National Quality Forum

Moderator: Lauralei Dorian
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12:00 p.m. ET

Lauralei Dorian: Great. Thank you. Good afternoon everyone, this is Lauralei Dorian and the NQF team here. Thank you very much for calling into the third workgroup call for the Person and Family-Centered Care Steering Committee.

We would like to thank you in advance to those committee members who took the time to fill out the surveys and evaluate the measure submissions. We know and acknowledge that they're quite complicated and time consuming, so we truly do appreciate that. And we'll make sure to try to answer any questions or concerns you might have about these measures on the call today.

And I would just like to remind you that this call as all NQF calls is open to the public. And we'll be having a public comment period towards the end of the call. And also just a quick note to please keep your phones on mute while you're not speaking, that can help with the sound for everyone.

And – so before we get started, we just like to remind everyone of – we touched the promise on the measure evaluation tutorials that the fact that these measures are based from surveys, patient experience with care surveys. And just to remind you that NQF does not endorse the surveys themselves. They only endorse performance measures that are based on the survey data.

So, we have provided you with some examples that we've sent to the developers in terms of what sort of information we are looking for to make it clear that these are measures, not surveys. And what we mean by that is that

the surveys are at end of the July level that NQF endorses measures for accountability purposes. So they'll be at a facility level, especially the hospital.

When we get to testing, for instance, we'll be expecting to see testing for validity and reliability of both the individual measure of the survey itself but then also of the performance score measure at the facility level.

So, are there any questions about that before we get started?

Peter Thomas: I'm sorry, I just joined the call. Would you mind repeating that? This is Peter Thomas.

Lauralei Dorian: Oh hi, Peter.

Yes, we just wanted to talk about the difference between surveys and performance measures and just note that NQF, as an entity, only endorse these performance measures that are tested at the level of our facility.

So, by that, we mean that we expect them to be able to differentiate performance between different settings of care, while the surveys themselves are usually at the individual level of one person, but they can be aggregated up to a performance measure. Does that make sense?

So there will be the testing of both of those levels to make sure that the instrument itself, the survey itself is reliable and valid, but also that as a performance measure, it's aggregated up to an entity that is also reliable and valid at that level.

Peter Thomas: Thank you.

Lauralei Dorian: Sure. And you actually reminded me. Let me make sure that we know – I think I know, I can see on the chat who we have on the call, but let me make sure. I see (Carol Lavigne).

(Carol Lavigne): Yes.

Lauralei Dorian: Great. Hi, (Carol). And Lisa Marie?

Lisa Marie: Yes.

Lauralei Dorian: Great. Lee Partridge?

Lee Partridge: Yes, I'm here.

Lauralei Dorian: Great. Peter, I just heard from you. Sherrie Kaplan?

Sherrie Kaplan: Yes.

Lauralei Dorian: Great. (Dawn Delving).

(Dawn Delving): Yes, I'm here.

Lauralei Dorian: Great. And Samuel Bierner?

OK. And then if I could just ask any measure developers that are on the call to identify themselves?

Julie Brown: Julie Brown from RAND for the CAHPS Consortium.

Lauralei Dorian: Hi, Julie.

Ron Hays: Ron Hays also from RAND.

Liz Goldstein: Liz Goldstein from CMS as well as Barbara Crowley, and Lori Teichman.

Lauralei Dorian: Great.

James Conroy: And James Conroy, Center for Outcome Analysis.

Lauralei Dorian: Great. Thanks.

And for those committee members who haven't worked with NQF before, we invite measure developers to be on this call so that they can respond to any questions that you might have about their measures.

So, thank you for the developers for dialing in as well.

So before we get started, we wanted to check to see if there were any sort of – if there's any feedback about how this process went for you. I know that it is pretty time assuming especially if you haven't – if you are not used to reviewing measures. And also if you had any questions or comments that pertain to all of the measures and not necessarily measure specific, but something that you'd like to clarify before we get into specific measure discussions.

Lisa Marie: This is Lisa Marie. At the risk of (founding) – I don't know, (inaudible) – I did not understand a lot of what was being said. I could glean a lot. I do have a background in statistics, so I understood that – I understood how the measure should be in the slide. Maybe it was the layout.

Also, there were a lot of acronyms and I could find most of them on Google, but that made it more difficult for me as a patient advocate that works in national advocacy. It made it more difficult for me to try to figure out what was being said because many things were referred to in short hand.

So, that was just my observation.

Lauralei Dorian: OK …

Peter Thomas: This is Peter Thomas. May I also make an observation, please?

Lauralei Dorian: Of course, yes.

Peter Thomas: I spent an awful lot of time with this. And that's – I bought into that, no problem there. The question is whether I really – there's so much material to get through and to truly understand in order to offer meaningful comment that I wonder if we could, in the future, perhaps flip this up even further so that instead of doing three of them, we really – maybe two people would delve into one of them and report back to the committee, a really serious way as opposed to trying to get through all three of these and really offer coaching comment.

It was a real challenge to get through this material and to really understand it.

And I'm not sure if it was how it was presented or whether it's just the nature to be, I'm not quiet sure after going through this.

It was also our first attempt and my first attempt with this. So I'm quiet sure in the future, it might get easier because I'll know what to look for and know what the issue spot and that kind of thing. But, I don't know. It just struck me that there could be some valuable time that might go into figuring out how to present this in a way to decrease the – frankly, the burden on the individual members of the committee.

Lauralei Dorian: Right.

(Carol Lavigne): This is (Carol). I agree with all of that. I don't have a background in statistics. And I really did struggle, I tried. And interestingly, some of the things jumped out of me without that background, but who knows what I missed. And I felt sort of unsure as I was going through it.

There seem to be an awful lot of repetition. I kept reading the same thing over and over again and didn't quiet know, you know, what I was really – where I was supposed to focus my energy. So I think there is something about the format that – and I like the idea of maybe two, but I would have like the opportunity to talk to another committee member and, you know, sort of go back and forth. But what is it that you're seeing, what am I seeing, somehow I would have felt more confident than I did feel or do feel.

Karen Pace: This is Karen Pace. So, thank you for those comments. And, you know, Lisa, experience of care measures are, as Lauralei said, more complex, but we appreciate your concerns.

And one of the things that we'll be talking with the committee about, hopefully, at the in-person meeting is suggestions for the measure submission in terms of any kind of special considerations we need to make in the future for these types of patient reported outcome measures.

So, definitely, keep those things in mind since we'll be revisiting that.

That being said, today, we really want to not so much focus on formal evaluation of you being able to say that, you know, you want to revisit a certain level, but really to identify any issues or questions that you had as you went through this so that either we can clarify with staff or as Lauralei said, we have the measure developers on the phone who can answer questions.

So, we'll use this as kind of input and kind of pre-review of these measures prior to the in-person Steering Committee meeting.

Lisa Marie: Hello, I'm – this is Lisa. I just want to say I'm glad I wasn't alone in my feelings and I feel (perhaps) inadequate now.

Lee Partridge: Lisa, this is Lee Partridge. And I just want you to know that I've been on CSAC for two years and I've been on several steering committees and I still struggle with all of the validity and reliability data. And, in fact, the workgroup call yesterday, we talked about a little bit. And Karen said that they would give us all sort of brief refresher or tutorial depending upon how much knowledge you bring to it, when we – at the beginning of our work session, because I think, you know, if you've never meet (cron back) or a (Peterson), or experiment, or whatever before, it's kind of daunting.

Lisa Marie: Well, I did go back and read the guide books again. And I didn't – it didn't connect somehow. So, I know we don't want to dwell on this for a little bit. I would just suggest that perhaps in the future to take the group when doing that original orientation through an actual set of measures and explain that.

Female: OK.

Lisa Marie: So, when we see the actual, it's a little more tangible because we actually spin it and done it sort of. Does that make sense?

Lauralei Dorian: Yes, that makes sense. OK …

Peter Thomas: So here's a threshold question. I don't want to drill the conversation. You said maybe we'll use this as an opportunity to ask some questions.

Here is kind of a couple of questions to maybe get us started. We received yesterday or the day before, I think yesterday, the responsive and the written comment that people on this committee had made. But it came in the form of a 60-page document for the clinician and group survey, another significant document for the home health and other significant document of hemodialysis.

And I went to the place where the consolidated written comments were listed, but a lot of – unless I missed something, it seems as though there was basically a reprint of the rest of the information. Was there a lot new here or does it boil down to the consolidated comments on the first several pages under each one of the, you know, reliability and each of one of the self measures that we're supposed to look at?

Lauralei Dorian: Right, that's a great question. And I should have clarified that that's actually the measure – what we called the measure worksheet that you'll be working with from now on. What it does is hopefully it makes it easier for you because, as you know, that it starts out with some brief measure information and then the survey result.

And then following that, it has combined those three attachments that you were reviewing, the four which was the measure information form, the evidence attachment and the testing attachment. And so it essentially combined them all into one that you don't have to be opening a bunch of different things. They're completely right that it, you know, you're viewing information that you've seen before but that's enough the reason why.

Peter Thomas: So, what's new? I mean, if you look at the pages, I think what's new is page five. Oh, I'm sorry, I'm looking at the clinician – CAHPS clinician and group survey version two.

Lauralei Dorian: The only thing …

Peter Thomas: Page three is new.

Lauralei Dorian: Right.

Peter Thomas: Page five is new.

Lauralei Dorian: And they're only new, that's – no – there is no new information other than the result of the survey and that's …

Peter Thomas: The survey of us?

Lauralei Dorian: Your – right, your survey results.

Peter Thomas: Right. OK. So that's really the only thing that's new here except the fact that you consolidated some of the other information and put it into one place to now work from this, correct?

Lauralei Dorian: Correct. And we'll be using this form for everything moving forward and we'll add to it, for example, we'll summarize this workgroup call and there's a section up at the front on top few pages beneath the survey results very well summarize the workgroup calls.

So it's all in one place for you. So it will grow a little bit, but the only added information will be your input, essentially.

Peter Thomas: So, yes, forgive me if this sounds critical, but that took me an hour and a half to figure out, because I had to go through each one of these to figure out whether this was new, whether – what this – how is this correlated to what we've been sent before. And so, it just – if you could perhaps give us a little bit more of a guide book as you sent out emails and stuff as to what does this constitute, you know, new, you know, focus on these pages, you know, so something that kind of walks us …

Lauralei Dorian: Right.

Peter Thomas: … through it to save a little time. It's really quiet voluminous and you just don't want to feel like you're missing anything, you know.

Lauralei Dorian: Right, no, that's a good suggestion. I think it's buried somewhere deep in that steering committee guidebook. But, I think it's a great suggestion. So, more explicitly explained when we first sent it out.

Peter Thomas: I have one more question if you don't mind me taking the floor …

Lauralei Dorian: Sure, yes.

Peter Thomas: So, what is the role – this goes to respective role. So, AHRQ was one of the – what did they call them? Measure …

Lauralei Dorian: Developers.

Female: Measure …

Peter Thomas: Measure developers. AHRQ was one, CMS was one. What is their role? So, if they – they're filling out this – the answers where the evidenced based and the kind of answering all of the questions that NQF has put forward in order to judge whether this is a measure that should be, you know, NQF endorsed.

So, what is their role in terms – I mean, they're the experts, right, in some real significant regard. If they don't feel that the evidenced based is as robust as it should be or could be, are they obligated to disclose that? Or are they making the best case that they can make based on the evidence?

In other words, are they lawyers in advocating a case and forgetting and sweeping the unpleasantries under the rug? Or are they supposed to be telling us what the real situation is, so that we can assess whether or not this measure is ready for prime time?

Karen Pace: This is Karen. And I guess I'll answer that and say, you know, there's probably a range there but, basically, NQF ask for as objective information as possible in terms of what testing was done and what the results of that testing was. And then, we do ask if the developer – to interpret that, but that's their interpretation. And, you know, again, that's useful, but it is up to the committee to judge that externally versus just what was interpreted by the submitter.

In terms of the evidence, I think since you brought that up, or if you're talking about the clinical evidence, as we get into this, for this type of experience with care measures which are considered a patient reported outcome, we really,

basically, looking for a rationale that there are things that healthcare providers and facilities can do to impact that particular aspect of experience with care.

So, it's not as owners of a systematic review of the evidence that we require when someone is submitting, for example, a process performance measure. So, we do ask for any outcome measure a rationale, you know, to first state, you know, what are the things that can influence that patient reported outcome or, in this case, experience with care, and provider rationale, because essentially these are being used to measure a healthcare unit quality.

And so, it should be something that they can actually impact. That's usually fairly easy to do. And in a lot of cases, especially with the experience of care, it comes down to common sense. And are these things that really go together.

But if we were looking at, for example, a performance measure based on a specific treatment or a specific intermediate clinical outcome like blood pressure control, then the clinical evidence based, you know, would have to be systematically assessed and graded in terms of what's the strength of the evidence could support having a performance measure.

Peter Thomas: OK, so this is my – this was the thing that I grappled with the most this entire – throughout this entire process. And it was – I must tell you, it's quite frustrating not knowing the answer to this question. I don't know if I'm being asked of the number of this committee to the dispense attorney, when CMS or AHRQ is the prosecutor, they're advocating that we adapt this measure.

And I don't know whether I'm supposed to poke holes in their argument and find how their representation of the evidence is flawed in some way, or whether I'm the jury. And I'm – and some other expert like NQF (staff) is supposed to be pointing out the other side to the argument, where the trial piece in the argument, or what have you.

And, we're supposed, as a committee, decide whether or not it's good enough to be – to get the NQF endorsement. Can you help me with that analogy? So what's our role?

Karen Pace: Well …

Sherrie Kaplan: Karen, this is Sherrie. Can I just jump in?

Karen Pace: Sure, sure.

Sherrie Kaplan: This is Sherrie Kaplan.

First of all, I think the adversarial kind of promises is the wrong way to frame this. It's not an adversarial, at least the way I've understood my role on these various different NQF committees.

It's more – you have to – it's really more of a science role. This is up to the task of doing what the people who are proposing to use this measure or proposing to use it for (NS). And so, rather than creating kind of an adversarial position, it's more like, is it up to (SNEF), does it pass enough of the test so that it can make the – it can assess the performance of the entities that purports to assess in a reasonable and appropriate way.

My concern, however, Karen, back to the issue that just got raised, is that some of these measures, a conceptual model that asserts a causal relationship between the patient's experience and things that happen, it's fine, except when you revert back to another measure that have like HCAHPS that's been around for a bloody long time.

And it – there's no evidence provided to address the question you raised, what – how sensitive is this measure to efforts to change it of the function of the things that the entity is doing, the hospitals are doing to improve care, for example.

And that, if you're going to lean back on those data, you should have provided evidence not internal to the patient experience data like it correlates with a global rating. These measures have been well around way too long to provide that as the level of evidence that we're considering.

So, you know, a conceptual model is one thing, that's fine, if you're in phase one development. But some of these measures are not in phase one or they're leaning back the evidence for validity to measures that have been around a

long time. Therefore, the measures developers, I think, should be obligated to provide us with evidence that, yes, in fact, when these measures are stocked up on efforts to improve quality, they are sensitive and therefore, mutable by the entity to changes that they're making to affect the patient experience.

Karen Pace: OK. Well, that's a good big question. And we have to think about where that fits in our – I think it comes back to what you're saying about in the validity discussion. Just in general, the evidence criterion is more about the – at the patient level versus the performance score level.

But definitely we want to look at the performance of the measure overtime and that is one of the questions, certainly, about the validity that it's an indicator of quality. And we'll definitely have – can have those discussions. And I think you raised a, you know, good point that has come up in the broader context of performance measures in general, that we probably need to be thinking about for measure maintenance.

So, appreciate those comments. And I'll just make sure that people know that I definitely agree with Sherrie's perception. It's really not an adversarial kind of situation. We try to, you know, work collaboratively with the measure developers. But, it really does come down to more of a, as Sherrie said, a science judgment, measurement science particularly.

And is the measure good enough for the purpose – and NQF endorse these measures that are intended to be used in various accountability applications.

So, why don't we start through the first measure? And then as additional questions come up, we can try to tackle them as they arrive. So …

Lauralei Dorian: OK.

Karen Pace: … Lauralei.

Lauralei Dorian: So the first measure we're going to look at is 0005, which is the CAHPS Clinician & Group Surveys version 2.0, (sorted) by the – by AHRQ. And this is a standardized survey instrument that asks patients to report on their

experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the proceeding 12 months.

So the first thing that we ask you to look at in the survey was the evidence to support the measure focus. And to health outcome or PRO, which, of course, (inaudible). We ask if the relationship between the measured outcome and at least one healthcare action should be a structure, process, intervention or service as identified and supported by the stated rationale.

And we might go to the …

Karen Pace: To the evidence attachment.

Lauralei Dorian: … evidence attachment.

Karen Pace: So …

Lauralei Dorian: Are there any preliminary thoughts about evidence to bring …

Karen Pace: So – yes, basically, we ask (inaudible) to health outcome or PRO. We asked two questions to state our diagram that pay us between the health outcome or PRO and any healthcare structure process interventions that influence it.

And then, the next question is support the rationale which certainly can include evidence and it's preferable if it does, but it's not the same as doing a systematic review of an evidence for every single intervention or process that might be related. But, let's look at the diagram first. So let's stay on one – that question.

So, any questions or concerns about what they're saying here?

Sherrie Kaplan: So, are we on 1a …

Karen Pace: Yes …

Sherrie Kaplan: … what's the evidence …

(Inaudible)

Karen Pace: Right.

Sherrie Kaplan: Yes. So my initial concern was that there wasn't a conceptual model provided and the attached materials that were forwarded afterwards, there is one, I believe.

Karen Pace: Right. And it – are you on the webinar, Sherrie? Can you see …

Sherrie Kaplan: Yes.

Karen Pace: OK.

Sherrie Kaplan: Yes. So that was, you know, one of my concerns was that the evidence was, you know, not all dimensions were represented, et cetera, et cetera. And now – that it looks like they provided the conceptual model so that was good.

And then my other concern, are we going to stay on 1a or we're going to 1b and 1a?

Karen Pace: So let's stay on 1a first and then we'll go to 1b.

Sherrie Kaplan: OK. Well, then my concern also was, was there's any evidence that patients actually use these measures but, you know, probably in the phase one of this in terms of its rollout. So, if those data aren't there yet, you know, if – you know, plans to get those data somehow monitoring what happens. Is that in the MAPs?

Karen Pace: Yes. Actually that's not one of our criteria that they provide evidence that patients are using the performance measure data. This is – this evidence criterion is really about whether there are things that the healthcare, in this case, clinician can do that will affect the experience with care that's being measured. So …

Lauralei Dorian : We will address later when we get …

Karen Pace: Right.

Lauralei Dorian: … the specifications whether families and patients themselves have input into the survey question.

Karen Pace: That's in 1c Yes.

Lauralei Dorian: We'll get to that later.

Karen Pace: Right.

Sherrie Kaplan: Yes. But I thought that actually the measures developers raised that as one of the things that they were suggesting, that the patients can use these measures. And then they didn't provide any evidence, but …

Female: What?

Male: What's going on?

Female: What's happening?

(Crosstalk)

Female: But that was not me.

Female: That was very dramatic.

Male: That was a really important point.

(Inaudible)

Lauralei Dorian: Definitely got your point.

Female: Oh my God.

Sherrie Kaplan: OK. I'm not saying anything else, that was (inaudible).

Karen Pace: OK. Any other questions about this relationship that there are healthcare interventions that can affect the experience with care measures that are being proposed or that are being use? If not, maybe we'll go back to 1b and look at performance gaps then.

Lauralei Dorian: And so …

Karen Pace: This is (inaudible) – yes.

Lauralei Dorian: Sure.

Karen Pace: Bring up the slide first.

Lauralei Dorian: So for 1b, we want to know whether the performance data provided demonstrated the gap in care so that can be variability or overall that's an optimal performance. So weren't a national performance measure.

And also, we ask whether it provided disparities data for certain population subgroup. So we can bring performance gap up from the measure (inaudible). Here we go.

Karen Pace: So here, we ask to – for the performance data which I don't see in the form, they …

Female: Yes, it's on page 49.

Female: Oh God.

Female: I think. I've struggled with this one, too.

Karen Pace: Was it in the appendix?

Female: I think it was in the main submission, Karen.

Karen Pace: OK.

Female: But if they didn't give actual scores, they did account of the, you know, how many were above the average and how many were below.

My principal concern with this and it comes up at several places, is the pediatric samples (inaudible) small. Now, I know when you're testing 20s and all of that smaller number, but it seem kind of been in here.

Karen Pace: All right. I think what you're referring to is they put in the testing attachment. Maybe – let's go to the testing attachment, 2b 5.2. I think this is maybe what you were referring to where they gave the percentage of statistically significant difference from the average. Is that what you're referring to?

Female: I can't find it in the …

Karen Pace: OK.

Female: But – yes, I think it – yes, it is …

Karen Pace: OK.

Sherrie Kaplan: … because it has the actual account, too. That's what I remembered.

Karen Pace: Right. OK.

So, and this – they referred to this under the identifying, you know, identifying meaningful differences with the performance measure. So, it's a little bit different than we often see for performance gap where we get kind of a distribution of the scores for the performance measure.

Female: (That's correct).

Karen Pace: And we are primarily interested in the measure not the individual questions that go under the measures. So, where are you at? Will you go back to the – OK. Why don't you scroll down a little bit so we can see.

So, for example, in here, the access composite was actually computed, it includes five items that are listed below it. So we're really most interested in that performance measure which would be the access and then let's go down to communication.

OK. So, we have a developer on the line. Maybe we'll ask if they want to make any comments about performance gap and where that – if there's additional information or if this is primarily what they're suggesting we look at for performance gap and their interpretation.

Sherrie Kaplan: Karen, this is Sherrie. Can I jump on that now …

Karen Pace: Yes.

Sherrie Kaplan: … to tell us what analysis this is based on, you know, statistically – how – what statistical method that they use to tell that? And my concern is around the communication dimension in particular, because it's highly favorably skewed. The mean values are all over, like 84, and the interquartile range is like 0.09 percent.

So – and the confidence interval is like 0.84 to 0.85 for the adult measure. So, sometimes statistically significant differences are meaningless.

Karen Pace: Right.

Sherrie Kaplan: So, it would be helpful to know if there is – there may not be, for example, a performance gap or a measurable meaningful performance gap in physician communication.

So could they kind of go down, one, and tell us what method they used to drive these differences and two, whether or not, they consider (a quotes) meaningful difference in some of these things that are highly favorably skewed.

Ron Hays: I'll just say that the regression is usually the approach we've used with the case-mix adjustment. So that's what is reported here and these are just significant differences.

We also look to see to the extent we can whether they are meaningfully different, you know, whether they're large enough, this actual table doesn't break it out that way, but that's done within CAHPS many times to see, you know, how it translates in terms of magnitude. But it's pretty tricky to do that.

And it shows that these measures are skewed, like you can still see significant differences. So, they're not – there is room for variation even though they're skewed towards the top end and that's always the case with every patient experience measure I've ever seen. So this isn't a typical at all.

If we want to able to detect differences, that would be a problem, but we are. So, it's good that they're skewed in a positive direction because that means that groups are doing relatively well, but there still is room for an improvement even at the top end.

Female: Is that Ron?

Ron Hays: Yes.

Karen Pace: Yes, please identify yourself when you're speaking. And Sherrie, where did you find the interquartile range in distribution information because I haven't seen that?

Sherrie Kaplan: You nail me somewhere, but it's in the …

Karen Pace: OK.

Sherrie Kaplan: … it's in here somewhere, I found it. So I didn't make that up.

Karen Kaplan: No, I'm sure you didn't, I was just trying to figure out where it was, because …

Sherrie Kaplan: Because you put – I didn't put in my notes on page whatever it was. But, Ron, so this is – help me understand, is this at the practice level or is this at the patient level and it's – how was the regression, was there a hierarchical model or how did you do it?

Ron Hays: Well, it's at the site level. But it's, you know, the focus of the site, it's not individual patients. And then we adjust for standard case-mix adjusters that we found in CAHPS to be, you know, related to reports and ratings of care but not necessarily reflective of the care delivered or, you know, the patient biases potentially.

So, you know, age and health status and education are the three primary …

Female: Right.

Ron Hays: … adjusters in every CAHPS analysis and then we have some additional adjusters as needed.

Sherrie Kaplan: But you didn't adjust for the number of providers within site, for example.

Ron Hays: No. That would be potentially indigenous.

Sherrie: Right, got it, thank you.

Karen Pace: OK. So – well, let me ask the measure developers – well, we can come back to that, where if you have just the information by kind of the distribution of scores versus this table of – those that are statistically significantly different. And with a …

Ron Hays: Well, if you want the distribution of scores, we can provide that. You know, part of the issue in filling this out is not knowing just like the questions that were raised by the committee, (so I'm) certain exactly what to put in here so you make your best judgment, but we can certainly provide more distribution-based information as it's needed.

Sherrie Kaplan: Actually – this is Sherrie again, the four pages from the back of what was originally distributed is a table that actually has the distributions.

Karen Pace: OK.

Sherrie Kaplan: Means and the standard deviates got green lines, looks like an Excel spreadsheet from staff that says output. And it's got a lot of distribution date on it.

Karen Pace: OK, great.

Sherrie Kaplan: That's where I found the interquartile range on the physician communication thing.

(Inaudible)

Ron Hays: I thought you wanted the full distribution, so, yes. We do have some summary.

Karen Pace: Yes, but …

(Inaudible)

Karen Pace: Yes, we're talking about summary, not every facility.

Peter Thomas: Were you talking about the – originally talking about the graph on page 50 and 51 kind of (inaudible) to update on 50 and 51?

Lauralei Dorian: We didn't have a …

Peter Thomas: 2b5.2A.

Lauralei Dorian: 2b5.2A.

Sherrie Kaplan: Yes.

Karen Pace: Yes, that's what we've got – look – we've been looking at on the screen.

Peter Thomas: OK. So, could I just ask a question, I just – this is very basic stuff. But I just want to make sure I understand this. So …

Female: OK.

Peter Thomas: … take the five – the first five questions about access. Apparently, 109 – you take the first one, got an appointment (verge) of care as soon as needed, could you just walk me through what this data says and means so I know what 34 percent or why it's relevant that it's 34 percent and not 78 or not 13?

Ron Hays: Well, that's the third column, right, you're talking about?

Peter Thomas: Yes, just …

Ron Hays: Yes, so that's the percent that are significantly different from the average. So, if that was 0 percent, you would say there's no differentiation among sites so this is a worthless measure. We don't know the exact amount that should be significantly different, but, you know, there's a substantial number that are, so

that suggest that at least there are some differentiation between the sites, that's the main bottom line message.

Peter Thomas: Got it, got it.

OK. So the (100) percentage in that column, the greater differentiation meaning that the probably the more useful measure that really is.

Ron Hays: Well, yes, I mean, you don't – I don't think 100 percent is what you're shooting for though, everybody is different. So, it's somewhere in between, we don't know the exact number, but we just know there should be some variation. Part of that is what's true in the world, you know, that you're – that's unknown. I mean, there could be two sites that are identical and they should score the same.

Female: Ron, can I have one comment, just to echo what you're saying. Is in certain systems, there are some homogeneity across sites so you'll see less differentiation, you know, sites are very similar than they are likely to perform similar in some of these composites.

(Julianne Cambean): This is (Julianne Cambean) from (Wesset). And I helped with this table. Just to help with the MAP, it's the 109 plus the 51 divided by the total number of practices, equals that 34 percent. So we're just trying to show you how many were below and how many are above. And then the percentage, how many were outside the range total. Does that help?

Peter Thomas: Oh, OK.

(Julianne Cambean): And going back to the distribution, there was a big Excel sheet that had lots of …

Karen Pace: Oh, OK. We do have that.

(Julianne Cambean): OK.

Karen Pace: Thank you.

Female: So, I think …

(Inaudible)

Peter Thomas: That Excel spreadsheet has a whole host of numbers on it. And a yellow bar that says, "Provider" in the middle of it, is that right?

Karen Pace: Let's – oh, we can open it up here.

(Inaudible)

Peter Thomas: I just …

Female: That's the – I'm sorry, that's the child (marring) that has the yellow bar in the middle and then if you look at the adult one …

Ron Hays: Adult is above, child is below.

Female: Are you talking about the CG-CAHPS means supplementary table which is an Excel file and has multiple worksheets?

Female: Yes.

Peter Thomas: I'm just trying to understand.

Female: I know. And I'm so sorry to ask, I just want to follow along with you in case of a question I can be helpful with.

Peter Thomas: So I really …

Female: I think you're looking at table 1b.2 which has adult and it's got green and yellow and yellow at the bottom line like (row 18) that says item 23 rate provider, does that sound like something you're looking at?

Female: It's staff output. It's …

Peter Thomas: OK.

Female: … marked at the top (disasters) and it's staff output, it looks like it's an Excel spreadsheet but it's a staff output.

Peter Thomas: OK, thank you.

Well, intuitively, I'm not surprised personally. If I may bring my patient perspective to this, that there is a greater percentage of statistically different from CAHPS database average for communications composite than for access composite.

And frankly for – I guess it's pretty close on the next one. But I mean, if you don't have good communication with your provider, I can see where a lot of these measures would be – or if you do have (difficult) communication with your provider, I can see where that would be a really telling factor in terms of whether or not a patient is really getting care they need, and following treatment regimen and the like. So, that's not an insightful scientific comment. That's just kind of a overarching patient perspective comment, I guess.

But is it accurate is what I just said, the half bakers that makes sense to the measure developers.

Ron Hays: Yes, it makes sense to me.

Peter Thomas: OK.

Female: No (quibbler) from Julie Brown.

Karen Pace: OK. So, shall we – any other comments about performance gap so the distribution was in this (barrel), so you can see the average and there's different percentile range. And Sherrie, I'm sure this is what you were referring to.

Sherrie Kaplan: Yes, it is. The one other issue I had was disparities, 92 percent of the sample is white and it was all done, it looks like in mostly Massachusetts and Maine. So, just to kind of – we really don't know what the disparities are but with respect to skew, if we know anything about how these things usually work in underserved populations, you get more variability not less.

So, if anything, the disparities hypothesis worked against them because they don't really have any kind of minorities in this sample, hardly at all.

Female: Yes.

Lisa Marie: This is Lisa Marie and that was my main point as well, although I wasn't exactly sure how to do horn that in to questions that were being asked. It – I believe it's Maine and Washington State and – were the main places, and Virginia.

And I'm wondering why, say, Treton, New Jersey or what area in Los Angeles weren't selected and wondering if the practices included a range between private practices and, say, federal health centers practices where you might pick up more disparities.

Julie Brown: This is Julie Brown and I think that one of the things we may not have made clear is that we are measurement developers and we put the measurement tools out for a range of users to use with instructions and guidance.

There is a CAHPS data warehouse and so these data that you see are from submissions, voluntary submissions. to the data warehouse. And so, in this instance and (Julianne), feel free to correct me if I'm wrong, we worked, you know, we were able to provide this submission using the data that was submitted to the warehouse.

And so, unfortunately, we're not in the business of data collection. We aren't in the visit of data measurement. Now, we had data in our original submission from the field test that we sponsored and conducted that reflected greater ethnic diversity and included Los Angeles, included, you know, different kinds of populations from what you're seeing here. But this is the data that we had to work with for this submission.

Karen Pace: And this is Karen, let me just clarify in terms of the committee and meeting the NQF criteria, the question is, is there a performance gap and it can either be across the entities being measured, in this case, clinician groups or clinicians, or it could be related to disparities and care. And I think what you're saying is we really don't have information on disparities, but that

doesn't mean that the measure couldn't go forward if there is a performance gap. It can be in either of those areas, though, I think it's certainly always an important question about disparities and it appears that they just don't have the data to be able to – for us to know one way or the other at this point.

Lee Partridge: But – this is Lee. It –but I think going back to comments a few minutes ago, if you're getting data from Washington State, participation in the warehouse is voluntary.

So if you're getting data that is – doesn't reflect the broad range of diversity and population and so on, and you're still seeing variation, you can – and we assume that there would be more variation if you pulled in centers, places other than Washington State and Massachusetts, this is probably OK.

Karen Pace: Right.

Ron Hays: Yes. And this is Ron Hays, following up on what Julie said, we don't have the data but we do know of data that's been collected, for example, at UCLA by Sam Skootsky. And we know there is disparities by race ethnicity and that's been consistently found in a lot of CAHPS applications. It's just we're not the warehouse for that data.

Female: Does this suggest some more or less systematic way in which those who choose to use this and report it will be more likely to have favorable outcomes and those who might be serving a population where the scores might be lower? I mean, it's not the question that were asked, but does suggest some issue for me that who chooses to do this and who chooses to report it.

Ron Hays: Oh, the warehouse is at the database, yes, it's not representative of the users. So we get what we can and that's definitely, you know, a limitation. But in general, I thought you were also referring to potentially case-mix adjustment, which we constantly revisit and, you know, when we see differences by race ethnicity, there's various sites best for that or not.

And in some cases, it gets adjusted for like in the specific business group on health, their applications, the CAHPS release, other people like NCQA don't adjust for – they don't even adjust for other thing.

So, we are always looking at those issues in trying to provide the most balanced adjustment …

Female: Thank you. Thank you.

Female: Karen, can you go back over the boundaries on what we're supposed to consider for the applications and ultimate uses of these measures?

Karen Pace: Well, the general consideration is that we've measured that are endorsed by NQF are supposed to be used in accountability applications, the two most common are public reporting and paper performance.

So, you know, ultimately they need to be reliable and valid for those purposes.

Female: But at what stage of development are – because in early phases when you wouldn't know, for example, whether they were – you hadn't texted them for the kinds of – those kinds of applications for public reporting and therefore use. It was my understanding that NQF sort of drew the line at, well, you know, how the people use these things, it's not under our purview. That it's considered by the MAP's group et cetera, but it …

Karen Pace: Yes, yes, that's exactly right in terms of recommending them for a specific program. So, in terms of endorsement, it's in general so we don't say that they have to have been tested in the paper performance program or tested in the public reporting program. The testing could have occurred in, you know, an example or through larger implementation. But you're right, it's the MAP, the Measures Application Partnership that would recommend specific measures for a specific program uses.

Lauralei Dorian: Well, this Lauralei. I'm just looking at the time and I want to make sure you can give fair of time to the next few measures as well.

So rather than going through each of the survey questions individually for this measure, in this point on, we just like to open it up to you to see if you have any questions or comments about the other criteria, for example, reliability and validity testing results.

Lee Partridge: This is Lee. Could we talk a little bit about the risk adjustment issue? I believe the submissions – my notes say that submission says risk adjustment is not required, it is the option of the user. And they recommend certain kinds of adjustment might be considered.

Could we talk a little about that issue and why they don't recommend risk adjustment and or if they – I'm sorry, what – does the measure specified include risk adjustment – adjusters? And if not, could you talk a little bit about what the recommendations are and why?

Ron Hays: I'll just say a little bit, this is Ron Hays, that we cannot really require anything in CAHPS for – because there are so many different users. We can say that this is a good recommendation. You know, and this is something you can consider. But as I've said a minute ago, different users will decide they don't want to do it. So, you know, we have standard case-mix adjusters and there are some additional ones depending on the context it could add it in, you know, there might be some unique variables in hospital that there isn't in, you know, group level adjustment.

But, we have done analysis and then we say, based on our analysis, "This is what we recommend you consider doing." But we can never say that you absolutely have to do it.

Lee Partridge: So then (caring) for us is the committee? Are we recommending the measure without risk adjustment?

Karen Pace: I think that's a good question, because it …

Julie Brown: Can we make one more comment about risk adjustment?

Karen Pace: Yes.

Julie Brown: And I want to make sure that we're very clear, this is Julie Brown, sorry, between risk adjustment and case-mix adjustment.

Karen Pace: Right, right, right.

Julie Brown: We recommend – as Ron said, we can't require, we can only recommend and most users with the exception of NCQA in many respects, adjust for the characteristics of the population, then are the function of the health provider. So that is things that aren't under the provider's control, the person's education, the – whether or not they completed the survey in an Asian language.

One of the reasons we don't recommend risk adjustment is that in some instances, that's a function of the provider setting. Imagine you're administering this survey in a pool of patients who are there for a diabetes clinic, or just a pool of patients who are there for a heart failure clinic, risk adjustment would be controlling for a characteristic that's a function of the care delivery or a function of the provider setting.

And I hope I'm saying this in a way that's clear to folks. And Ron, feel free to add what I'm saying. And that is why we've never recommended risk adjustment. It could adjust for some factors that are a function of the care delivery and a function of the provider setting.

Karen Pace: So, this is Karen. So basically, a lot of people use these terms interchangeably, risk adjustment and case-mix adjustment, what factors are used depends on the particular measure. And, you know, the empirical evidence of what affects it. So, I don't think that generally, as far as NQF, that adjustment always – risk adjustment always – it's often used for clinical adjustment. But I think Lee's question was specifically about case-mix adjustment related to these measures.

And I think the question is, what are you asking NQF to endorse, the measure with adjustment or the measure without adjustment – case-mix adjustment.

Ron Hays: Well, (inaudible) my opinion. I don't think that it has to be linked, we're not saying – we're saying, we want the measure endorsed and we have a lot of recommendations on how the data is gathered and what's done with the data when it comes in. But, they don't have to be linked, you know, that you don't have to endorse every part of what's potentially recommended.

So, that's – we allow flexibility in CAHPS as Julie was saying and I was saying depending on the specific circumstance and the opinions of the users,

whether they want to do it or not. We provide guidance and that's all we can do.

Peter Thomas: Again, can you (turn) this down for me for a minute. We're talking about risk adjustment, I understand that concept completely. I don't really understand why it really matters with respect to these measures. Why would it matter if a patient is, you know, has multiple comorbodities and a very challenging case as to whether they can get an appointment for urgent care as soon as needed versus a person who comes in with a flu. I mean, what – am I off based or what?

Female: Yes …

Ron Hays: I'll take the example of the health status because that's where we generally recommend adjusting for self-reported health, not these comorbodities because we feel like, generally, we capture it with what we've got in self-reported health.

And we've – if you find that people who are healthier are more positive in their assessments, and that's not due to the care they receive as Julie was alluding to. What we're trying to adjust for are things that our reporting biases or differences rather than what happened in actual care.

So, if we do a lot of analyses of data and we see there's a systematic difference that appears not to be related to care, are just something about the patient, that's what we're trying to take out of the equation.

Peter Thomas: I see. OK. OK.

Female: Peter, for example, this comes up in some other measures, older people apparently tend to like their – rate their doctors a little more highly than …

Peter Thomas: Yes, I know – yes, yes.

Female: Yes. And that's – as I understand it, that's what you just observed statistically across all of these measures, am I right, Ron?

Ron Hays: Yes.

Female: Yes. We …

Ron Hays: So, you have more older patient all of the things being equally, you're going to look like you're doing better when it's just, you know, something different about the characteristics of the patients you have.

Peter Thomas: And so perhaps, socioeconomic status might factor into that as well, the person who's not used to getting access to healthcare and gets access, and couldn't care less if they wait a little while. They have access to care. And that's kind of give them a high score versus someone who's typically used to getting access to care when they need it and they've got to wait seven days and that's a major problem, that kind of thing?

Ron Hays: Yes, that's the idea, yes.

Peter Thomas: OK, OK. Thanks for that.

Female: This maybe a strange question, but is there a difference in that particular question about someone, you have to wait for an appointment, did you see a difference between specialty care versus general care because you always have to wait to get an appointment. I mean, if somebody who – my daughter collects people who's credential (inaudible), like some people collect doll, you know.

And we just know, I mean, in some cases, appointments for clinics are six, nine, 12 months out. That's not very timely, but that's the way it is. So they would slump every time. Is that something that is adjusted for or?

Ron Hays: Well, we're not really asking about appointment waits, I mean, we have asked that, but that's not a CAHPS' question. I mean, that's been asked in some studies. But we're asking about things like, "Did you get appointment for care you needed right away", so that would be urgent care as soon as you needed it, that kind of thing.

And so it's kind of various depending on whether you're talking about urgent care or a regular care. But we have, you know, different items to (stuff) those.

Female: Ron, you – that's one of the things where you wouldn't want to adjust the way the thing you're trying to explain, right? You're not at the practice site level planning on adjusting for specialty.

Ron Hays: Right. And …

Female: Correct.

Ron Hays: … again, going back to, you know, if it's indigenous, if it's something related to the care that's delivered, we don't want to adjust that out. You know, like some sites might have, you know, more specialists available. We don't want to adjust for that.

Female: Well, I just – I know that locally, you, often, that if it's urgent can't get in to see a provider and so you go to the emergency room.

Julie Brown: I think that's a different issue.

Female: OK.

Julie Brown: And while it does capture access, you know, and these analyses are at the site of care, remember, they were the systems that voluntarily provided data.

Karen Pace: OK.

Peter Thomas: Now this …

Karen Pace: Go ahead.

Peter Thomas: This Peter Thomas. You asked if we had additional questions and …

Karen Pace: Yes.

Peter Thomas: … I would be really happy if someone could talk with me, talk to us, I guess, in just, you know, layman's terms and interpret Cronbach's alpha reliability coefficient on page 42 …

Karen Pace: OK, let's bring that …

Peter Thomas: … and the graph on …

Karen Pace: Right. Let's bring up the measure testing attachment and we'll just ask because we do need to move on to the other measures, but why don't we just ask the developers to briefly describe the testing at the scale or …

Sherrie Kaplan: And this is Sherrie. And Ron, you also give us some information about why or whether you plan to do intraclass correlation coefficient to test for between site differences versus within site variability, because at the site level, that's something that we would be concerned about.

Ron Hays: Yes. Well, very quickly, that's – actually what you just said is our main focus. And we look at reliability and we have that data here. We're interested in the site level where the unit that's being compared reliability which is, like you just said, between versus within site variance.

So, we really want measures that are going to have variance between sites and not a lot of variance within sites. So, the latter thing, not much variance within sites, I mean, if the patients are telling you sort of the same thing about care, they're not all kind of randomly telling you something that has not – doesn't agree.

So, that's our main focus. And we estimate the sample size you need to get adequate enough reliability at the site level. That's the primary focus.

We also report Cronbach's alpha internal consistency reliability, but that's actually secondary to us, because that's really more useful if you want to see how correlated items are that are measuring the same thing which is important, but it's just not as important in CAHPS or as it is if you're assessing individuals and their characteristics like a personality measure or a health measure.

That's when you really focus more on internal consistency reliability and how the items are correlated whereas, our main application is always at comparing different sites or different doctors or different hospitals. So we do report both of those things.

Karen Pace: So this is Karen. And just in terms of what we asked them to provide which is what they did, if this reliability at the scale or level and then at the performance measure levels, the Cronbach's alpha is reported and this looks like the access composite, the Cronbach's alpha's 0.80.

And Ron, do you mind to just explain in general what the 0.80, you know, means at these items that go into that composite, or basically addressing the same basic concept or …

Ron Hays: Yes, not literally. I mean, there's a debate about that, of course, but …

Karen Pace: Yes.

Ron Hays: … saying that the items are correlated at, you know, enough – and you have enough items to get reliable enough data so there's a threshold of 0.70 or higher for group level comparisons.

So, we kind of use that standard as pretty typical standard. You know, reliability could be between zero and one, where one is perfect. It's never going to be perfect. If it's zero, you know, you have a horrible measure. So, it's just saying that the items are reasonably correlated, but then we always want to take it to the next step and go beyond …

Karen Pace: Right.

Ron Hays: … Cronbach's alpha and look at site level reliability.

Karen Pace: So, we'll look at that in the next table. Keep going, past the child, is the practice site level. There we go.

Oh, OK. So, then this is what you're reporting in the practice site level as the site level reliability, the ability to distinguish one site from another, correct?

Ron Hays: Yes.

Female: So Ron, are these ICCs?

Ron Hays: No. Those – somewhere, we translate this into the sample size needed on average per site which are based on the ICCs. You can get the – I don't know if the ICCs are in here or not. What we're looking at right now is the reliabilities so that's, you know, across all of the people in a site, what's a reliability, the ICCs are going to be tiny because it's, you know, for – on average one person per site which would never have. But we use that as the basis of estimating using Spearman-Brown formula, what number of people you need per site to get reliable enough data.

Female: Right. I get that. It would be helpful, I think, for us to get the intraclass correlation coefficients because – at least within site, you'd have some sense of comparing a 117 or however many …

Ron Hays: Yes. But, I mean, you can get that yourself. You'll find it's really tiny. I mean, that it would be – you could take that reliability and say "OK, what's the average number of people per site." Now, I can Spearman-Brown it down to what the …

Female: Yes, I got that, but the idea that we're able – we're not very good at discriminating between sites if the clustering is that low.

Ron Hays: No, that's just the way it is. I mean, it – you wouldn't expect that there'd be any higher. It isn't like you have another measure and it's going to go up very much. If it's horrible, the ICC will be zero.

Female: Yes, I know …

Ron Hays: I mean, the real thing you should focus on is how many people does it take to get whatever target you're interested in, 0.70, 0.80 or whatever. And we generally provide both of those, 0.7 and 0.8. And if the, you know, if the sample is a million people per site, you'd say that's crazy but it's …

Female: No, no, no, yes, because they don't give you any actual. What I'm asking, I guess, we can take this offline is how many – what the level of discrimination between sites, because if there is a lot of variation within sites, you'd be concerned that these aren't really good for discriminating between sites.

Karen Pace: So …

Ron Hays: Well, that's what I'm saying. The bottom line is how many people to get a target level over reliability. That's summarizing everything you just said.

If you – you have to have between site variance and you have to have a limited within site variance in order to do that. So the bottom line is how many people does it take to get a reliable data.

Female: Yes, yes. We can talk about this offline because I don't think we're quite on the same page.

Karen Pace: OK.

Why don't we – we'll move onto the next measure so that we can, you know, at least identify any questions that we need to explore and more – which one are we doing …

Lauralei Dorian: Which is 0258, the CAHPS In-Center Hemodialysis Survey (sorted) by CMS. And that compare services and quality of life of dialysis facilities provide from the perspective of ESRD patients receiving in-center hemodialysis care.

I think let's open it up for comments in general, maybe first, starting with the three evidence criteria for the – sorry, we'll do evidence to support the measure focus so that's, what is the relationship between the measured PRO and at least one healthcare outcome performance gap. And also high priority, which was how was it determined with the target population values the PRO and find it meaningful.

Karen Pace: So, any observations or questions from the committee members about any of those aspects, the – that Lauralei just mentioned.

Peter Thomas: This is Peter Thomas. Before I say anything about this measure, I just want to make sure I disclose that my firm represents Fresenius Medical Care North America, which is the largest kidney dialysis company in the country and in the world.

So to what extent should I refuse myself or can I just participate as anyone else?

Karen Pace: It's simply a problem with refusing because you want to involve in developing the CAHPS measure, correct?

Peter Thomas: No, not at all.

Karen Pace: OK. No, that's fine. Thank you for …

Peter Thomas: OK.

Karen Pace: … asking that. Thank you.

Peter Thomas: Can I continue and just say that there's a few statements upfront that I didn't see a whole lot of support for and just wanted to know, I guess, from whoever that the measure developer where some of those statements came from. It seemed a little skewed and a little anti-provider – I'm not representing them now. I'm just saying that this, you know, objectively sounded like that.

Let me give you a couple of examples. This is under – maybe I'm jumping ahead here, but under performance gap, I hear – let me see, that there is many patients are reluctant to provide feedback for fear of retribution. And they perceive that these bodies, meaning, in certain networks and state agencies are not responsive to patient concerns.

And if those are, you know, justifications for developing these measures, I think these measures are great. I've got no problem with the measures at all. But it struck me that those reasons, A, weren't particularly well supported but, B, didn't strike me as the real reasons behind doing this. I mean, this is a very compromised, very expensive Medicare population that – and these measures are really important. But I don't think it's particularly well not justified. It was not particularly strong in the evidence as to where they came up with those expressions.

So I'm just wondering what we do with that at anyway.

Liz Goldstein: Can I – Karen, can I go (inaudible).

Karen Pace: Yes.

Liz Goldstein: Yes. In terms of fear of retribution stuff, I think that's related to the protocol in terms of implementation or how you would implement the survey. And CMS with AHRQ has been involved in lots of development work for patient experience of care survey.

This is a population when the survey was field tested, where we got a lot of concern about retribution. So in any of this having for (redone) passing of surveys, I think we've seen it the most for this population. And this population, they're in that dialysis facility, you know, few times a week and they're concerned, they want to make sure the protocols for survey implementation really are separate, segregated from that facility. So they feel free to voice their concerns.

We heard that, you know, even more recently when we did some testing because we're moving to implement the survey nationally this year among facilities or with reporting of data to CMS, and we did some testing of prenotification and other letters not to (seeing) that continued when we did testing with patients.

So it's not rationale for the measure, but it's a rationale for how we're – how we would recommend the survey be implemented in the protocols and (staff) vacations around implementation.

Lee Partridge: So, Liz, this is Lee. Would you then think that there is a preferred protocol to be followed for administering?

Liz Goldstein: It clearly – it has to be independent of the facility …

Lee Partridge: Right, you can't use it in the survey …

Liz Goldstein: … in terms of the protocol as much as possible, so that the patient feels free to respond, you know, for good or for bad, their responses. So they don't feel that the staff of the facility have access to that information.

(Carol Lavigne): This is (Carol). That raise the question for me, first of all, seemed – this is a largely, heavily minority, low income population which is for good reason, distressful in general so it didn't seem to me that that was, you know, speaking on the nephrology world, but just recognizing that this is an area where people are – they're really dependent on this kind of care for their lives. And would, you know, would need to be feel very comfortable.

But I didn't see anything in the material that said patients will take – they're reassured that this information will be kept confidential that it won't affect their care, which seems to me that's the standard way of describing a survey and I don't know if it's just that we didn't see it or is it not there.

Lee Partridge: (Carol), this is Lee. I think …

Liz Goldstein: So, in terms of reassurance for the patient, there will be a prenotification letter that goes from CMS or privacy officer. In that letter, we've done extensive testing with patients, you know, prior to them receiving either the first mailing or telephone (tap).

So, we're trying to do as much as we can to reassure to the patients that, you know, the facility is not involved for this survey for some of our surveys facilities, hand over discharge list or list of patients, as you say, to a survey vendor to administer the survey for them.

In this case, CMS is pulling the sample and we'll be providing them directly to the survey vendor so the facility, all they need to do is contact within the pre-vendor to do the survey on their behalf.

Sherrie Kaplan: This is Sherrie Kaplan again. The – for people on the call, these are quality improvement activities, correct? And therefore, are protected from discovery?

Female: I don't know that.

Liz Goldstein: (inaudible) what you mean for saying their quality improvement, the state doesn't go to like a quality improvement organization, is that what you're …

Sherrie Kaplan: No, it's not research in the sense that the same kinds of patient protections need to be of quality improvement activities, anything that falls under the rubric of quality improvement activities is protected from discovery unlike research which has that patient consent.

Female: I don't know if that that applies here, but I'm not sure.

Liz Goldstein: (Further clarification) is how we – these services are voluntary so the information is protected and not shared even when the data comes to CMS, it's not going to have patient name and identifier summit.

Sherrie Kaplan: Right, and then sort of legally protected. It's protected from, for example a clever lawyer couldn't solicit this information. So it's all confidential and it's protected under the quality, the things that are done in order to improve quality of care different from research.

So, I think the kinds of concerns about patient consent are – and confidentiality and stuff are all fall under that general rubric.

Female: Yes. But the point is that the patient has to be reassured. It's not the legal part of it. It's that people are worried about what's going to happen to – if they say something.

And so, I think that, you know, you can't say it enough times to someone, this is not going – not so much is not going to go back to the facility. It's not going to affect what happens to you, this is (inaudible) private information. I'm not sure that that distinction between quality improvement activities and research is always the right thing to make the – hang their head on, but …

Female: Right.

Female: … I'm looking at it from the person's point of view.

Female: All right.

Female: And I would want to know this.

Liz Goldstein: Right. And that's why we went out and did testing of prenotification and cover letters with patients just …

Female: Right.

Female: … to be assure how many languages they understand not just (inaudible).

Female: Right.

Karen Pace: Are there other questions about the – this – the performance measures included based on this survey in terms of the testing, the performance gap or any of the key issues we've talked about?

Female: I don't know where it fits, but I had a question about the inclusion criteria of requiring three months of continuous care or however it was raised. I think like awful very long time. Somebody in dialysis is they are all the time and charge 12 hours a week at least. Why is – why do you have to be – three months seems, you know, too – almost too long that two months would certainly work or six weeks even. It just seem to me that it was make – setting the bar very high.

Liz Goldstein: So, the three months is what originally was tested when AHRQ developed the measure a number of years ago. But there was interest at that point and when we're talking to patients to one for them to have a sufficient amount of time to get acclimated if this was the first time they were receiving dialysis. So, I think they didn't want at that point when they were designing the inclusion criteria giving them an opportunity to settle down because it's a major, you know, life changing experience.

Female: It seems I – yes, but, yes but. I just think it seems – still seems it's an intensive introduction through, but you do – it doesn't take three months to me. But, again, I don't know what the basis was here.

Female: OK.

Ron Hays: This is Ron Hays. The other thing is we did have a (tap) for this. And so they were one of the ones who recommended it. But I see your point, it's just that I

don't think you lose too many people with this requirement in any way because once they're on dialysis, they're on dialysis for a long time generally.

So, I don't see in that facility …

Female: Well, the only people you might lose are the people who had a really, really bad experience and will go anywhere else, so you don't lose them …

Ron Hays: Yes, but you'd probably lose them anyway. I mean …

Female: Yes. Well, maybe.

Ron Hays: … it's just not much time, you know, you said six weeks or two months, it's not that much different so …

Female: No, I suppose not. But it just struck me is, you know, we allow in other settings one visit, one this, one that, all of a sudden, it's three months of 12 hours a week which does strikes me as a little much, but I understand.

Barbara Crowley: Another – hi, this is Barbara Crowley at CMS. Another point is within that first month, their modality could change that they could come in, start on hemodialysis, then qualify for a transplant, or decide they want to do peritoneal. So we will have patients who switch their treatment modality.

Female: Well, I think – I just think it needs to be explained why that three months criteria was used, because here, it's just OK. Well, this is what we decided. And I don't think it's clear enough in the explanation as to what the reasons were. The reasons maybe perfectly fine, it's just, you know, just takes this on trust.

Karen Pace: OK. Other questions or observations and maybe we could ask the developer to briefly explain the testing that they provided?

Sherrie Kaplan: This is Sherrie. Can the developers focus or give us some back-up materials, the actual factor loadings from table one and their summary on page 47?

Karen Pace: So, let's go …

Female: Yes, our page numbers are different than yours …

Female: Yes.

Female: I printed using our print function, so.

Female: Is it table two?

Sherrie Kaplan: OK, no, it's – sorry, it's the psychometric properties of the number of measures in each item and I would – or numbers of measures …

Female: I see it.

Sherrie Kaplan: … the factor structure concerned and I would like the factor loadings.

Female: Because it's a – let's …

Female: (inaudible).

Karen Pace: I will also – you hear in the second, it's in item 2A.2 in the measure testing attachment.

Female: 2A.2.

Karen Pace: 2A2.3, and it move down to table one, pyschometric evaluation of alternative – was that one you're talking about Sherrie, of alternative measure structures?

Sherrie Kaplan: Yes.

Karen Pace: OK. The table one.

Female: Got it.

Karen Pace: OK.

Female: No, no, I mean, they can just forward them to us.

Female: Yes. We can forward them to you. It's hard to find – it prints out so just like I feedback for NQF, when you try to print the forms that was submitted, it prints really weirdly.

Female: Yes, that's why …

Female: … anything.

Karen Pace: But we can talk with you about this. There are other print options that you could use that …

Female: It has to be a better one.

Karen Pace: Yes.

Female: We keep trying to find stuff and then we're missing pages.

Karen Pace: Right, so …

Female: (inaudible) that.

Karen Pace: Anytime you have a question just contact me or Lauralei, but we can help you with that.

Female: OK. So we can provide the factor loading, so it's not in there. I'd probably …

Karen Pace: So, would you briefly just describe the reliability and validity testing? Did you provide it at both levels or primarily just at the facility level, the reliability and validity?

Female: It was at the facility …

Female: It was at the facility level for the performance measure level for most of the staff, although we did provide information about how the individual measures (inaudible) measures the individual survey item, you know, come together in …

Female: Right.

Female: … each of the multi-item measures.

Karen Pace: So you did provide the internal – did you do it with that internal consistency reliability then to the scale …

Female: There's a whole bunch of tables (inaudible) of that that we provided. I can't tell you which page because it's been …

Karen Pace: No, don't tell me the page. Just tell me what item number or …

Female: We can provide that information in the package.

Karen Pace: OK. So if we bring that table two, for example, can you just explain what we're seeing here?

Female: In table one, it's entitled Psychometric Evaluation of Alternative Measures. This was done 10 years ago. And Ron Hays and Julie Brown were part of the team then, the part of the CAHPS Consortium. And we were developing what measures would fall together to develop the overall measures so …

Female: OK.

Female: … I don't want to use the word composite with the measures.

Female: Right.

Female: So we look at different loadings of measures and sometimes we had nine items, sometimes we had six, five, four or three.

And in table one, you can see. And between table one and table two, you can see the number of items that would fall under a particular measure whether it was about the kidney doctor or the nephrologist, or about the facility in each operations, or about patient empowerment and education.

So, in table one, there is a line that talks about internal consistency of the measure and you can see it ranges from 44 percent to 100 percent with the three measure structure being at the 100 percent level.

Female: I – this is really confusing to me, Ron Hays.

Ron Hays: One thing I should say, this is Ron Hays, is that I don't know if it says in here because I don't have the documentation in front of me. But there is a paper in press in the American Journal of Kidney Disease that kind of gets to the bottom line. I mean, this has a lot of detail which is useful, but there's a table on this article that has the reliability internal consistency for the three composites and the one is 0.7, one is 0.89 and one is 0.93.

Female: Right.

Ron Hays: We also got the same center level reliability estimates and it's so …

Female: OK.

Ron Hays: I'm sure it's in here somewhere. This was kind of …

Female: And that show the table two if you look in the last column, the alpha equals 0.89 with kidney doctor.

Ron Hays: Oh, there you go. That's it.

Female: For dialysis facility care and operations, the alpha is 0.93. And for patient empowerment is 0.75.

Karen Pace: OK. So that's the internal consistency for the scale. And then in the first column, that ICHR, the facility level reliability that you were talking about or is that …

Female: The ICHR, it's the overall internal consistency with the – all of those measures. I guess, I would say, the average is the R for those measures, all of those measures that fall into that single measure, all the items that fall into that single measure.

Karen Pace: OK.

Female: (inaudible) just to –I don't want to fall us down, but that is confusing again because, you know, if that's true and you got a bazillion items underneath

dialysis caring ops, you should have a huge – I forgot the smaller, so that can't be what that is.

Karen Pace: Well, yes, if you look at …

Female: If you look some of the individual, the ones that are small, is 0.14, which that'd be a less open decimal point.

And some – or as high as 0.80 – 0.86. So yes, it – and some of these items have been dropped because their, you know, consistency was low. The reliability was low.

Female: It would really help, I think, if this got updated with what you're proposing because I'm confused now about what we're endorsing.

Female: Well, we just …

Ron Hays: I think this is it here. This table two, so those alphas are corresponding to the three composites, and then I think that first column, the ICHR thing is the reliability for those at the in-center hemodialysis site level.

Karen Pace: That's what I thought. OK.

Ron Hays: Yes. So that's what those column entries are.

Karen Pace: And – OK. And your method for doing the in-center hemodialysis reliability is the intraunit reliability, is that correct?

Ron Hays: Same thing that Sherrie was talking about earlier and now, we're talking about hemodialysis site. So it's between site versus within site variance.

Female: Right. OK.

All right. Any other questions about the dialysis facility measures before moving on?

(Dawn Delving): This is (Dawn). I just have one query about …

Karen Pace: OK.

(Dawn Delving): … the date that the original survey was (considered), because it seems it's been developed 10 years ago. And all the piloting was done 10 years ago and I …

Female: Yes.

(Dawn Delving): … if that's done any update to piloting to make sure it's still appropriate.

Liz Goldstein: So for CMS, a couple of years ago, are requiring facilities to collect those information on their own. There were a number of facilities using it voluntarily prior to that. But today, CMS does not have the data that begins this fall. So in January 2015 will be the first time where we get all the data to CMS.

So we will look at these types of things actually for all of our service on an ongoing basis, so this is something when we start getting the data submitted to CMS will be things that we look at to see, you know, are the same numbers thicken or not, are there any changes that would be needed.

Ron Hays: And there is another paper that's in press Amgen analyzed the survey in a whole different application. So, at least there's another example where someone evaluated the psychometric properties.

Sherrie Kaplan: So this is Sherrie again. I'm sorry, I cut myself off. Can you give the answer to the – what we're endorsing question, because I'm confused if this facility level reliability don't look so good. Are we – are you – have you edited this down and now, it's a very much more abbreviated version? Or is that the more recent manuscripts are going to address? What are we being asked to endorse?

Liz Goldstein: The three measure structure with the multi-items plus the, you know, global ratings.

So right at the very beginning, the measure description list three measures and the three – four rule rating.

Lee Partridge: Sherrie, this is Lee. I think, you know, measure number two has 17 questions.

Female: (inaudible) 22.

Lauralei Dorian: OK. Well, it's the last 20 or so minute, why don't we turn to measure 0517. And just to remind you that we will get to review all of these again during our in-person meeting.

So, in 0517 is the CAHPS Home Health Care Survey experience with care from CMS. And that's a standardized survey instrument, data collection, methodology for measuring home health patient's perspectives on their home health care, Medicaid certified home healthcare agencies.

And so I think, again, we'll begin by opening it up for any comments about evidence or performance gap, or high priority in terms of how it was determined that the target population values the PRO.

(Carol Lavigne): This is (Carol). I guess I have another question about the criteria on this one of – (inaudible) two questions. One is the sort of generic use of home care staff, or agency people, or whatever the word is, as opposed to distinguishing from between nurse and aid which most people do make distinctions about.

I understand that, you know, people that you can't include every person that might be coming through, but somehow it felt very unreal to me as what people are responding about some sort of generic agency rather than the nurse, the aid, where that's really critical.

The other question has to do with the time, occurred one or two home care visits within the past two months. What kind of home care is this? This is not through generic home care that I found that very, very odd. So if you can explain that to me, I would be very appreciative.

Lisa Marie: This is Lisa. I can kind of speak to that as a frequent home care user. We've had home care here at our house almost everyday for 10 years when my daughter had a tracheotomy.

Doctor point to that consistent having a nurse try not to sleep in my house every night. We have had visits and generally it's two maybe three visit post-

Operator, so that my daughter can come home, but have her progress monitored by nursing visit.

They're not spending eight hours in the chair anymore, but are helping with issues related to (proceeding) than multiple medications and that kind of thing.

So sometimes, there's home care that is regular. Some people have a few visits a week or a number of weeks. Some people have just a few visit post-op or it maybe even one. And then there's the extreme of having eight hours a night for 10 years. So, we are definitely home care aficionados at our house.

Female: Yes, yes. But the typical – I mean, that's an extreme example on. I can …

Liz Goldstein: So this is – yes, Liz Goldstein from CMS. And I think we can address a couple of – they're good questions. So …

Female: OK.

Liz Goldstein: … when the survey was developed, we did a lot of testing with Medicare patients and their family members. And we thought too before we did the testing that they maybe could distinguish between a nurse and a home health aid, and all of that. As we did more testing, cognitive interviews, and focus groups and all of that, that was an area of major confusion.

You know, not among everyone, but a good number of our Medicare beneficiaries, they wouldn't know there was a skilled person versus the unskilled. So, that is why we do not distinguish between the two of them in the survey. There are a lot of issues with that.

You know, most patients got more care than, you know, two visits, so for a two-month period, but there are situations – and we want to past through these situations. There are situations where someone needs an IV, you know, regular intervals or, you know, we have some people receiving home health care in the Medicare population that receives it for years, but they receive maybe once a month or something per skilled visit, usually relate to an IV or something like that.

Female: OK.

(Inaudible)

Female: Apart from what people, it suggest to me that home care people should do a better job of introducing themselves and making it clear who they are when they come to visit because if people don't understand what a nurse is and what an aid is, that's a problem for the home care agencies.

Lisa Marie: This is Lisa. And while I would agree that introductions are extremely important and valuable, I would back up because I work with, literally, hundreds of families here in Utah. Many of them received home care for the exact reasons that were described. I have a family right now who has a child who is receiving regular IV infusion and has home care coming.

Obviously, that is a skilled nursing level job. And I'm going to assume they have skilled nurses. But most of these families really don't understand – they don't understand when they go into clinic that the person who sees them is a medical assistant and not a nurse. They don't understand that the person who comes to their home maybe a CNA level, a certified nurse assistant level, instead of RN or many of the nurses that we had caring for my daughter were LPN.

They couldn't do certain things so that they could freshen the strike in that fall, I really cared about. So …

Female: Yes.

Karen Pace: So, one clarification that – Liz, this is Karen, that you might make. Is this survey specifically for Medicare reimbursed home health? Is that our, you know, from the …

Liz Goldstein: Yes, it covers Medicare and Medicaid patient.

Karen Pace: OK. All right.

Female: Which is, most of the patients that I'm dealing with are Medicaid.

Karen Pace: OK.

Female: … patients, Medicare patients.

Karen Pace: All right.

Female: But …

Liz Goldstein: It is – I should add the clarification that's 18 and above. So it's not for the pediatric population.

Female: OK.

Female: You know, we are mostly pediatric, but I think you can find that the parental perceptions would be similar to patient and other care perceptions.

Karen Pace: OK. So, other things that we should take a look at?

Lee Partridge: Karen, this is Lee. You asked the question about whether it's intended to be used only for Medicare and Medicaid patients. Is there any reason why it wouldn't be useful if it were a private pay?

Liz Goldstein: I don't think there's any reason why it would not be useful for private pay. It says we move to implementation of the survey. It's what we have authority in this setting to …

Lee Partridge: Right. But we …

Liz Goldstein: Also – right.

Lee Partridge: We shouldn't feel that it had to be endorsed in some limited – so this only – those categories have the coverage, right, I mean …

Karen Pace: No, you're right, you're right.

Liz Goldstein: Yes.

Lee Partridge: OK.

Female: So that's …

(Inaudible)

Peter Thomas: I'll just ask a question. This is Peter Thomas.

Karen Pace: Sure.

Peter Thomas: You mentioned the service is provided Medicare and Medicaid, but I'm wondering if there's a distinction here. I didn't – no, (inaudible) that. I didn't see any significant discussion of this. I just wanted to clarify.

You know, under Medicaid, there's often people with long-term disability who receive personal assistance services and all kinds of services in their home that aren't necessarily "homecare". Is there a distinction between the two made in this survey or not really, they all lump together?

Female: So there is for inclusion in the survey and the sample is same. Those two visit reference two skill visits. So, this would not include, for example, (inaudible) Medicaid only and all they receive is aid services, they would not be included in the survey.

So they have to have at least two skilled visits during that two month period.

Peter Thomas: OK.

Female: The survey is – as I understand it, we're surveying its performance of the agency.

Female: Correct.

Female: Right? A lot of home health agencies don't provide the …

Peter Thomas: Those things.

Female: … those things. The (charane) is a different program.

Peter Thomas: OK, that's clear.

(Inaudible)

Peter Thomas: What?

Lisa Marie: I'm sorry. This is Lisa again. I wanted to point out that on page 12 of what I pointed out and understand that it maybe different from what you have. It says the proportion of respondent to give the hospital an overall rating of seven or eight.

I think you mean the home health agency there.

Female: That could be a typo. We'll fix that.

Lisa Marie: Yes. And then, I wanted to say that I really like that this particular survey was available in multiple languages. I thought that was really nice, but that was captured.

And I have – I really have this question on all of the surveys that people are asked to rate if they're treated with courtesy and respect. And I'm wondering what respect looks like. What does it mean?

And has there been any testing done on how people perceive – what people perceive that term to look like or mean to them?

Female: So, in terms of the terminologies, they are not similar terminologies that used across all of the top surveys. So there has been …

Lisa Marie: Right.

Female: … extensive testing of courteous and respect.

I don't know if Julie is on the phone so that I can address that.

Julie Brown: Sure. I'm sorry, am I unmuted now?

Lisa Marie: (inaudible) all the testing that I figured.

Julie Brown: Yes. Courtesy and respect, we ask about the two together because it's one of those things where the combined phrase is a little bit more powerful to patients that the individual components.

And courtesy and respect is something that patients are very clear in describing how they perceive it. It has to do with – it has a body language component quite often, often times and help people – caregiver especially in home health care may touch the patient or manipulate the patient when they're providing care.

It has to do with tone, that the words a provider chooses in talking to the patient. It's a pretty critical measure and it something that across the board in all types of care, inpatient and outpatient, all of the different drill downs we've done in CAHPS, that the literature – but the literature in patients identify as an important component of their care experience.

Does that help to address your question?

Lisa Marie: Yes. I appreciate that explanation. That is – I think that's really helpful. I want to say that as I read through this, of the three, I like it the most and maybe because I have so much experience with home health care.

But I like the way the analysis was reported. I had an easier time, I think, understanding it. And I'm really excited about it because the statement was made several times that because this survey maybe administered, the home health agencies are starting to look more at their quality and safety and their responsiveness. And that is really necessary that their ability currently between agencies is pretty significant.

That's my two sense.

Sherrie Kaplan: This is Sherrie again. I apologize, my mute button is right above my off button on my phone. So I disentangling myself somehow and cutting myself off, but I wanted to follow up some of these items like the courtesy and respect item that had been around for over 30 years in various versions of patients, what we used to call patient satisfaction questionnaires.

So, the content of these items is really – is got a lot of historical vetting and testing.

My concern about this particular application of it, though, is the evidence that there is between agency discrimination. Can – is Ron's on the phone?

Ron Hays: Yes.

Sherrie Kaplan: Ron, do we have any evidence of between agency discrimination at the agency level of the data that I got in? I think I am missing a couple of pages in between here.

Look like it discriminates at the state level, there's a lot of variability. But are – did you do or has any testing within state variability across agencies within state?

Ron Hays: Yes, that's kind of have to go back to Liz because I wasn't involved in this analysis.

Liz Goldstein: So this is – so you're interested in seeing within state variability versus …

Sherrie Kaplan: I actually am interested in within – is there a good discrimination between state? Now, obviously there is good – there's a lot of variability across state. So, you'd have to almost do it within state, but is there evidence of variation between agencies?

Female: Yes, between agencies.

Female: So, I'm looking at the measured testing. We've got the measure testing attachment open and there's a table about factor loading. And then there is a table with descriptive statistics and correlations of the measure global items.

But I think Sherrie is asking about kind of the intraunit reliability to discriminate between agencies. Is that in here anywhere?

Female: (inaudible) I'm pretty sure that our print to that for us was not (inaudible).

Female: OK, do you want to answer …

(Inaudible)

Female: Well, I'm sure in – OK, item, where this is working.

Female: Actually we do have a …

Female: Positive, we included that, but.

Female: OK.

Female: All right. Oh wait a minute, let's see. Oh, I see there's several tables here. So let's look. Table three is factor loading. So let's go on, table four is the item total correlation, table five, (listing) and (unlisting). Table six is about (missing). Table seven, correlation between …

Female: Table eight, I think.

Female: Table eight, no, it just says descriptive statistics. But maybe it is, I …

Female: So that's …

Sherrie Kaplan: No, (inaudible) is not what I was looking for.

Female: Yes.

Karen Pace: OK. So we have all the tables that you've presented from one to eight. Or (inaudible) – yes, sorry. Nine.

So we can follow up and get that if it's – we just wanted to make sure we went over looking it here in the …

Female: Yes, I'm not, but I thought it wasn't include, I'm not saying it right here, I was printing. We can pull that (inaudible).

Karen Pace: Do you want to just briefly state anything about the (IRT) – any of the tables that you did provide or anything that you want to highlight for us to take a look at. Or Sherrie, I don't know if you or others have questions about any of the other table.

Let's go back to table one, yes, no, that's OK.

OK, well, we will – I'm sure Liz will send us those, the facility level of reliability between facility. Any other last questions or comments about the home health measures? OK, Lauralei.

Lauralei Dorian: OK. And (Amy), I believe all lines are open, right?

Operator: Yes, ma'am.

Lauralei Dorian: Great. So if there's any member of the public who's on the line right now who'd like to make a comment, please do so now.

All right. Well, thank you to committee members and developers both for being on the call today. We had a very …

Liz Goldstein: Actually – this is Liz. So under …

Lauralei Dorian: Sure, OK.

Liz Goldstein: It's 2A2.3.

Lauralei Dorian: All right, OK, OK.

Liz Goldstein: That same result come back office.

Peter Thomas: May I – this is Peter Thomas, can I ask a question?

Karen Pace: Oh, OK, so it's not in the table, that's why we missed it, OK. 2A2.3, that says it …

Liz Goldstein: Yes, I was sure it was some place.

Karen Pace: Go up, it's above this – all these tables.

Keep going. Keep going, 2A2. There (inaudible) now, down a little bit.

Liz Goldstein: So it describes the method and then the result.

Lauralei Dorian: OK, Sherrie, do you see that now?

Sherrie Kaplan: Yes, thank you.

Liz Goldstein: You're welcome. Anyway I've (placed it in) so it's going to bother me.

Karen Pace: We were just expecting to see that in a table, but there a lot of tables there. Thanks.

Liz Goldstein: That …

Female: OK.

Female: All right.

Female: Peter has a question.

Lauralei Dorian: Sure. Go ahead, Peter.

Peter Thomas: Oh, I'm sorry, I didn't hear you. Maybe it's just about the launching of this, but I'm just asking, I guess, what should we be doing in preparation for the in-person meeting between now and then?

Lauralei Dorian: Right, so I was going to briefly go over some next steps.

So what we staff will do is summarize these calls and send you those summaries. And then we'll assign each of you as either a lead discussant or a secondary discussant for these measures. And we'll expect that you review all of the 12 measure submissions in preparation for the in-person meeting, so that you can participate and discuss about each of those measures.

And then for the measure which you're assigned lead discussant or secondary discussant, you can use the summaries to sort of introduce the measure and the issues that arose during the workgroup calls to the entire committee during the in-person meeting. And that'll be a good starting point for conversation with the committee.

Karen Pace: Right. And we're going to be taking with Lee and (Jim) to …

Lauralei Dorian: Right.

Karen Pace: … see if there are some other suggestions of how we can help facilitate that at the in-person meeting. But that's the general approach for all of our committee meetings.

Lori Teichman: This is Lori Teichman with the Home Health CAHPS. I was just wondering will the lead person for each of the surveys or measures, whatever you have for the presentation, will that person be communicating back with us in the between if they have questions so we can provide them with the materials before the in-person meeting?

Lauralei Dorian: That doesn't typically happen, but if they have any questions, we can certainly facilitate that interaction or that responses from about anything if there are questions about it.

Lori Teichman: Right.

Karen Pace: Yes, if there's anything that came up on these calls that we need information or that comes up as we continue to prepare for that meeting, we'll definitely notify you.

Lori Teichman: OK. And do you know when the meetings are?

Lauralei Dorian: Yes, it's July 28th and 29th.

Lori Teichman: OK.

Lauralei Dorian: From approximately 9:00 to 5:00 PM, the first day, 9:00 to 4:00 PM, the second day.

Lori Teichman: And you'll give a list about which surveys are covered each day shortly?

Lauralei Dorian: Yes, yes.

Peter Thomas: And can we assume that the measures (inaudible) will be available during the meeting as well?

Lauralei Dorian: Yes, so either be they're in person or over the phone.

Peter Thomas: OK, great.

Female: Yes, but, Lauralei, I think for the sake of the developers, we should warn them that some of these issues are going to crap up, perhaps, not in the context of their measure. But will get discussed perhaps on day one. And then spill over to day two.

So I would encourage them to try to monitor the two days. I know it's a lot of work, but I can see so many of the things that are crapping up in each workgroup are going to crap up again in the full session. And we may deal with several of them on day one. And their measure is not slated until day two.

Female: OK.

Lauralei Dorian: Right, that's a good point, we'll mention that …

Female: Where are the meetings?

Lauralei Dorian: They're at the NQF headquarters in Washington, D.C. And I was just going to mention our travel department either Friday or Monday last week or this week should have sent you information on booking your accommodation and flights if you need them.

So, if you haven't received that communication yet, please let me know. And I can make sure to make that connection.

And for those who aren't developers, we have all of our information. We have the dates and the time of the meeting on our public website. And we'll soon be publishing our agenda with once we finalized what measures are being reviewed during which days.

Peter Thomas: Well, thank you for all your work and this …

Female: Oh, thank you.

Peter Thomas: … incredible amount of work went into this.

Karen Pace: Well, thank you for all …

Lauralei Dorian: Yes, and thank you.

Female: Thank you.

Lauralei Dorian: We look forward to seeing you here in D.C. and please reach out if there's any questions.

Female: And if you have questions that we can help or you want us to be sure to address at the, you know, at the opening of the meeting, definitely send those ideas to Lauralei.

Female: OK.

Female: All right, thanks, everyone.

Female: Thank you.

Female: Thank you.

Female: Bye.

Female: Bye.

END