And, you know, while I'm standing with the Congressional mandate to remove it, it's unfortunate because there has been studies in the past of some variation in pain management across population subgroups.

(Chris): Exactly.

Brenda Leath: So, it's unfortunate that that has had to take place. I don't have any other comments. I think everyone else has actually covered everything.

(Chris): Great. Thanks, Brenda. Sherrie.

(Sherry): Yes. This is (Sherry) and I really don't have a lot to add. I really appreciate Brian's very thorough review of it. And I agree with - I appreciate that also was brought up the - oh gosh, the - I'm losing now. The construct validity question but I think that - oh, I agree fully with what was said before that it changes if it's okay the way it - that the review committee was comfortable with it I think the level of being moderate.

And I really appreciate (unintelligible) addressing on the call the burden and cost questions. I found that extremely helpful for this measure and would just really want to encourage that that be done in a written format in a more, you know, with a little bit more information provided to the extent that they're able in the future. I just - I think it needs to be prioritized more so than it has been to date. Thank you.

(Chris): Great. Thanks. Okay. Let's open it up to the committee for brief comments or additions to what's been said.

Don Casey: This is Don Casey. I just want to maybe round out that initial statement about our discussion about pain vis-a-vis counter stating that I believe the regulatory disincentives at whatever level you want to call it provoked more problems than let's say so called incentivizing others to prescribe opioids. Secondly, we have a lot of evidence now that you don't need to use opioids. In fact, it can be very - more effective in treating both acutely and chronically by not using opioids.

There are several high-quality guidelines here. So, I hope we keep this pain conversation going although I understand the legal consequences of keeping it out. I think the, you know, again I'm always looking at trends. I looked at the 2014 April to October versus the '18 April to October and I don't see between

the, you know, there are some differences obviously in the questions because of the changes but I don't see a whole lot of movement at that rate.

And I'm actually at Rush today because I have a doctor's appointment and I looked up Rush because I trained here, and I know this place. And my question, I guess, that doesn't need to be answered is wondering - looking at their - they publicly report their own HCAHP scores which I think are easier to find for consumers.

But the difference between always and usual when you add in the usual as opposed to the always in many of these questions, you know, the numbers get into the mid, maybe upper 90's depending on the question. It looks the same across the state of Illinois and the U.S. So, I just - I always struggle with the psychometric differences between always and usual vis-a-vis how we're calculating (unintelligible).

So, just bring that to the table. I don't think it changes by thinking about how I'm going to vote, but I think it is important to think about because I think it's not clear. So.

(Chris): Great. Thanks Don. Others' comments?

Sherrie Kaplan: This is Sherrie Kaplan. The degree of mutability and when a measure stops being able to be improved and I understand Doctor Cleary's point about, you know, these are cross sectional samples that are repeated, you know, so if you don't get a trend from a cohort of folks.

But at some point when a measure begins to either have ceiling effects or begins not to change over the course of time -- and certainly with HCAHPS we've had a long time to kind of look at these scores -- one wonders what part

of the remaining variation is actually mutable given improvements in quality of care. I wonder if that's a legitimate question to ask at this point.

(Bill): This is (Bill) at CMS. Yes, a couple of notes. Don is correct. Since 2014 or 2016 the change or improvement in the top box scores for the HCAHPS measures has flattened to a greater degree than it had been previously. Also, Don mentioned always and usually. You know, of course always - the always response is the top box response. We don't combine that with usually or anything else. In fact, we discourage people from doing that because I think they are throwing away a lot of information if they combine always and usual.

In terms of the ceiling effects, I think the highest measure right now top box wise is about discharge information which is about 94%. That's a yes/no composite so it's a little different. The other composites in individual items, the top one is doctor communication. That's at about - currently at about 81%. So there still is room. I agree that, you know, it would be interesting to look at while, you know, how much more improvement is possible.

That's something that we should look at because there has been a gradual -- across the universal hospitals that participate -- there has been a slowing of improvement the last say four years. So that's something we can look into. On another hand, maintaining high levels in all the measures have improved greatly since the introduction in 2006 has been impressive.

Don Casey: This is Don, could I just jump back in? I meant to say that the - not just the top box between the four-year period but across the percentiles of each year don't seem to change much. So, I'll just leave it at that. It's top to bottom.

(Chris): Okay. Great. I think it sounds like we may be ready to vote. Any other burning comments? Okay. So, let's start by voting on evidence.

Suzanne Theberge: All right, we're pulling that up. Okay, voting is now open on evidence for measure 0166 HCAHPS, Hospital Consumer Assessment and Healthcare Providers and Systems. Options are A for pass and B for no pass. And we are looking for 18 votes. One more vote. All right. Well, the measure passes with 17 votes for pass and zero votes for no pass.

Gap.

(Chris): Okay.

Suzanne Theberge: Pulling that vote up.

(Chris): Let's vote for gap.

Suzanne Theberge: Voting is now open for measure 0166 HCAHPS on performance gap. Your options are A for high, B for moderate, C for low and D for insufficient. Waiting for a couple more votes.

(Lisa): Suzanne this is (Lisa). I just want to let you know that I'm voting by email because I've lost my internet access briefly.

Suzanne Theberge: Okay. Great. Thanks for letting us know. We are - give us a moment just to pull that. I think we're okay. I think we're… All right here we go. Our measure passes performance gap with two votes for high, 13 votes for moderate, three votes for low and zero for insufficient. And we will move on to reliability. Again, the committee has the option to take the Methods Panel recommendation on reliability. For this measure it was high for reliability and also high for validity.

We're pulling that vote up. Sorry, I have lost the vote. We are - okay. The measure passes with the Methods Panel recommendation of high. And we will now open for does the committee accept the Methods Panel recommendation for validity? Options are yes or no. We are just sorting out - okay. Here we go. All right. The measure unanimously - this committee has voted to take the Scientific Methods Panel rating for validity from (unintelligible) votes.

We will now move on to feasibility. Okay feasibility is now open. Your options are A, high; B, moderate; C, low; D, insufficient for 166 HCAHPS.

((Crosstalk))

Suzanne Theberge: Waiting for one more vote. And there it is. Okay. Measure passes feasibility with four voting for high, 11 voting for moderate, two voting for low and zero voting for insufficient. We'll now move on to use. Voting is now open on use for A for 166 HCAHPS. Your options are A, pass and B, no pass. All right. Voting is now closed. Fifteen votes for pass and two votes for no pass. The measure passes use.

And now, we will vote on usability. Voting is now open for criteria for B, usability on 166 HCAHPS. Your options are A, high; B, moderate; C, low; and D, insufficient. All right. Measure passes usability with three high, 12 moderate, and two low, zero insufficient. Any final comments before the committee votes on an overall recommendation for endorsement?

Okay. We will… All right. The committee is now voting on overall recommendation for endorsement on measure 166 HCAHPS. Your options are A, yes or B, no. And the committee has unanimously recommended the

measure 166 HCAHPS for maintenance of endorsement with 17 votes for yes. Thank you.

(Chris): Okay. So, time check. It's 13 minutes before the hour. Can we begin the discussion of the child HCAHPS or what would you recommend?

Man 2: Well we'll defer to however you want to approach it (Chris). If you think that's the best way to go, we can go ahead and do that.

(Chris): You know what, just because we've got so many more measures, I would favor beginning, you know, and maybe go through the discussion summaries realizing that they may have to kind of do a brief re-summary but at least to identify things to think about. If we get to a vote, wonderful. Probably won't but anyway. I'd like to start.

Man 2: All right. Very good. Let's go ahead and hand it over to the developer to lead in with (unintelligible).

(Chris): Great.

((Crosstalk))

(Sarah Cumey): Great. Hi, can you hear me? This is (Sarah Cumey).

Lee Partridge: Yes, we can.

(Chris): Thanks.

(Sarah Cumey): Great. Perfect. And I just want to also acknowledge that (Mark Shuster) and (Alan Phisgloski) are also on the line. So, just - I'll try to be really brief. So,

the child has to look at consumer assessment and healthcare providers systems (unintelligible) survey child HCAHPS was developed at our center -- the Center of Excellence for Pediatric Quality Measurement -- as part of an ARC and CMS funded pediatric quality measures program.

And we did this in conjunction with the CATS consortium using their design principles and partnering with them throughout the process of developing the survey. For the sake of time, I'll just say that we went through a rigorous process during that development process and ended up with a survey that consists of 39 items organized into 18 composite single item measures that are packaged into five overarching groups.

Since endorsement, the number of hospitals fielding child HCAHPS has grown and I should really say from the perspective of pediatrics, quite substantially. So, we know that at least 347 hospitals from the information that we received from two of the largest survey vendors are currently voluntarily administering the survey.

Child HCAHPS measures are being used at a local to drive improvement and benchmark performance. We also know that child HCAHPS measures have been incorporated into insurance contracts and are being used in accreditation and recognition programs such as Nine Net recognition the program that's run by the American Nurses Credentialing Center. In addition, the Leap Frog group a national non-profit organization that publicly reports hospital performance and safety added child HCAHPS to the Leap Frog hospital survey in 2017.

So, in some I think child HCAHPS is the only publicly available, nationally developed pediatric inpatient family centers of care survey and is use is growing. We anticipate that the impact of child HCAHPS will continue to

grow and will be an important measures that as hospitals strive to improve patient experience for their pediatric patients. Thank you.

(Chris): Great. Thanks very much. Ryan I think you're the lead discussant on this. Ryan Coller.

Ryan Coller: Sure. Thanks (Chris). Thanks (Sarah) and everyone for a really great (unintelligible) summary. I think the essence of the conversation here followers from what a lot of the other caps measures that we've discussed already. And I think the spirit of the measure is really important. A few things I think to discuss throughout the components just from the standpoint of maybe hearing a little bit more detail and (unintelligible) the chance to discuss as a big group.

As far as the evidence goes, the meaningfulness is I think well illustrated through qualitative work with focus groups and interviews. And the lit review suggests a number of links between patient family center care as well as outcomes including readmissions, ED visits, mortality. Some of the data is not entirely child specific so I think to some extent you have to feel comfortable extrapolating some from adult data. But there is some child specific data in there.

The pre review comments included just a little bit of a notation that there was less evidence on how to change scores as a hospital but there's some indirect evidence there. And then, regardless there's quite a bit of variation in performance that's been demonstrated including data that's been submitted from over 172 hospitals in 2018 and 122 from 2015 to 2019.

The prereview evidence summary was preliminary pass for meaningfulness, importance to measure and moderate for gap. There were noted differences in

responses by race ethnicity as well as education levels. And then a couple of things to discuss, so the Scientific Methods Panel passed this with respect to reliability. It was noted that a few of the composite scores had lower than sort of typical thresholds including mistakes and concerns. Reliability by chrome box itself was .26 and communication about meds, .43.

And then the single items don't have chrome box (unintelligible) so it might be an opportunity to discuss a little bit around that. However, the Method Panel did pass this with moderate. Validity, there were no major concerns. Feasibility, I think there are a couple of questions that I think would be worth discussing around. I just wanted to clarify from the developer's side if the response rate is currently around 17% if that's accurate.

And then I know this measure I think is a little bit distinct from the other measures in that there's not an electronic modality to respond with. I think it's just thrown in mail at this point. So, kind of where that's going. And use and usability, I think the main concern there was around data for demonstrating longitudinal improvement. And so, the preliminary review there was insufficient at this time. But that's kind of the main sort of summary.

And I just wanted to point out also that there was public comment I wanted to mention about - that pointed out just the desire for an electronic version. And then there was some comments about some concepts that the commenter thought should be included around content.

Woman 2: Thanks Ryan. This is NQF. We wanted to just quickly interject and say it's 3:54. If we can keep a quorum of the committee on the call for the next 15 or 20 minutes till, like, 4:15 eastern time or so and the developer is available we'd like to try to get through this measure and then we could cancel Friday's

call rather than trying to get on the phone for one measure. First can the developer - can you - (Sarah) can you confirm that you're available for the next 20 minutes or so?

(Sarah Cumey): I can. I want to make sure that (Alan Phisgloski) also can. (Alan) can you be on?

(Alan Phisgloski): Yes, I can stay on.

(Sarah Cumey): Great.

Woman 2: And committee members can you let us know if you need to leave, if you have a hard stop at 4:00?

(Tim Alley): This is (Tim Alley) also when my plane takes off.

Woman 2: Okay.

(Tim Alley): It's due to leave in about ten minutes.

((Crosstalk))

(Tim Alley): It's running late so it may be okay.

((Crosstalk))

Woman 3: This is (Unintelligible). Unfortunately had a hard stop at 4:00 and I do think there are other measures that are still on this agenda that we've haven't gotten to.

Woman 2: We do have other calls scheduled for next week. So, we'd like to try to get, you know, get through as many as we can today. But we have calls on July 1 and 2. So it sounds like we're losing at least one committee member. Are we losing anyone else? Why don't we keep going and when we get to the vote we'll see where we're at in terms of quorum. And if we've lost quorum, we'll terminate the call and otherwise we'll just try to get through this measure. So, back to you committee.

(Chris): All right. So, it sounded as though there were a couple of concerns about feasibility and I think it was usability, Ryan, is that the other one?

Ryan Coller: Yes.

(Chris): So, this might be a good time for the developers to address those. Are you - (Sarah) are you clear as to what the concern was and would you like to respond?

(Sarah Cumey): Yes. I can certainly respond to some. So, in regards specifically to the modality of child HCAHPS, we - when we developed it it was developed using mail or phone. That is correct. What I can say is that it is being administered by email also by all of the survey vendors. So that aspect is not - is no longer a concern.

In regards to - and I guess it's just a general comment about usability and feasibility is that, you know, most pediatric sort of hospitals are administering sort of a family experience of care measure to their patients and families. And from our perspective the fact that so many of them have switched over to child HCAHPS has been significant from that perspective.

More specifically, in regards to the - I think there was another mention of hospital level unit reliability. And actually, our overall add and end of 300 which is what we recommend the level of reliability is generally over .7. So, if you look at Table 5 on Page 10, with the one exception of involving teens in the care and in that context given the fact that actually teens are only a proportion of that 300, actually reliability is actually surprisingly high in that context.

But I might be missing Ryan what you were specifically referring to when you had mentioned the hospital level unit reliability.

Ryan Coller: I guess it's on the chrome box alpha's that were reported out in the prereview for - I think most of the composites looked good. It was just worth, I guess, noting in discussion that I don't believe all of them were above, like, a .7. And then I think for the single item measures, the chrome box doesn't work but maybe just speak to other elements of reliability that we can from the testing that's been so far on those.

(Sarah Cumey): (Alan) do you want to comment. I think - sorry I was just on the wrong table. I think he's referring to Table 3 on Page 9.

(Alan Phisgloski): Okay. I'm not going to try to look for that right now but…

(Sarah Cumey): Yes.

(Alan Phisgloski): Spend my time combing through. But I think the composites was really lowering liability (unintelligible) the one that was kind of the physical plan composite that - it's clearly (unintelligible) sort of the substance of the subject matter more than by the correlation between the items and, you know, you have different aspects with physical parameters.

There's no particular reason why it isn't so (unintelligible) correlating with each other across hospitals that (unintelligible) group them together just because it's a common topic. And there's - I suspect that in some ways the (unintelligible) the multiple informants, you know, the child and the parents are all speaking through the parent. In some ways the information is more complicated in the child than the adults HCAHPS.

So, the scopes are having redundancy that you need in order to get the big alpha's is less (unintelligible).

(Chris): Okay.

Ryan Coller: Yes, I'll note that this did pass the Scientific Methods Panel. I just wanted to make sure the opportunity to discuss was there in case anyone had any other concerns.

(Chris): Sure. Ryan was your point about feasibility and burden adequately address do you think?

Ryan Coller: Yes, I think from speaking personally, although I'd invite other committee members I think that it is really telling that an electronic version is available and people are using it. I think that that's very reassuring.

(Chris): Okay. Great. All right. Let's see. Others. Lisa Morrisse, Beth Averback, Stephen Hoy. Lisa would you like to chime in?

Lisa Morrisse: Sure. I only had one question as I was reading through this again. And that was the exclusion of children who are in foster care or state custody because that's currently about 13% of the entire U.S. population. And many of those

children actually have special health care needs. And I'm concerned about their lack of representation.

((Crosstalk))

(Sarah Cumey): I think that's a great point. I think the reason we excluded them at the time was because of the difficulties in actually being able to follow up and have adequate addresses. And there was a sort of in that also even in knowing in many of our systems who has actual custody.

And those contexts can be quite challenging so legally speaking even though a guardian or I should say a parent might be present, you know, with DCF having custody it's unclear in regards to knowing who, you know, who would be the correct person to be sending the survey to. So, in that context they were excluded in that initial way and that is the - for the standard approach that sort of most, you know, hospitals were using prior also in that context.

But I clearly hear you and recognize that they are a substantial number of patients in our system and hearing their voices is clearly very important.

((Crosstalk))

Don Casey: This is Don Casey. I just have to say I have to get off the call. I would be disappointed if I didn't get to vote on this. But I'll see you guys later. Bye.

(Chris): Okay.

Lisa Morrisse: (Chris) you probably have experience with that population. I'm wondering if there isn't some way that kids -- especially those in medical foster care -- can be included because they're submissions would be valid. They are

demographically also more likely to be persons of color. And we probably should hear their voice because they may not be treated the same way in some situations as children whose bio parents are present.

(Chris): Yes, Lisa this (Chris) and I'm not going to talk as chair here, I'm just going to talk as me. I have to say I disagree with the developer's rationale for excluding the foster care population. You know, satisfaction doesn't equal custody. And, you know, the foster parent may not have a kid for that long, but they do, you know, have really a lot of involvement in episodes of care.

And so, I just really am not sure that that's a valid exclusion. You know, being that the way it is I think there's a lot of - it's a little bit of a culture change that's needed to really bring foster parents into the healthcare system as, you know, as - maybe not as important decision makers but at least as people who can accurately reflect on experiences of care. I'll get off my soap box.

(Sarah Cumey): I think that as we - yes, no, I don't disagree with you that they're an important group. And certainly, we've been doing a lot of additional experimentation around administering the survey. For instance, we've done and recently published a paper looking at administering child HCAHPS actually on the day of discharge. And you can imagine in that kind of setting that it might actually allow us to be including groups like foster parents and other groups for whom follow up might be an issue in that context.

(Chris): Okay.

Lisa Morrisse: That would be great. Keep us posted.

(Chris): Yes.

(Sarah Cumey): Definitely will.

(Chris): Beth or Stephen. Any other comments?

Beth Averback: Yes, this is Beth. In the interest of time I support all of the comments made and I am very pleased to hear that we have an online capability because I think that that would be a barrier to moving forward. So, pleased to hear that.

(Chris): Great. Stephen.

Stephen Hoy: Yes, this is Stephen. I won't echo the other comments that support fully from previously. My only other comments are kind of almost even applicable to the other HCAHPS as well and the other experience surveys being that the evidence draws very tight and close lines between quality and experience as experienced by patients and families.

We, you know, more and more are looking to what information do we need from patients and families in terms of understanding those aspects of care. Quality of care, safety of care, and experience of care are three very distinct names in my mind that interest. And I see that as a common trend in our surveying of patients and families recently. That being said, I think that rating experience is an important domain to learn from patients and families.

This is a good tool to highlight opportunities for improvement, but it does not actually get to quality. It is not as closely tied to quality and safety. And we need special expertise in rating quality and safety. When I look at the domains about attention to safety and comfort I would want these experience scores to then be tied to safety scores, right, in looking at the intersection of those. So, I guess that's just a comment to be considered out there.

(Chris): That's great. And it says a lot I think about future measure potential development. Thanks. Great point.

Stephen Hoy: Absolutely. We're looking - I use my Uber example. We can always get an Uber because we know if - we can tell if you if the guy smelled bad or talked too much. It requires special expertise to understand quality, right? And as patients we don't know if another X-ray was needed or that was a potential safety hazard. Right?

And tying experience to those things has gotten us where we are and is great to shine the light on, again, opportunities for improvement especially in these domains. But I don't want to piggyback on the need for patient and family - the alignment of these measures and patient and family center care that includes quality and safety (unintelligible).

(Chris): Okay. Good. Thank you. Okay. Any other committee comments before we proceed to a vote if that's okay?

Sherrie Kaplan: This is Sherrie Kaplan. I'll keep it really quick. First of all, I wanted to know if the child literacy level influence the reliability and validity issues. Have you ever tested that? And second, it would be nice to have kind of the - as was for the 0006 measure that interclass correlation coefficient just to make sure we eyeball those.

(Sarah Cumey): This is a survey for parents so from that perspective the child literacy, unless I'm misunderstanding your question…

((Crosstalk))

Sherrie Kaplan: There's no version yet for self-reports?

(Sarah Cumey): Correct. This is a parent reported measure.

(Chris): Yes.

Sherrie Kaplan: Okay, so if there - are there - this is just aside, so it's not worth troubling about. But are there plans for it?

(Sarah Cumey): If we can get funding, I would be more than happy to develop it as would I'm sure the team. So, please put in a good word.

Sherrie Kaplan: Thank you. And the interclass correlation coefficient you have or you don't have?

(Sarah Cumey): I would have to look back at our data. I'm not sure, (Alan) if you remember whether or not we have it or not.

(Alan Phisgloski): Well, it's in the consolation, you know, it's either if it's under there or you can decide two things and get it. It doesn't matter whether it's included in the submission. And if it wasn't then we can certainly provide it.

(Chris): Okay. All right. Good fast discussion. You know, I don't want to leave anything else out that's important, so I don't want to rush things, but do we feel like we're ready for a vote?

Group: Yes.

(Chris): Okay. Okay. Suzanne take us away.

Suzanne Theberge: Okay. We'll be pulling up voting shortly and we'll use this first vote to see if we have quorum. We do need 14 votes to have quorum. So voting is now open on evidence for 2548 child HCAHPS. Options are A, pass; B, no pass. All right. We do have quorum and measure passes evidence with 15 votes for pass and no votes for no pass.

All right. We will now move on and vote on performance gap. Voting is now open for performance gap on 2548. Options are A, high; B, moderate; C, low; and D, insufficient. All right. And the measure passes performance gap with three high and 12 moderate, zero for low, zero for insufficient. Voting is now open - sorry, we'll now open voting for accepting the Scientific Methods Panel rating for reliability of moderate. Options are yes or no.

All right. The committee has accepted the Scientific Methods Panel rating of moderate for reliability. Unanimous 16 votes for yes. And we will now move on to does the committee accept the Scientific Methods Panel rating of moderate for validity? Your options are yes or no.

All right. And the measure passes with a moderate for validity. Sixteen votes yes. We will now move on to feasibility. Your options are A, high; B, moderate; C, low; D, insufficient for 2548 feasibility. All right. We have three high and 12 moderate, zero low, zero insufficient. The measure passes feasibility.

We will now move on to use. Just opening that. Voting is now open for four A, use. Options are A, pass; B, no pass. This is on 2548 child HCAHPS. All right. Measure passes use with 15 votes for pass, zero votes - 16 votes for pass, sorry. Zero votes for no pass.

And we will now move on to usability. Voting is now open on usability, four B. A, high; B, moderate; C, low; D, insufficient. This is on 2548 child HCAHPS. All right. The measure passes usability with five votes for high, 10 votes for moderate, one vote for low and zero for insufficient.

We will now move on to an overall recommendation for endorsement. The committee is voting to - whether or not to maintain endorsement of 2548 child HCAHPS. Your options are A, yes or B, no. And the measure is unanimously recommended for continued endorsement with 16 yes votes and zero no votes.

Okay, thank you everyone for sticking with us for just a few extra minutes to allow us to complete that discussion. We will now open the lines for NQF members and public comment. If you would like to make a comment, please speak now. We also will take comments via the chat box.

Okay. Hearing no comments, we will move on to next steps. So, the child HCAHPS measure was the only one that we had scheduled for Friday so we will be cancelling the call on Friday, June 28. We'll be convening next week via webinar again on July 1 and 2. We'll be in touch in the next couple of days with some more information about which measures we're discussing when. Please let us know if you can't attend one of those calls.

And then we'll be putting - writing all this up and putting the report out for comments in August. And then we'll speak to you again in September. Thanks to everyone so much for your time today. We especially appreciate the extra few minutes on the call to allow us to get through that last measure. And we hope everyone has a wonderful weekend and we'll speak to you next week.

Group: Thank you.

END