National Quality Forum

Moderator: Lauralei Dorian
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1:00 p.m. ET

Lauralei Dorian: Thank you. Good afternoon everyone, this is Lauralei Dorian in the NQF team. Thank you very much for dialing in to the second conference call for the Person and Family-Centered Care Steering Committee. I just like to remind everybody, before we get started, this call is open to the public and we will be having a public comment period towards the end of the call. Also just a reminder to please keep your phones on mute if you're not speaking and also note that the developers are on the call today and they'll be able to respond to any questions that the committee might have about their measures.

And before we start talking about the measures, I just like to take attendance to see who we have on the call. I know we have Katherine Bevans and Becky Bradley, is that right?

Rebecca Bradley: Yes.

Lauralei Dorian: Great. Welcome. And do we happen to have Jim Merlino or Chris Stille? OK, and any other committee members?

Lee Partridge: Lauralei, this is Lee Partridge.

Lauralei Dorian: Hi Lee. And can I ask any developers to please identify themselves.

Female: This is (inaudible) (Selena Billerman).

Female: (Sarah Tommie) and (Mark Schizer).

Lauralei Dorian: Hello.

Male: Hi there. This is (Alan Lazowski).

Lauralei Dorian: Sorry.

(Crosstalk)

Female: Just want to let you know Julie Brown from RAND is here and (Mike Pasadi), the member of the CAHPS Consortium.

Lauralei Dorian: Great. Hi Julie.

Female: (Alan) has a lot of these numbers in CAHPS (focused groups).

Lauralei Dorian: OK, well I just like to thank any committee member who happens to submit surveys. We know that these are difficult in times of doing measures. They're not our typical measures but you know they're based on surveys. And so we just like to acknowledge that we really appreciate the time and we know we can talk through phone with the continuing elements (there) and answer if there're any questions you might have had.

We'd also like to remind everybody of the conversation we briefly on the tutorial calls about the differences between surveys and measures and just to note again that NQF is not endorses surveys but we do endorse performance measures at a facility level that used those surveys. So all of these measures that we'll be reviewing today, you should be expecting to see for example casting at (both) the data element level in terms of the survey but also at the performance score measures so we can know whether the measure is actually able to differentiate performance between facilities for example at a hospital level. So before we get started talking about a specific measures, we just wanted to check with you to see how you found the process, see if you have any overarching questions that might pertain to all measures or just any comments about the process of reviewing and submitting the survey (staff) bar.

Chris Stille: Hi everybody. It's Chris Stille. I just joined.

Lauralei Dorian: Great. Hi Chris!

Chris Stille: Hi. I just had one comment about the process is it was a little hard for me to figure out which document to look – or you know, within the individual documents there that were several things which one to look at first. So, after I after I (venture) one, I sort of realize, OK, this is the form to look at first. And …

Lauralei Dorian: Yes.

Chris Stille: For whatever reason, that wasn't immediately clear to me when I started.

Lauralei Dorian: Right. Now that's a great point. I think they can do a better job at explaining sort of step-by-step process of how to walk through your first measure evaluation. Thank you.

Chris Stille: Yes.

Lauralei Dorian: Yes. Because there are certainly are a lot of attachments. I don't see a – are there any other questions or comments before we get started?

Rebecca Bradley: This is Becky Bradley from HealthSouth. Could you just explain – I guess I was a little – when I as looking at the measures, I guess the thing that shock me was – one of them is the current HCAHPS measure, the (TMF) uses and not sure how that is kind of rank or viewed in terms of – if it's already a measure that is emplace and is being used as a public. I guess I'm not clear of what the role of this committee is in relation to that one versus measures that are being introduced or submitted for the first time or renewed but (that were) not kind of likely used in the public.

Lauralei Dorian: Great. So I can take it first step at this and then Karen Pace can jump in. So we have a process of measure maintenance here which is essentially any measure that is endorsed. Every approximately three years, we do require that (intern) goes a full evaluation again. Mostly because some of the evidence I have change in that time and also our criteria have been updated so we want to make sure that the measure and its current form reflects our current criteria.

So we expect that all of these measures are evaluated in the exact same way whether their new measures or maintenance measures.

And so – Karen, did you have any?

Karen Pace: No, that's basically the reason. So, and also part of the – you know criteria are that as Lauralei were saying it that they continue to meet the criteria. So for example, performance gap, sometimes measures that have been previously endorsed and implemented are what people refer to as topped out meaning there's not really much room for improvement. So that's raises the question of whether they need to be continues with (endorsement) or part of our NQF endorsement is for measures that are intended to be use in accountability application such as public reporting and pay-per-performance.

And if a previously endorsed measure after three years still hasn't been used, it doesn't necessarily mean we can't endorse it but we need to explore a little bit, you know, what's the plan is. Is it going to be implemented in some accountability program?

So, and in the other reason is that a lot of times when measures come in initially under in – for initial endorsement, the testing may be quite limited. And so we'd like to see continued analysis of the performance data. So, a variety of reasons but good question.

Lauralei Dorian: Thank you. That was very helpful.

Chris Stille: And this is Chris again. Another newbie question related to that, (which is) though when we went to put in our comments that all of the measures were under new measure even though only one actually was a new measure. Is that OK or we're supposed to be doing something else?

Lauralei Dorian: But do you mean that when you went in to the survey that was the auction (inaudible).

Chris Stille: Yes.

Lauralei Dorian: All right, yes. That must just have been a mistake on our end. Sorry about that Chris.

Chris Stille: OK. I didn't know if there was some other survey, some other place that you should have been doing. But I did all of them as a new measure and it seemed to go through.

Lauralei Dorian: OK and we'll take a …

Karen Pace: Yes, we'll take a look at that. Thank you.

Chris Stille: OK.

Katherine Bevans: This is Katherine Bevans. One other comment or I guess suggestion regarding maintenance versus new submissions, for me I think for the maintenance measures, I sort of figure out they were maintenance measures because of that spot on the form that says, you know, the date when it was originally endorse and then the most recent, you know, endorsement.

Actually, thought it would be really helpful if there was maybe a kind of a timeline in there that gives us maybe a little bit more information about what – folded it out even something very simple but you know, what kind of additional work has been done with the measure since its original endorsement. Just because I think that you know, as we saw with the new submission, there is you know, obviously not as much information about that performance measure relative to you know, measures that we're getting or being reviewed for maintenance. To me, it would probably would help to just get a little bit more information kind of timeline of when certain evaluations were done with the tools.

So for example, with the HCAHPS, I got a lot of information about that measure actually from the website that maybe would have been helpful that will summarize even in full and simple format in the actual submission.

Lauralei Dorian: Great. That's a great point.

Karen Pace: OK. Yes, we do have a question where we ask about changes in the specification but that's very specific. So we'll definitely take that under advisement as we continue to look at you know, revising the submission forms.

Lauralei Dorian: OK, well we thought, (inaudible) any other comments or questions. We're actually changing the order a little bit from what's on the agenda. We're going to start with 0725, the Validated Family-Centered Questionnaire for Parents' and Patients' Experiences during Inpatient Pediatric Care.

And maybe if we could bring up the survey question?

Karen Pace: Maybe we should double check if that's the problem for any (inaudible).

(Crosstalk)

Lauralei Dorian: Is that a problem for any of the (developer)?

Karen Pace: We're going to go into …

Lauralei Dorian: So first, work planning on doing 0725, the family questionnaire and then the child CAHP survey and then HCAHP. Or is the developer's OK with that order?

Chris Stille: That explain the best …

Lauralei Dorian: OK. So …

Karen Pace: Yes, just one other comment. All right, we know that it's probably been somewhat difficult to find information. We've had that difficulty ourselves in terms of the information maybe in the form but not where we expected or as we shared with you the instructions that we had provided to the developers. So, we really want to use today as an opportunity for the committee to ask the developers anything that's they have questions about. If you weren't able to find something and you know, this would be our opportunity to get any clarifications.

So, and we'll – for this first measure, we're going to maybe walk through it a little more systematically with some of the kind of guiding questions. And you know, do it criterion by criterion so that we get – try to get more familiar with the criterions. We're going through this as well.

OK, Lauralei?

Lauralei Dorian: OK. So the first questions as Karen said, this is in the order that you would have entered your responses in the survey. So we're asking whether and we are assessing a measure a health outcomes. So this is the health outcomes, the patient reported outcomes is the relationship between the measured outcome or PRO and at least one healthcare action so structure of process intervention or service. Identified and supported by the stated rationale. So you might just open that up.

Karen Pace: Right. And just to – maybe you want to just give a brief synapsis of what measure we're talking about.

Lauralei Dorian: Sure. So, this is from Boston Children's Hospital and its family-centered survey questionnaire with specific questions that assesses various aspect of care experience during inpatient pediatric hospital stage.

So that's what we're looking at and they've seen as just going to bring up measures submission form.

Karen Pace: So, just to orient to in terms of the committee that the first section of the document is the compiled comments from the committee members to share amongst you. But we're going to flip to the measure information form which is all the information provided by the developer and it starts with some brief information about the measure and then we'll start into the measure evaluation criteria which goes down – starts with 1a – so that it's the measure information form I mean.

OK. And then the evidence is provided in a evidence attachment which we are going to bring up now, so Lauralei.

Lauralei Dorian: OK, so this is what we are talking about is the relationship between the PRO and at least one health outcomes as identified and supported. And how is the evidence related to that specific structure processor intermediate outcomes. Are there any thoughts on the evidence according to the measure focus?

Karen Pace: So, if you look at what they provided in item 1a.2, we ask them to first just state a diagram. The relationship of what's being measured and just again, a reminder that experience the care measures are patient reported outcome measures. And so, they kind of fall in our exceptions criteria for evidence meaning we don't require a systematic review of a body of evidence. We're really asking for what healthcare services, structures, treatments, interventions, processes of care relate to the particular experiences with care that are being measured through the individual performance measures.

So typically, and what we ask for is that for each of the measures that are being constructed from a particular survey that there would be some statement of how healthcare processes actually influence that. So this was provided. It doesn't necessarily go through each of the individual performance measures but we'll – I'll stop there and just ask for the committees thoughts about this or sorry, if you have any questions for the developer.

Katherine Bevans: This is Katherine. I don't need questions. I thought that developers did a nice job in the latter part of the application starting on about page 27 of justifying the – each of the performance measures as either composites or individual items and how that was linked up. I thought in the introductory section of the application, it may have been helpful to just kind of summarize that briefly. But I appreciate that. You considered each of the different meaningful elements of the patients experience as opposed to sort of patient experience as a whole because we knew they can operate quite differently and be related to different aspects of patient outcomes.

Karen Pace: Right. So, you're right and we'll get to the measure testing components in a few minutes. But basically, what we were looking for here is you were saying what are the kinds of processes that would really lend itself to a positive experience on the dimensions that they're measuring.

Any other comments? OK. We can move on …

Lauralei Dorian: We move now to 1b which is performance gap.

Karen Pace: You need to go back to 1b.

Lauralei Dorian: So ask that the performance data provided demonstrate a gap and care so variability are overall less than optimal performance to warn a national performance measure. And also does it demonstrate disparities for certain population subgroups.

OK, so let's look at the information provided. So here is in 1b.2, so they did not provide the information in the form as we ask for and the reason we do ask for it is so that the committee can get through this in a systematic way and expect the same information in the same place. But they should provide some in the appendix. The developer call maybe you can explain the data that you presented regarding performance gap?

Karen Pace: OK. Let's ask if the committee members were able to find it.

OK, well why don't we – we'll move on and then we can come back and clarify that with the developer.

Katherine Bevans: All right, just one comment before we move on. I guess, one question I had about that was there any – the obvious questions. Will there disparity were or it's group differences evaluated by any other group aside from white, non-white race that's question to the developer?

Karen Pace: All right. Under performance gap, we look at not only the performance on the facility level but also by disparities and that's in section 1b.3 and 4. So, they indicated that they didn't have performance data on this specific measure by population subgroups that in one before – I'm sorry. 1b.4 is where they provided the data as we should. Sorry. And they also mentioned there is some more information in the appendix. So, in your question Katherine is whether they had anything besides just the breakdown of white and …

Katherine Bevans: Yes, would there any population's subgroups that they could evaluate for example, you know, ethnicity or through a pediatric measure age of the child would be something that maybe of interest?

Karen Pace: OK. So let's just double check if we have anyone from …

Lauralei Dorian: We (Sonia) or (Maria Jurina).

Karen Pace: And if you're unable to speak would you signal the operator by pressing zero?

OK, we've got that question. So we will go on to the next one, 1c high priority. And one of the things here that were – is specially relevant to what we referred to a PRO-PM, PRO based Performance Measures is this item 1c.5 which is really talks about and this came out or our PRO work a couple of years ago. But to ask about how patients and family members who are actually involved in identifying what's included in the patient reported outcome that is meaningful and a value to them.

So this is the information that was provided by the developer that they use focused groups to identify ideal impatient care experience. So, any questions from the committee about that?

Female: It seemed that the focus groups are kind of limited and the universe of the (focus) group was …

Karen Pace: OK. And we don't have it specific requirements on how broad this has to be but you know, certainly something for you to consider if you think there were some limitations.

Katherine Bevans: So adding for that – first I'm going to say I really appreciate the use of the focus groups of evaluate this issue. I think a lot of PRO-PMs and PRO measures are developed about any, you know, family and we input. Every success is looking for you know, more numbers but also just more information you know, about who are these focus group participants? Do they fully represent the families that are served, whether – or there are children involved and I think, if I remember it correctly, there were. You know, did you get to

the point of concepts saturation and that's a concern given the number of folks involved.

I also was really curious about this patient experience committee that is reference in the application as well which really sounded like a nice opportunity to get some information about what experiences would really be about used in families. But I think the way that it's described that the committee is comprised mostly of providers. It wasn't clear on whether there were patients of family members included in that committee.

And so, I sort of wondered, you know, if they are why not and is that – it could be supplemented with some patient has (inaudible) represented as to – it gives some more of the family-centered feedback on the satisfaction measure.

Karen Pace: OK, any other comments. Go ahead.

(Crosstalk)

Chris Stille: Yes, this is Chris.

Karen Pace: Go ahead. I was just going to ask you to identify yourself. I'm sorry with that. (inaudible) phone I think.

Chris Stille: Yes, this is Chris Stille. You know, again I think it was great that there were focus groups than in interviews done with family members. Given some of the demographics if I recall correctly of some of the people that were involve and the, somewhat limited diversity, I think it would be good to get feedback as things move forward from a more racial and ethnically and socio-economically diverse sample of parents. And I think within the network of children's hospitals that you have, you can do that. I don't know how – I don't think a whole lot came from outside Boston Children, but there are certainly other teaching hospitals in Boston that do have a more diverse population that you can draw from as time goes on and the measure gets used.

Karen Pace: That's a good point. OK.

Chris Stille: And maybe outside Boston too, I mean you know.

Karen Pace: Right. Too many go …

Lauralei Dorian: There was no questions. There are no other comments about (them). We can move on to specifications which is 2a.1 – it should be 1 so we'll start with the specification reliability. Will you bring up the slides?

And that ask with specifications if any are unclear the data (inaudible) submission, post with descriptors, definitely a calculation or (rest) – (flash) case from adjustment and as it clear especially for PRO-PMs which questions and response item, options are used for the performance measure. And do they include survey sampling instructions? Do you have any concerns about the likelihood of this measure can be consistently implemented.

So I'll pause there.

I'll go on. I'll go on actually to do 2b.1 which is specifications consistence with evidence validity. That asked if there any ways that the specification seems inconsistent with the evidence and for a PRO-PM are they consistent especially with the target population value is quite meaningful. OK …

Karen Pace: OK, so we'll go to the measure information form and start looking at the specifications. We had asked that the individual measures and the questions that went with them be specified in the numerator sections. And here, they gave a summary first and then if we move down we can see that there are actually eight kind of multi-item measures and then there are five single item type measures. So, there're actually 13 performance measures that are computed loss of the survey data. And if we go down a little bit further, they actually identify for example the questions that go with the various performance measures.

Lauralei Dorian: You should see on your screen.

Karen Pace: So, I'm going to stop there and in the – well maybe we'll just mention, if you go down to the denominator, we ask them to identify the target population and here they indicated parents 18 years of old – or older of children who are discharge from an inpatient stay and the (S10) identifies any denominator exclusions.

So, let's stop there and see what the committee has to say about the specifications. Any questions or clarifications that – or comments about the classifications.

Katherine Bevans: This is Katherine. I thought the section here on how the measure is specified and used was, (I split) down and clear as if you need to follow the question that I had was actually about children who are repeatedly hospitalized within the period. Is there an attempt to exclude those kid and I apologized. I may be missing this, somewhere in here. But you know, if a child is hospitalized more than ones within the period of time that's being measured, are they excluded or if it's not twice you know, given that is a unique hospitalization experience.

Karen Pace: That is the question. I think (Maria), are you on the phone now? (Inaudible) took off. If you're on and you can't – maybe just call up to the operator. You might have been placed in the line where you're unable to speak or you should press star one. And man, if you're (something) it seems – as (Maria Jurina) is on the line. If you could please turn and open the line, that would be good.

Operator: (Maria) is not on at this time.

Karen Pace: Or (Sonia Vanille).

Operator: No.

Lauralei Dorian: OK, thank you.

Karen Pace: All right. So we will note that question. Good one. Any other comments from the committee? As you pointed out, the schooling algorithm and – or is actually in the numerator details. But I think the question you ask, we could look in (S20) about sampling as well.

Katherine Bevans: Yes. I wasn't (inaudible) without was for (inaudible) so.

Karen Pace: Right and I don't see it there either. So, (inaudible) out, make a note about that.

Lauralei Dorian: Is there any comments or questions about the specification?

OK, if not then we can move on to testing that where – if you would have seen the testing at separate task …

Karen Pace: No. We need to go to the slide maybe and (see) ....

Lauralei Dorian: And so, just to remind you that we do expect that both reliability that any testing has been conducted at both of the element and the performance (fourth) level. So we asked whether they accept at both levels or tested with an adequate scope to generalize for widespread implementation with an appropriate method.

Karen Pace: So…

Lauralei Dorian: So, I'll pause there and see if you had any questions about testing result or any comments about the adequate data.

Karen Pace: Yes. Let's go to the – now they didn't go to the measure testing form and we'll go down to reliability.

One of the things that we're going to do on this call – because you know that this can be a little confusing is that we were going to ask the developers to just briefly describe the distinction between their testing of the instrument versus the computed performance for and just for everybody on the – to be on the same page. I know that this is so – maybe a little strange terminology.

But we basically are looking for how the instrument with testing for reliability, the patient level, scores are responses as well as the computed for this facility, the performance major.

So, as you know NQF if endorsing the performance measure but it's based on an existing survey with various scales and items that are (socio) with scales and that's why we want to see testing at both levels. So, let's move on to it's – we'll check one other time and see if anyone from Boston Children is one the line.

Lauralei Dorian: Operator, (Maria) doesn't say that she's on the line. She can hear but she's unable to speak.

Operator: All lines are open and she dialed in or just on the web.

Lauralei Dorian: Let me check with her to make sure.

Karen Pace: OK. So, while we're waiting to see if we can get her to be able to speak, I'll ask – let's go on down to the reliability testing. They provided prescriptive information about the sample on which the testing was done. And then if we move onto 2a.2 reliability testing and I'll ask the committee if you have any comments about this it's – what your thoughts are in terms of the testing that we've conducted.

So, they describe doing test retest reliability and the internal consistency reliability both of which seemed to be at the level of this survey, the patient level survey.

Katherine Bevans: I was wondering about the claim in here that the alpha which I know is really just the correlation between two items because it's a composite's made up of two items about communication, about medication, the (ChromeBox) Java is 0.55. I think they justify that by saying that's acceptable for measure that only contains two items.

I have not heard that before and so I was wondering from – if anyone can comment on that. But to me raise the – a little bit of a reflect on the combust of those two items.

Karen Pace: That's a good question. And I – again I think we'll need to ask the developer to respond to that. You know, they mentioned that generally if you like to see at 0.7 so – are higher so I think it's a good question to ask to developer.

Any other committee members who want to …

Karen Pace: Just to (ask) for about that. If it is determined that that's not an acceptable level of internal consistency, it worries me a little because of the scoring algorithm around this and this. That's that if, you know, you want to assign a

score for this composite, if your answer in this case 1, the single item, you know, you can be assign the scores. So, it's not an internal. It just sits there – set of items as I added the item. I mean, I would be a little bit worried about using that as scoring algorithm where one (interpret) represent a global concept of communication about (meds) and sort of tie those to two issues together.

Karen Pace: OK. And I think the other, you know, your comment also points to the reason that we'd like to see reliability at the computed performance for level. So that could, you know, provide some justification that even though this – at the patient level may not that high that it's still working as the performance scores. So, we'll definitely need a follow-up with them on those (request).

OK.

Lauralei Dorian: OK. Now we can move on to validity testing. And again we want to ask what level does the measure tested. We want to make sure it was test at both levels but with an adequate scope (inaudible) describe the widespread implementations and we are looking for developers to describe how the result either do or chat demonstrate the patient validity. So we can make conclusions about quality.

Well I'll pause for the – if there are any reflections on the sociability section?

Karen Pace: On the validity…

Lauralei Dorian: Sorry.

Karen Pace: (That's through) ...

Chris Stille: This is Chris. I think sort from the validity standpoint, you know, it goes very long well with (patient) family experience of care measures that are currently use for children. Some of the data elements are taken from, for example, the national survey with special healthcare needs. So I think it goes along very well with that.

I think that as we talked later about the child HCAHPS that will be important to kind of harmonize those two as they go forward but it seems good at this point.

Karen Pace: Right. And I think just as with reliability, it appears that they – their validity testing was ask to be level of the patient survey. So, but then they talk about performance measure, score validity so perhaps Chris did you have notice anything about that in terms of doing both levels or does it looks like ...

Chris Stille: About which level I'm sorry.

Karen Pace: Validity. This is – could you tell from the submission whether they tested at most the survey and the computed performance score levels or was it clear from the description.

Chris Stille: I could not tell.

Karen Pace: OK. All right, so that we can get a response from (Maria)? Or trying to dial back in. OK. All right.

Female: One of the thought about validity this is a pretty global issue actually in pertain to some of the other measure we're evaluating today too. And there is this notion that it is – or you know, the fact that these are parent-report measures as opposed to, you know, there are by pairing report. They're not (box feed) evaluate the child's perspective and I just want to bring this point to say that, you know, measure title reference, you know, questionnaire for parent and patient experience. It's not patient's experiences. These are parents impressions they are two parent experiences on behalf of their child which no, at least from the outcomes world can be really quite different from what patient-report experiencing. Him or herself and bringing stuff into the validity to just be clear about the definitions in the concepts and the actual meaning of the outcome that measure through this. But it is a parent-report measure and I think that's important to remember.

Karen Pace: OK. Thank you. Are there any other comments?

Lee Partridge: Karen and Lauralei, this is Lee. I've been listening to all these. At the beginning of our in-person meeting, are you going take us briefly through the (Combaxions), Steersman's and so on. I think for many of us struggling through the validity and reliability section is it's a little though if we don't have a background and statistics.

Karen Pace: Right. Lee, that's the good point that I think we can work with you and Jim as co-chair to kind of work on the agenda and some things that we can do at the beginning to get everybody on the (inaudible). And one of the same step we'll do today as the start of that is that would be measure developers to from their perspective to explain what they did and maybe they'll started down the road of understanding that. But appreciate that comment and I think that's a good idea.

Lee Partridge: Thanks.

Chris Stille: Yes. This is Chris. I'd sort of bring up of question. Are there committee members who have experienced in clinical psychometrics and quality measurement?

Female: Yes. We do. And so, you know, obviously persist kind of first, look at the measures so we're looking at a smaller subset and kind of divided you up but we do have members in the committee that do you have that background and experience.

Chris Stille: OK. So, we'll have to make a list of questions for them.

Karen Pace: OK. OK.

Lauralei Dorian: There are no other comments. We move on to the next section which is actually combined to see different questions. It's 2b.3 to 2b.7 which is testing related to potential threat of validity. And so the sort of things slide sorts of things we want to know is whether exclusion supported by the evidence – whether the exclusions are supported by the evidence and that the PRO was the risk adjustment or in this case usually from (casement) adjustment appropriately developed instructed, (problem) analysis indicate this measure identified meaningful differences. New analysis indicates that they produce

comfortable result and if there any information provided about missing data in terms of a not biasing results.

So there are few things we need to think about but if any of them stood out to you in terms of being having concerned with or question it out, I'll open it up.

Rebecca Bradley: This is Becky Bradley from HealthSouth. I had a question about the lack of risk adjustments for this particular survey and just wondered what the rationale was for not trying to do some type of risk adjustment.

Karen Pace: Right, so let's look at they – in 2b4.2 provided a rationale, maybe and if we could go to that item number. There we go. So, they, you know, as you mentioned acknowledge that it's not risk adjusted and we saw that in terms of the surveys generally they term case mix adjustment is used.

But they are saying that they think it's necessary because it's subjective experiences. And that there were no significant differences for whites compared to non-whites. And then they go on to say (race) test seem to make it significant difference with regard to individual item scores testing subjective satisfaction and emotional satisfaction. And parental education levels did not seem to influence some of the sub categories.

So – and then they go on to provide a table. So, I'll just stop there and see if anyone a chance to look at this and if this health or continue to raise questions.

Chris Stille: Yes. This is Chris. I've spent some time sort of looking at that and throwing it around in my mind. I think it's really interesting, you know, why risk adjust or why kids makes – mix adjust to measure and I think, you know, the biggest thing is to, you know, to compare institutions or organizations with different groups to people to one another.

I'm not sure that this measure as a starting point kind of wants to set out to do that but really be more of a measure, you know, how our parents feeling about this and, you know, and how to use this as a quality improvement tool within institutions. I think if the use of the measure eventually is bigger scale and wants to compare institutions to one another. Then there's probably more of a

mix assuming that there are differences among populations and how parents do respond to a survey like this.

There's some hint that there are some differences but again maybe we need some more data to look at that, you know. We look at the larger HCAHPS survey, there do seem to be some differences. But then again the HCAHPS survey, it meant very strongly to compare hospitals to one another. So – and this one may not be at that macro of a level we at so. So, I don't know. Just some thoughts.

Lauralei Dorian: Right, right.

Karen Pace: So let's take some good comments and just because the backdrop, you know, one of the basic reasons for NQF endorsement is for measures that are intended to be used in comparative performance assessment. And – So you're right. You know, the reason you even consider case mix adjustment is if there were systematic differences and responses based on a particular characteristic as a respondents. And we'll probably hear more about that with some of the other measures.

Katherine Bevans: So this is kind of a -- (Katherine again). It kind of combined question I guess and it's actually because I'm talking this idea around in my head but there's particular type of measure whether case mix adjustment is actually appropriate and if it is on what characteristics. What worries me a little bit about this is – I guess is that it's not so much in my mind that the developers claim that we should never case mixing up. They said – I think they said, because is a subjective experience they didn't use a case mix – mix adjust.

I'm not sure that's a fair claim across all sort of patient experience, measures. However, in this case we're talking about, you know, people, you know, satisfaction basically with their experiences in the hospital on under patient setting and what might worrying be a little bit about this we're not very careful to select those person level variables that we think, you may alter someone's experience with this. If we're not careful about that, we have the potential to (match) some really important sort of disparity link differences, you know.

For example if we chose race and determine that through the adjustment that now there's no difference you know. It's just as an example is not what happened here. But in fact, you know, there are true disparities in people's impression on how they are treated. What's the potential there for I'm asking of very important information about testing disparities and treatment?

And so, I don't know if that's more into larger discussion among the group because we've did a couple examples (figure out) patient experience, measure some of which have control for some of these factors and someone at least some which better not. I think it's really important issue, a huge implications and maybe it would (you suggest) of a larger conversation about this with the instrument developers.

Karen Pace: Katherine it's a good question. And I'll just mention briefly that NQF is engage in a project nearing the end specifically about risk adjustment and some big demographic factors. And so I think it would be worth just giving a brief synopsis of that and also at the beginning of the in-person meeting so that everyone on the same page in terms of the trying thinking about that. But it's a good question, and definitely a complex one. So we'll definitely provide a little more information on that.

Rebecca Bradley: So, and this Beck Bradley again. I guess I was also looking at the differences in tie types of hospitals. I thin there were some pediatric units that were included in the sample versus free standing children hospitals that may treat more critically ill patients and it seems like there might be differences and they're perception of care or just based on the different settings even –

Karen Pace: Right. OK.

Chris Stille: Yes. That's a great point. So just, if there are other indicators in data kind of sort of other indicators in this data kind of sort of other indicators as severity of anything get some point and some of the qualitative information, a parent, noted of several (occurrence) noted maybe for a different measure. But sometimes, you know, for a very complex situation or critical situations there are many decisions to be made. So maybe some other indicators of severity of

the condition as well as setting would be appropriate but maybe not other classic demographic characteristics.

Chris Stille: Yes. Yes. And this is Chris again. One nice thing is that some of the national experts in complexity measurement for kids happened to work at Boston Children so, I'm hoping that all these people are talking to one other so that they (fine tune) that.

Lauralei Dorian: Yes. OK. So, looks great. While in – just looking at the time here, we want to make sure we get through the next two measures. The facilities out there.

But the next one that we're going to be talking about is 2548 which is the Child Version of HCAHPS. And that is the child is standardized survey instruments that ask parents and guardians of children under 18 years old to report on their child experiences with inpatient hospital care.

Karen Pace: Right, and just to note someone mentioned just a moment ago, you know, the measure we just talked about is about child and this one as well. So, conceptually at least initially, NQF would see this as potentially competing measures. But it's something we would ask you to evaluate each of them individually first and then we'll decide whether they are competing measures to determine which one is the better approach or whether they need to be harmonized in some way.

So, I just want to mention that because some of the questions referred to that, you know, competing measures and harmonization but the first level is really to look at them individually. So, we'll do that with this one first and …

Female: Great.

Karen Pace: You want to.

Lauralei Dorian: And rather than go through every single question I think at last time. I think at first we'll just open it up to any reflections on the evidence of course the measure is focus. So, again for PRO, that's the relationship between the outcome at least one healthcare action. That's 1a, 1b is about the performance gap to – with the performance data provided this demonstrated a gap in care.

And then 1c is high priority. Just to measure a drift – a draft that significant health problem or issue and does the target population value, the PRO and find that meaningful.

Karen Pace: So let's go to the evidence attachment in 1a.2. And we'll see if you have any questions or thoughts about the things that they identified that will affect these measures. In terms of either – will this be affective by saying that the healthcare unit can actually do their processes and structures and providing care to children that will affect their ultimate evaluations along with – I think there are 18 performance measures identified.

Male: (Inaudible).

Karen Pace: Maybe if the developer is on the call, you could about how and whether you involve to patients and …

Lauralei Dorian: Well that's 1c. Let's go one-by- one.

Karen Pace: Yes. But we'll come back to that in just a moment. So, their evidence talked about provider communication, patient-centeredness. Any particular comments? If not, we'll move on to 1b.

Katherine Bevans: This is (inaudible) one comment. I thought that this was a very nice description of importance of these issues and compelling argument for why the measure if this is needed.

Chris Stille: OK.

Lauralei Dorian: Alright. Let's go back to performance (caption) and this is a new measure. So, you know, it's not one that would previously endorse that some of you had already identified.

Chris Stille: Yes. This is Chris. I was looking at the performance gaps and just sort of the performance ranges. Some of these items are kind of skewed toward the top of things. I don't know what can be done of that. For example, you know, communication with nurses, 86 percent – the 26 percentile is an 86 out of a 100, and 76 percent out of 94 out of a 100.

So, you know, it's probably – it will be hard for hospitals to figure out what to do with a one point difference. But – some – a lot of measures that are sort of patient reports of care suffer from that. I think it's just important to kind of point out that it's a little bit of a limitation.

Lauralei Dorian: Right.

Lee Partridge: Yes. This is Lee again. That comes up a lot I think or will in some of this. And yet as I look at them I think I don't want some of these measures to go away because they're exactly the kind of measure that a consumer will look for it.

Chris Stille: Right.

Lee Partridge: Yes. So, do you leave it in and figure there isn't much for improvement but its valuable public reporting?

Chris Stille: Yes.

Karen Pace: So, which one Chris were you specifically talking about?

Chris Stille: Well, I was just looking at performance more than 1b.2. There's a matrix of performance scores for the different dimensions of the measure.

Lauralei Dorian: Right (inaudible).

Chris Stille: And I just looked at the top one that was communication with nurses.

Lauralei Dorian: OK. OK.

Chris Stille: But there are others that are sort of like that.

Lauralei Dorian: Right. Right, right.

Karen Pace: OK. So I think, you know, that brings up a good point. This is a new measure and the question is if there's not a lot of performance gap balance by what Lee has talked about. And certainly, you know, that something that committee as a whole will need to balance in terms of their assessment.

Chris Stille: Yes.

Lauralei Dorian: OK. Go ahead to 1c.

So 1c high priority. How was it determine that the (inaudible) two values (appear) and finds it meaningful. That the committee members like justify anything on this sufficient form that indicated there or the developers work specifications?

Female: (Inaudible)

Lauralei Dorian: If not maybe does developer wants to respond to that?

(Sarah Tommie): Do you want us to response specifically to 1c right about family involvement?

Lauralei Dorian: Right, exactly.

(Sarah Tommie): Yes. This is (Sarah Tommie). So, I think we try to involve families throughout and other stakeholder throughout this whole process. So, we began in the beginning by going through and not only doing an extensive literature review but also doing extensive interviews with different family groups. We've had members or a national stakeholder panel who are involved in parent advocacy groups.

We've gone to the coalition here in Massachusetts. And then we did focus groups in three different cities in English and in Spanish in a wide variety of socio-demographic environments. In addition to also doing two adolescent focus groups so that we could make sure that the issues that were important to them were at least represented in this survey.

After that, we did extensive cognitive testing with over a hundred in the end cognitive interviews of parents. To help us really make sure that questions that we have in the surveys, these items are items that are important to parents that they are items that parents can understand and also reliably report on.

And then I guess lastly, I don't want to leave out the fact that after this (array) was developed and fully validated in regards to the psychometric testing, we've entered it back to the (inaudible) ended and user testing. And we did

this in two different communities and it was a valuable experience to make sure that parents we're able to not only understand the measures that were developed but also find them meaningful and also be able to put labels on them that were understandable and that parents once again thought were valued.

Katherine Bevans: This is Katherine Bevans from HealthSouth. I've really appreciate this attention to the qualitative, you know, instrument development processes especially the returns of, you know, and users and the interviews that I think that's a commonly ignored part to ensure that we'll be able to, you know, they're be a way to transmit information about PM scores back to people in an understandable way.

I was wondering in your youth focus groups whether you've learned anything from the youth the maybe are – is not represented. I know you said that the concerns that the, you know, were pretty consistent with what's included in the measure but whether additional aspects or elements of care that they mentioned that didn't make the (cuts) into the parent report measure.

(Sarah Tommie): You know, to be frank I'm not being as coming to mind right now. This is…

Katherine Bevans: Yes.

(Sarah Tommie): You know, I think for the most part we were actually quite (pleased) that the adolescents, you know, this is the inpatient setting. So the adolescents and the parents often rely on another quite a bit. And actually they – their parent is being real advocates for them.

And if anything I think just validated the need for good communication. At this point, I just take the moment to day that although what we said is correct. This is a parent's reported survey.

We do have several items, however, that are geared towards the child and/or adolescents perspective from the parent's eyes. And we did extensive cognitive interviewing and (inaudible). Actually pretty confident that parents are able to distinguish on the items that we have and give a report of what they think that their child's experience was? And these are mainly around

communication. And we find that these are actually very valuable items to have in this survey.

Katherine Bevans: Yes. Have you ever done any testing to this to look at that (inaudible) coordinates between that's doing for this particular items. Between what the parents feel the child's impression is and his or her, you know, they use impressions from his or her report?

(Sarah Tommie): You know, it's a really great question and it's something that we're definitely interested in in perusing. At this point, we are, you know, just trying to have this measure up and running. And so we haven't had the chance to do that yet.

Katherine Bevans: Yes. OK.

(Crosstalk)

Lauralei Dorian: Great. So I would like to move on to the best medications now which is 2a.1 and 2b.1.

Karen Pace: Right. Before we go to those, let's look at the specifications and the measure information form beginning at the item numbers (F).

So, one of the things that we had ask for is in the numerator sections to identify what, which questions go into which measures. I think we're missing that in here maybe in another attachment. So there's a general statement about which kinds of questions will go in the measures? But I'll just stop there and see if anyone has any questions or thoughts about the measure specifications in terms of which questions go into what measures and then any of the other specifications regarding case mix adjustments or sampling and survey instructions.

Katherine Bevans: What is the rationale for a particular – excluding parents and children with the psychiatric diagnosis and (discharge)?

(Sarah Tommie): This is (Sarah) again. So, I think the rationale is sort of twofold one of which is that the impatient experience in the psychiatric unit is a very different experience in being anywhere else in the hospital. Often, a (lot of) unit for

which parents have very limited access to their child for psychiatric reasons. And the – also, we would be very interesting in exploring more, what an inpatient psychiatric measure would look like for the children.

We didn't feel as though – we felt as though there are probably be some domains that would not be present that would be needed for our survey that focus on that population.

Katherine Bevans: Great. Thank you. It might to just – so be just that you, you know, just write those touch down in the applications perhaps because it could be misinterpreted as excluding that population without a very clear reasons I think.

(Sarah Tommie): Sure. We are also harmonizing and making sure to harmonize as much as possible with the adult HCAHPS measure.

Katherine Bevans: Yes. And I thought that too but then I thought, well if it's given that this is other reporter that perhaps it would be possible. But I appreciate your description.

Karen Pace: And I believe the developer provided the specifics about the individual questions that go into the performance measures in the day the (dictionary) attachment which would have been in the Excel files at the – within the folder about this measure. So that's where those details are at this point.

Any other questions about the specifications? OK, if not I might ask the developer (Sarah) to explain both levels of testing for reliability and validity to explain how you – the differences between how you tested of the data elements level and the performance score levels.

(Sarah Tommie): Sure. Let me start by saying that actually what's reported here is our performance score. So, these are all hospital level analysis and this is what we think is probably was – is most valuable for evaluating these types of measures. With that said we would be happy to provide individual level analysis if that would be helpful. In terms of what we did we – for our reliability testing we did internal consistency reliability, hospital level unit reliability which we really think is at the core of developing strong measures

that can be use to be compared across hospitals. And then, since you mentioned also the validity testing there we – in addition to doing the qualitative work that I've already discussed, we did a factor analysis, items composite correlations, composite correlations, and composite and single item correlations with overall rating.

Karen Pace: OK, and yes we will ask you to provide some information about the instrument level, but appreciate that, you're right we – we are most interested our endorsement of the computed performance score. And could you speak just a little bit more because I think a lot of people are familiar with internal consistency, reliability when its used at the scale or instrument level and just kind of what you're testing for here and what – what's your result is indicated.

(Alan Lazowski): This (Alan Lazowski). We were – as we mentioned primarily interested in looking at the – into unit reliability but we did look at internal consistency reliability. Primarily, in a more exploratory sense of trying to see which items were essentially measuring the same facets of hospital quality or related facets of hospital quality so that when we report thing in composites, we can minimize the loss of information from providing information plus different items.

So, the fact – those factor analysis again that's a level of a performance score for hospitals. Did find the kinds of associations we were expecting among what would have been the main (inaudible) composites. There were also probably strong associations across composites and we only divide that as a problem and if hospitals that have good communication, the doctor is also a good communication, and nurses we can still report those things separately because it's more interpretable to the end users that way and there're several items on those questions if the information is fairly reliable.

Lauralei Dorian: OK. Great. Does the committee have any questions or comments about testing?

Katherine Bevans: Is this the appropriate time to talk about the case mix adjustment or?

Karen Pace: Sure, sure. Yes, go ahead.

Katherine Bevans: Well actually my question is really looking at the appendix that looks like it's kind of a general description of the, you know, how such an adjustment will be done. I apologize again if I'm missing a lot of material here. What was the final conclusion about case mix adjustment or is that something that you'll determine in the future as you further develop the measure?

(Sarah Tommie): We do provide details in regard to our case mix adjustment model and we would recommend for the purposes of making comparisons across hospitals that case mix adjustment is done. The variables that are included in our case mix model include child age, respondent reported health of child, respondent relationship to child, respondent age, respondent educational level, and respondent preferred language.

Katherine Bevans: OK, yes I do remember that now. I'm sorry in this, but yes thank you.

Chris Stille: And this is Chris just to add sort of (inaudible) to our discussion of the last measure as well. Once there is a fairly standard measure of complexity that becomes well accepted that should be a really good thing to do by case mix adjustment as well.

(Sarah Tommie): That would be great.

Chris Stille: I don't think the (consensus) of that now or else I'd recommended now, but I don't think there's a good consensus yet.

(Alan Lazowski): I think also we have to keep in mind that the information we get from the hospitals does a communication from the clinical information of the hospital to the survey implementer is not always as complete as you would like and you don't want to use things you want get from half the hospitals.

Chris Stille: Right.

(Alan Lazowski): So, the – there's a strong practical presumption at this point in terms of using things that you can get from the survey.

Lee Partridge: Yes, this is Lee. I was curious about how you got the ages of parent.

(Sarah Tommie): It's a survey items.

Lee Partridge: OK.

(Sarah Tommie): OK, are there any other …

Karen Pace: Any other questions about (potential threats) to validity. I think we've already talked about exclusions and case mix adjustments. Any other issues that or questions that you have for the developers?

Lauralei Dorian: All right, well then we can move on to our final measure which is the HCAHPS measure (0166). Its seven multi-item measures and it has four single items. And so, it looks at things like communication with doctors and nurses, responsiveness and hospital staff similar to what we just examine. And then some of the single item measures for example are friendliness with the hospital environment, (fight) and toher overall ratings of the hospital.

So, we begin again by discussing the evidence. Just to bring that slide up. Slide form (inaudible) OK. So, that anybody ...

Katherine Bevans: A question about process here since this is one of the reevaluation measures rate, (preventive) measures that we have. Is there an expectation that the instrument developers or this include all of the information that one might assume they might have submitted on the initial submission. So, I'm thinking specifically about their in response to the evidence here is that there is a – and some reference on the website about reference to service groups and cognitive interviews, not much information provided here. But I want to raise that something that was included in the original submission?

Karen Pace: So, we do expect the measure submissions to be complete even if it was the prior measures submission. The question about focus groups would really be under 1c and we'll go to that in just a minute. So, in this section of evidence about the patient reported outcome, what we're looking for is there a rationale or discussion of what kinds of healthcare interventions or actions on the part of the healthcare unit can impact this patient experience item.

So, if you look here they went measure by measure and they – it's kind of an iterative thing that the items that are in the measure obviously are things that

the healthcare unit can do to improve their scores or get a good patient experience. So, I guess that's the first question, then we'll go to 1c about how they developed it.

So, just go back to – no just stay in the – is there any questions about the – just there are actions, processes that the healthcare unit does that affects this patient reported experience with care, hospital care.

OK, so let's go on to 1b then performance gap.

Lauralei Dorian: Performance gap. So, again with the performance data provided that demonstrated there's a gap and care, can be variability between entities are overall an optional performance.

Karen Pace: So, up to 1b now, 1b.

For those of you who have looked with this 1b.2 is where they provided distribution of the performance scores on these various measures and there we go. So, any questions and thoughts about this?

Chris Stille: This is Chris. I have sort of the same thought as I had with the other HCAHPS. It's just that the variability with some of them was kind of low.

Karen Pace: Any comments from measure developer about that or your perspective?

Female: Yes, I think for most of this we do see, you know, variation at the hospital level. So, mean general for patient experience surveys you don't have like clinical measures a huge, huge gap that (we guide) clinical measures you'll see, you know, on a 100 scale, you could see some 20 percent, some near a 100 percent, you normally don't see that why on patient experience survey. But I think we do see at the hospital level variations.

Karen Pace: So, that's a good point. I assume that because we asked for this on the performance measure, this patient level or this hospital level scores?

Female: It will be hospital level.

Karen Pace: Oh these are ...

Female: All our analyses are hospital levels.

Karen Pace: OK, OK.

Female: This also is (drop box) scores.

Lauralei Dorian: (drop box) scores.

Chris Stille: Drop box score, that's the most positive response category in the survey for an item.

Karen Pace: (inaudible). Right, right. OK, so let's go to 1c then. And 1c.5. So, I think this is where the thought about. Go ahead.

Katherine Bevans: Yes, just a comment about focus groups and any qualitative work that have been done since where that this is consistent with patient perspective that I think it has been done, I just didn't see a description of it in the application. So, I don't know if the developer wanted to comment on that.

Female: Yes, we put a lot of information about that in the initial application and maybe we should have included again here. There is published research describing the focus groups that we did and it was published in Health Services Research December 2005. But there's a whole series of focused groups than to solicit information about what they wanted to know about the quality of care in hospitals.

Katherine Bevans: As you get in that about process.

Female: There's roughly is whole special issue of health services research on the development of the HCAHPS survey.

Lee Partridge: This is Lee Partridge again, is most of that research dating back to some of the original development of CAHPS. What I think well probably little curious about is we use CAHPS now for quite a while, do people respond different now? Do they feel that there might be some different questions?

Female: For HCAHPS you mean?

Lee Partridge: Yes.

Female: In terms of do people want different questions that we have added, you know, questions overtime. So, you'll see in the submission there are care of transition measure. So, those are the new ones.

Lee Partridge: Yes, I know that's coming out but in the next workgroup. I was just curious if you had learned from using it which questions seem to be more meaningful to patients for example or to the hospitals themselves for QI.

Female: For QI, I mean the – this is now linked to hospital value base purchasing.

Lee Partridge: Yes, true.

Female: So, hospitals and that's more recent development. So, hospitals are paying attention, you know, to the different items in implementing, you know, quality improvement activities.

In general the communication items are most, you know, correlated with the overall ratings, so you do see a lot focus on those communication items. But we have the, you know, improvements, you know, very significant improvement in the scores over time with the additional focus by hospitals. We also see that these items – it's not task specific testing but we do a lot CMS's lab testing on the hospital compare tool where this information is displayed and this information happens to be the place where consumers first go for information.

The patient experience information resonates the most to them compared to the clinical information.

Female: Right, as I remember you deep down in the patient experience and looked at some of the individual measures and I'm – I guess I was just curious, the extent to which I suspect the communication one is the one that comes up most often of what people click on.

Female: All right, well let's move on classification. We'll just bring that up. OK, so let's go down to the numerator statements. So again we don't have the specific

question with the measures in the numerator statement but I believe I saw them somewhere else. I don't see them in the specifications but we'll double check.

Female: Here on to the screen is the numerator detail.

Female: Yes, if you include the specific questions talk about sponsors (inaudible). So we'll ask the committee if you have any question about the specification, could you tell which questions when with which measures or how the performance scores were computed? And any questions about other specifications?

I see, down in – let's see, yes, the calculation algorithm SA team. There's question numbers but not the actual language of the questions to know that actually goes in there but there'll be a cross reference.

(Off-Mike)

Female: There we go 4.4, there you go. Right there. OK. And then the questions are included later on. They are at page 17. So broken up a little bit but, yes, 17 you're on 25 now. There we go. Yes. So here you see for example and you can scroll back up just a little bit the specific items that go into that particular measure.

Female: I found that to be clear.

Female: OK. All right. Well then, you know what? The questions about specifications for all this cost, if there are any other questions or comments. OK then as of the last, measure we've – we'll ask the measure developer to explain your testing approach and how you just (branchiated) your different approaches for testing of the data element versus the facility level for reliability and validity.

Female: So, I'm not sure what you mean by the individual measure level, the information we put in the package is for the performance measure score there at the hospital level. And that's what we've extremely wanted for the package (inaudible) and/or the same measure…

Female: Right, but so the requirement for pro-PM is some information about reliability and validity as the underlying scales and as well as the performance measures. So it's absolutely the need, the performance measure information and I appreciate that, so maybe just talk about what you did then for just your method of something, reliability for the performance measure and also the validity.

Female: So I think in the package (gem) people have questions that we've described as variance component models for years but the reliability information for each of the 11 HCAHPS measures. I don't know if people have specific questions about that. For the validity testing, we put more recent stuff about the correlations that we did as well as those correlations are updated every year on our website.

So in a lot of this data, we put, you know, every year on the website. We update it for the public as well as we included some of the initial, you know, factor analysis that we conducted.

Female: OK. Fine. Any questions from the committee about the reliability and validity testing or what the results tell us?

Female: I think I had one kind of detail clarification question, at one point in the application of page 22 of the review document, it's noted that the domain of care is cleanliness and quiet of physical environment. But it appears that in the analyses and in other places in the application, those are considered, you know, stand-alone items. There are no composites. They're actually just performance measures that stand-alone (inaudible) different one for quiet.

Am I interpreting that correctly because I find that to be a little bit confusing, but there's – work together as a domain?

Male: Originally.

Female: Originally. Yes I think the confusion maybe and we're trying to figure where we're looking in that package. Originally, they were grouped together in a

domain together, measuring environment and for half the value-based purchasing, they are grouped together for value-based purposes.

On the website though, we do present cleanliness and quietness separately. And this is really based on feedback from consumers. They did not like when we did focus groups of testing with them. They wanted information separately about cleanliness and quietness, so there's two areas that are extremely, you know, important to them but are very different from their perspective.

So to meet the needs of the people who are using the web (sign) and for use of the data, we ended up separating them out.

Female: I think that makes – there's a good sense and I guess maybe this is why the factor analysis of the individual level maybe important to demonstrate that these are not, you know, two items that are so inter-correlated that they should be considered their own domain.

Male: Yes, I agree.

Female: I don't know if this is the right place to ask this question but I know you all have made some adjustments, and I'm sorry, thank you Bradley. Based on the mode of survey and it doesn't indicate that you've updated that since the original application but I know you're continue to test that.

Can you explain, you know, if that's still – are you still finding that the adjustments that you made whether it's telephone versus mail or kind of holding true or are you all continuing to look at that and make your recommendations in this about changing that…

Female: Right. It's an area where we're continuing to look at so recently we did some analyses to add mode adjustments for that care transition item. We will be doing in the coming year a fairly large mode experiment to reevaluate the mode effects but thus far we're seeing, you know, similar patterns than we initially saw.

Female: OK. Thank you.

Female: Are there any other comments or questions?

Female: Let me go back.

Female: All right. Well, I see, so we're through with those three measures. Does anybody have any questions or those that weren't addressed or answered today? Did you want to go back in the other measures or any comments on the process?

Chris Stille: Yes. This is Chris. And I'm sorry I overlooked this when we're looking at the Child HCAHPS. I just had a small question that maybe one of the measure developers can answer real quick. The denominator that is the number of respondents with a completed survey and that just sort of drew me a little bit. I don't know what their definition of completed survey is. And I didn't see any place in the documentation. I guess my only worry is if you have to complete a large amount of the survey to be measured on any item, that would be a problem, but that's probably not what they meant.

Female: So for HCAHPS, to complete a survey is they have to answer at least 50 percent of the items relevant to every one.

Chris Stille: OK.

Female: So, if it's item with a skip pattern, that wouldn't be an item relevant to everyone.

Chris Stille: OK.

Female: And it's the same for the Child HCAHPS.

Female: Yes, it is.

Female: OK.

Chris Stille: OK. That should probably be written someplace on the child HCAHPS I think.

Female: I think it's in the technical specs (Chris) that I can double check exactly what page. Is there – if they were the first part of the appendix.

Chris Stille: Oh, OK.

Female: OK. We probably need that kind of information in the specification field, but we can…

Chris Stille: Yes.

Female: …make sure it gets there.

Chris Stille: Yes. I have to admit I did not pay much attention to the appendix.

Female: Right. And we tell the developers that same guarantee that that will be looked at because there's so much – you do need to pay attention to. The other thing is for everybody's knowledge of why it's useful to have the information in the field to the form is that this is the information that it's actually publicly available when people are searching for information and measure. So, it's more useful for people after endorsement as well when it's in the field. So, that's another reason that we ask right there.

Chris Stille: OK.

Female: I think Karen, the price of some of the developers, I think that some of the cost in other places, we were told if we have a manual just to reference a website or in the manual and some of those fields, so.

Female: I think that is correct. Well, we'll work with you on that. No problem.

Female: Yes. So just to make sure especially for existing surveys, their specifications and our specifications is three or four inches thick. So clearly won't fit in to…

Female: Right. We did…

Female: You know, all these forms.

Female: Yes, exactly. For example, we don't need all the details, but with sampling and survey instructions, but definitely we'll get back with you about it. Thanks.

Female: OK. Any other – anything else?

Lee Partridge: Lauralei this is Lee again. Did Boston children staff ever get on the line?

Lauralei Dorian: Unfortunately they were unable to. Currently, they are having some difficulty with their phone system.

Lee Partridge: OK.

Lauralei Dorian: But they said, if we have an emailing and they said that they'd be happy to answer any questions over email. And they will definitely be there or at least on the phone during the in-person meeting.

Lauralei Dorian: Well, yes. Operator, can you open the line for public comment please?

Operator: Thank you. At this time, if you would like to make a comment, please press star then the number one on your telephone keypad. And there are no public comments at this time.

Lauralei Dorian: Than you. And then just quickly if in terms of next step, there will be writing of the summary of this and I'm sending it out to you. And for the in-person meeting, everybody will be assigned as either a lead discussant or secondary discussant for one measure. Yes, for one measure, one or two measures.

And so for that, you'll be using the summaries that we send to you to sort of introduce the measure on the issues that are wrote during the call today. And then we'll evaluate and you – we'll be expecting you to evaluate all of the measures that were submitted for this project in time for the in-person meeting. So there are 12 measures available.

And you should have received travel information. I think today, Friday and today, we spent out from our travel department. So that will be about arranging accommodation and flight information. If you don't receive that, let

me know and I can make sure that our travel department gets the (inaudible) review.

Female: It seems to have come out. Yes.

Female: Oh good.

Lauralei Dorian: OK. Are there any questions about the next step? OK, well, thank you everybody for joining the call today and for reviewing these measures and speaking with it. We're looking forward to seeing you here in DC, and the (inaudible) as well.

Female: Thanks to the instrument developers who are available that's incredibly helpful to get your viewpoints on it. I really appreciate that.

Lauralei Dorian: Great. Thanks everyone, have a good afternoon. Thank you.

Male: Thanks.

END