NATIONAL QUALITY FORUM

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PERSON- AND FAMILY-CENTERED CARE STANDING COMMITTEE

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TUESDAY
JULY 29, 2014

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., James Merlino and Lee Partridge, Co-Chairs, presiding.

PRESENT:
JAMES MERLINO, MD, Co-Chair
LEE PARTRIDGE, Co-Chair
KATHERINE BEVANS, PhD, University of Pennsylvania School of Medicine, Children's Hospital of Philadelphia
SAMUEL BIERNER, MD, UT Southwestern Medical Center
REBECCA BRADLEY, LCSW, HealthSouth Corporation
SHARON CROSS, LISW, The Ohio State University Wexner Medical Center
DAWN DOWDING, PhD, RN, Visiting Nurse Service of New York
CAROL LEVINE, MA, United Hospital Fund
BRIAN LINDBERG, BSW, MMHS, Consumer Coalition for Quality Health Care
SHERRI LOEB, RN, BSN, EMMI Solutions
LISA MORRISE, MA, National Partnership for Patients
ESTEE NEUWIRTH, PhD, Kaiser Permanente Care Management Institute

LENARD PARISI, RN, MA, CPHQ, FNAHQ, Metropolitan Jewish Health System
DEBRA SALIBA, MD, MPH, UCLA/JH Borun Center for Gerontological Research, VA Greater Los Angeles GRECC, RAND Health
CHRISTOPHER STILLE, MD, MPH, FAAP, University of Colorado School of Medicine, Children's Hospital Colorado
PETER THOMAS, JD, Powers Pyles Sutter & Verville P.C.
CARIN van ZYL, MD, FACEP, City of Hope National Medical Center

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
NADINE ALLEN, Project Analyst, Strategic Partnerships
LAURALEI DORIAN, Project Manager, Performance Measurement
KAREN JOHNSON, Senior Director, Performance Measurement
KAREN BECKMAN PACE, PhD, RN, Senior Director, Performance Measurement
SARAH SAMPSEL

ALSO PRESENT:

JULIE BROWN, RAND Corporation*

CHRISTINE CROFTON, PhD, Agency for Healthcare Research Quality (AHRQ)*

RON HAYS, PhD, RAND Corporation*

GLORIMAR ORTIZ, MS, NRI, Inc.*

LUCILLE SCHACHT, PhD, NRI, Inc.

MARK SCHUSTER, MD, PhD, Boston Children's Hospital

DALE SHALLER, MPAFF, Agency for Healthcare Research Quality (AHRQ) Consultant*

SARA TOOMEY, MD, MPhil, MPH, MSc, Center of Excellence for Pediatric Quality Measurement, Boston Children's Hospital

ALAN ZASLAVSKY, PhD, Harvard Medical School

CARLA ZEMA, PhD, Agency for Healthcare Research Quality (AHRQ) Consultant*

SONJA ZINIEL, PhD, Boston Children's Hospital

*** present by teleconference**

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Adjourn

P-R-O-C-E-E-D-I-N-G-S

8:31 a.m.

MS. DORIAN: Good morning, everyone, and welcome back for day two of the Person and Family-Centered Care meeting. We hope you had a good evening. And we thought the discussion yesterday was very robust, and we're looking forward to another day.

Before we get started, this was actually on the agenda for later in the day, but, just in case people start to trickle out, we're going to do the committee selection of terms. As I mentioned yesterday, we're doing two- or three-year terms, and these are selected at random, unless anybody wants to let me know now that they definitely do not want to do a three-year term. Then we'll put you on for a two-year term. And Nadine will walk around for those in the room, and you can just select your term out of the bowl at random, and I can note it.

MEMBER DOWDING: Dawn Dowding,

two.

MEMBER BEVANS: Katherine Bevans, three.

MEMBER STILLE: Chris Stille, two.

MEMBER LEVINE: Carol Levine, two.

MEMBER PARISI: Len Parisi, three.

MEMBER MORRISE: Lisa Morrise, three.

MEMBER LOEB: Sherri Loeb, three.

MEMBER SALIBA: Deb Saliba, three.

MEMBER BRADLEY: Becky Bradley, two.

MEMBER BIERNER: Sam Bierner, three.

MEMBER VAN ZYL: Carin van Zyl, three.

MEMBER NEUWIRTH: Estee Neuwirth, two.

CO-CHAIR PARTRIDGE: Lee Partridge, three.

CO-CHAIR MERLINO: Jim Merlino, two.

MS. DORIAN: And we can select for those who are on the phone. Sharon Cross, two. Brian Lindberg, three. Liz Mort, two. Sherrie Kaplan, three. Peter is two. And two.

Okay. Thank you, everyone. Thanks, Nadine. And now I'll just ask if Lee or Jim wanted to say any words about yesterday before we get started. We also have some slides Nadine can pull up just to remind you of the results of the voting.

CO-CHAIR MERLINO: The only thing I would say is that, just to remind everyone at yesterday's wrap-up we talked about having Karen review the validity and reliability before we open it up to conversation. And so for the members of the public and the developers who are here, Karen from the staff is going to review the methodology in the NQF staff review first, and then we'll open it up for discussion. Yes, just on reliability and validity.

MS. DORIAN: And are there any Committee members on the phone? I know Liz was calling in, but I don't know.

CO-CHAIR PARTRIDGE: Excuse me. I want to echo Jim's good morning and welcome to everybody. And I just wanted to raise one question with Lauralei briefly for all of us to think about, and that is, as she's drafting the report that comes out of this meeting and goes out for public comment, if there are particular points that you think should be emphasized or something that you wanted to use as an illustration share it with her. We will get a chance to look at it before it goes out for public comment. But sometimes you only have a short period of time if you're on vacation or something, and so it's a good idea just to share those thoughts as you went along.

And I had one myself. As I was looking over the material that CMS, Liz Goldstein handed me about the HCAHPS box

scores, the care transition mean for the latest quarter of all 4,000 hospitals was 51.27. The top score, the 95 percentile was only 63. So if you thought that a measure was important, that new care transition measure is really important.

And, Esther, the discharge, in contrast, the discharge information measure had a mean of 85.73. So, clearly, we need that 11th component to HCAHPS.

MEMBER NEUWIRTH: Yes. I mean, I guess I just wonder, that's really great information and I wonder if anybody has really done any comparison between the discharge on the CTM-3 to see if they really are distinct. Maybe we don't need the discharge questions. Maybe there's some redundancy. And that might even further streamline the CTM-3 into the HCAHPS. So something for consideration in the future.

DR. PACE: Well, they did present information yesterday about the correlation

among those two scales, and it was fairly low. But, certainly, it's something that they can continue to take a look at.

I was just going to put up here, and feel free to add to it throughout the day, but it seemed like yesterday the main issue that came up perhaps is not being addressed in the experience with care measures is something about being informed about what is covered, you know. I know we had this discussion about, you know, there's other efforts about affordability measures, but I think, Lisa, you specifically wanted at least to note that this would be an area of interest to the people that you know and represent that they would like, you know, some aspect of at least they were informed about what's covered or what their responsibility is going to be.

So I'll note that. That's something we can at least note in the report for future consideration.

MS. DORIAN: Yes, and I do echo

Lee's sentiments. Please feel free at any time to let me know what we should be including in the report. And it doesn't necessarily even have to be about these measures specifically. We do also have a gaps section, so, if you have strong feelings about an area where future measure development really needs to focus, you can let me know either through email or you can write, we'll leave markers around maybe on the table over there if you wanted to put something up during the breaks.

So you can see on the screen in front of you, this is just a recap from yesterday, that that first family evaluation of hospice care was recommended and we'll move forward. The next two measures, the bereaved family survey from the PROMISE Center and the CARE from Brown University, were both not recommended on reliability. The CAHPS In-Center Hemodialysis Survey, those three measures were deferred until they have future

testing that they'll submit to us. And the three multi-item scale measures fall in that green zone, or the gray zone, so they will move forward and we'll see what public comments say about those measures.

The CAHPS Home Healthcare Survey was recommended. And the HCAHPS and the CTM-3 were both recommended, as well.

So were there any comments or questions about the measures yesterday or anything that was raised yesterday that we wanted to consider today? Yes, Len?

MEMBER PARISI: I have a question. In preparing for today and thinking about yesterday and all the CAHPS surveys, does CMS -- is anybody here from CMS today? No. I'm wondering if they had a resource to really define the variations among the different surveys because there seem to be some redundancies now, and it would help from this perspective but it would also help as a consumer because, as they continue to develop

more of these tools, there's definitely going to be some overlap. Like today's tool that we're going to be reviewing, to me, is reminiscent of the CAHPS survey itself.

So I was just wondering if that resource exists. It would be helpful to have access to that.

DR. PACE: We do have some folks here from the CAHPS Consortium.

DR. TOOMEY: I'm Sara Toomey. I'll be one of the presenters for Child HCAHPS. What I can say is that all of the materials are actually available online. There are two main sites that they're available at. One is the AHRQ CAHPS website, and that site will actually link you to absolutely every one of the CAHPS surveys.

The CMS has direct control over the adult HCAHPS because of its reporting requirements, but there are links from the AHRQ website to the CMS site and there are extensive documentation about how to use all

the instruments, how to access the databases that are involved when they're a part of the databases, who to contact, basically all of the information that was there.

DR. PACE: Okay. I think what you're referring to is some crosswalk where you can actually see what questions, and I know that that's something, for the Person and Family-Centered Care project, our staff tried to do is to -- pardon me? Not this one but the measure gap project where we tried to identify all of the questions that are used across the CAHPS items. And there isn't really one place that that's done, and I think that's kind of what you're getting at is --

DR. ZEMA: Karen, this is Carla Zema. I work with the instrument team and am part of the CAHPS Consortium, and I just wanted to -- I think this is what the gentleman was speaking about. But we actually went through a massive, what we call reconciliation process across all of the CAHPS

surveys because there are so many different CAHPS surveys for so many different centers now. And what we wanted to make sure was we wanted to look at that overlap, we wanted to see where overlap made sense, and we wanted to make sure that we were consistently measuring those areas and making sure that our measurement represented what we call the best survey science. And if we learned about measurement of, for example, communication in one area, we would make sure that then that got translated back to other settings, as well.

DR. PACE: Okay. Thank you.

DR. ZEMA: We are still in that process, and all of those crosswalk things are not public information.

DR. PACE: Okay.

CO-CHAIR MERLINO: We can also get that offline for you, but let's move forward, I think. Okay. So the first measure is 2548.

DR. PACE: Okay. So could we have

the measure developers for the child version of HCAHPS?

DR. ZEMA: Is Chris Crofton in the room yet?

DR. PACE: I don't know, but we've got people here in person who are going to be speaking for these measures.

DR. CROFTON: Yes, I'm here. This is Chris Crofton. And I'd like to give a little introduction before we start going through the measures.

CO-CHAIR MERLINO: Hold on one second.

DR. CROFTON: Sure.

DR. PACE: So who is speaking for the child version of HCAHPS? Okay. And, Chris, can you be brief, please?

DR. CROFTON: I can be very brief.

DR. PACE: Okay, thanks.

DR. CROFTON: I'm Chris Crofton. I direct the CAHPS project at AHRQ, and I just wanted to say that, since the time that we

worked with CMS on developing HCAHPS, I think we immediately began getting a request for a version for pediatric settings. And I know that came up at different points in the conversation yesterday. We always have more requests for surveys than we have funds to develop them, so we're really glad when Mark Schuster and his team from Boston Children's approached us about developing a child HCAHPS survey in coordination.

So what that means is that we followed the guidelines for developing CAHPS surveys in terms of cognitive testing, field testing, selecting questions for which patients are the best or only source of information. It also means that this survey includes the CAHPS' core items that are across all CAHPS surveys with some variations for different settings. And, of course, my team has developed a number of new items pertaining specifically hospital care for children, such as helping the child feel comfortable,

involving teens in their care, and assessment of how well caregivers communicate with both the patient and the parents.

The reason AHRQ began developing CAHPS surveys in the first place is because we received many requests for surveys that could be administered across a number of different organizations and a lot of comparisons. That standardized approach is the reason that CAHPS is here, basically.

So I think that's all I need to say about the background. We're very pleased with this version of the survey that we've developed with Boston Children's. And from that, I will turn it over to Sara Toomey.

DR. TOOMEY: Hi. I'm Sara Toomey. I'm the managing director of our center at Boston Children's also assistant professor at Harvard Medical School.

DR. ZASLAVSKY: I'm Alan Zaslavsky. I'm a professor of healthcare policy at Harvard Medical School.

DR. SCHUSTER: And I'm Mark Schuster. I'm direct of our Center of Excellence for Pediatric Quality Measurement and a professor at Harvard Medical School and vice chair for health policy in our department of medicine.

DR. TOOMEY: Thank you. We, at the Center of Excellence for Pediatric Quality Measurement at Boston Children's Hospital, are funded by the Pediatric Quality Measures Program sponsored by CMS and AHRQ. They have assigned us to develop an inpatient family experience of care measure, as you just heard from Chris.

Just to be clear, both our measures and the Children's Hospital of Boston inpatient experience survey that will be discussed next were developed by teams in different parts of Boston Children's. Our instrument, the Consumer Assessment of Healthcare Providers and Systems Hospital Survey - Child Version, fondly known of as

child HCAHPS, is a standardized survey instrument that asks parents and guardians of children under 18 years of age to report on their and their child's experiences with inpatient hospital care. We have followed CAHPS design principles, as was mentioned, and partnered with the CAHPS Consortium throughout the process of developing this survey.

We began by reviewing over 1300 abstracts, articles, and measures related to inpatient experience of care and by talking with experts in the field. AHRQ published a Federal Register Notice on our behalf to solicit public comments on potential items and domains for the survey.

Based on what learned through this background work, we conducted focus groups in Boston, Los Angeles, and St. Louis, in English and in Spanish, with parents of recently-hospitalized children and with recently-hospitalized adolescents. From this formative work, we drafted an initial survey. We

conducted over 100 cognitive interviews in Boston, Los Angeles, Miami, and St. Louis, in English and in Spanish, at various stages of survey development. Our aim was to test whether our survey items were consistently understood and to identify confusing or problematic wording.

Based on cognitive interviews, we revised the survey and then conducted a pilot test of the draft survey by mail in English and in Spanish in eight hospitals across the country. We received over 2,000 surveys and examined item non-response, inter-item correlation, and response variation. As part of this pilot, we also conducted behavioral coding by administering 60 surveys by phone and analyzing the audio recordings to identify problematic items.

After further survey revisions and additional cognitive interviews, we conducted a national field test of our survey in 70 hospitals in 34 states across the United

States. We fielded our survey in both English and in Spanish and either by mail or phone and received over 17,000 returned surveys. We used the national field test for psychometric testing, composite development, and development of our case mix adjustment model.

We found our measures to be, generally, both reliable and valid at the hospital level. And we conducted end-user testing of our composites with parents to ensure understandability of composite groupings and labels.

The Child HCAHPS Survey consists of 18 composite and single-item measures. These measures have been packaged into five overarching groups. The groups are communication with parents, communication with child, attention to safety and comfort, hospital environment, and global rating.

Our measures have been submitted to AHRQ and CMS, and our instrument will be on the AHRQ CAHPS website. And we're currently

finalizing the materials for the website itself.

Thank you very much for having us here. And we're very happy to answer any questions you might have about our measures.

CO-CHAIR MERLINO: Thank you, Sara. Any comments from the Committee members who are on the phone call?

DR. PACE: So we could start with the evidence then. And this was something that was submitted later, you know, for the PROs who are looking at are there healthcare services, interventions, actions that can influence the experience being measured. And this document was sent, I believe, last week and is on your SharePoint site.

But we'll leave it open now to those that were reviewing this measure. If you have any questions or comments about this part of the submission, in terms of are there --

CO-CHAIR MERLINO: Anybody think

there's not enough evidence? Should we vote on this and move forward? Okay. Let's vote.

MS. ALLEN: We're voting on evidence rationale supports the relationship of the health outcome, or PRO, to at least one healthcare structure, process, intervention, or service. One yes, two no. Voting starts now. We're still missing a vote.

CO-CHAIR MERLINO: Everybody check your green lights.

MS. ALLEN: Please vote again.

CO-CHAIR MERLINO: Green light.

MS. ALLEN: Please make sure your green light is flashing. All votes are in. Sixteen yes, zero no.

CO-CHAIR MERLINO: Carol?

MEMBER LEVINE: I just want to say that this sort of form would have been useful in some of the ones we reviewed yesterday because it left us to our imagination to figure out what those things that could be done. So having something like this is very

useful.

CO-CHAIR MERLINO: Okay. Moving to -- so we have 17, right? So moving to performance gap. Comments from the members who took the call? Any general comments or questions?

MS. DORIAN: We can bring up what they submitted.

CO-CHAIR MERLINO: I think they were pretty much in agreement that this is a huge opportunity, so we can probably vote on performance gap. Anybody disagree? No. Let's vote on performance gap.

MS. ALLEN: We're voting on performance gap, data demonstrated considerable variation or overall less than optimal performance across providers and our population groups. One high, two moderate, three low, four insufficient. Voting starts now.

CO-CHAIR MERLINO: Still 16. Somebody is not registering. We have 17.

Somebody is on the phone.

MS. ALLEN: Okay. Can everyone please vote again?

CO-CHAIR MERLINO: No, no green light? No, we still have 17. Okay, 16. All right. We're good.

DR. PACE: So now we're counting up to, we can make it up to 16 we now have, right?

MS. ALLEN: All votes are in. Thirteen high, three moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: Moving on to high priority. Comments from the people on the call? Anybody?

DR. PACE: Do any of our pediatric members want to speak to priority? We've already heard about how they involved parents in developing the survey.

MEMBER BEVANS: This is not so much a comment about this version of the instrument but a more general question. First

of all, I want to say that I really think that the instrument, the process through which, the rigorous process that you used to develop this instrument is really commendable. It's a really nice model, I think. And I appreciate all of the work that you did with parents and youth and adolescents to sort of make sure that the child-specific and youth-specific items were integrated.

And also I think, just to point out to the Committee, that this group did some really interesting and neat work around the understandability, making sure that the labels for the reporting side of the outcomes were understandable. I think that was -- I personally hadn't seen that before. I think that's really very neat and important.

My question is a bit general, and, again, I bring it up here because I think it is sort of a priority for the HCAHPS sort of program in general, and that is the inclusion of youth report items. I don't want to push

this too much because I feel like it's a huge step forward to involve, you know, to develop a child HCAHPS period. But I'm curious about the parent report versus asking children their impressions when we know that parents and children often differ, you know, in their experiences of healthcare and certainly other types of outcomes.

So could you comment on why you decided to ask parents some of the questions, especially around perceptions of communication with the child, instead of asking the child directly?

DR. TOOMEY: Thank you for the question. So, yes, I'll talk to you about it in a couple of different ways. So first of all, from our perspective, we wanted to include as many people as possible in this first go at developing a national survey. So from our perspective, teens represent somewhere between a fifth and a quarter, somewhere in that range, of admissions to the

hospital. So were we to make it a solely child-reported survey, we would be only able to reach a small portion of the pediatric population that's hospitalized.

So as our first decision point, we decided that, for that purpose, for this first go-around at a nationally-developed survey for children's inpatient care, that we should start by having it be a parent proxy survey that would -- actually, a parent-reported survey of their experience that would apply to all children, rather than just a subset.

What I will also say is that, within our survey, we do have a couple of key sections for which we have asked the parents to not report on their own experiences of care but to actually report on their child's experience, in particular around the communication items. And what we were able to find in cognitive testing is that parents were able to differentiate from how nurses and doctors in particular were talking with their

child versus talking to them and then also, on the teen side, how much the care team was involving the child in their care. And as a result of that, and we actually can see some differences in performance on those measures, so we do have reason from the cognitive interviewing and then also from the measure testing to be able to feel comfortable that we're at least getting at some of the differences that you're recognizing. We would love to develop a self-reported survey in the future.

DR. SCHUSTER: Could I just add one little thing to what Sara said? We discussed with AHRQ and CMS the idea of possibly two measures, one that would be an adolescent self report, because we would enthusiastically develop that, as well. At that time, they wanted the parent report first. And we hope that in the future there will be interest in having an adolescent self-report developed and that maybe we'll be lucky

enough to develop it.

MEMBER STILLE: For this point, I basically just wanted to echo most of what Katherine said. I think, you know, it's really good that you used a racially and ethnically-diverse sample among a lot of hospitals, as well, because that's not always done. So great work.

MEMBER BIERNER: I just wanted to ask all the cities you chose were large urban centers. Is this because you feel this is where most of the pediatric hospitals are going to be located? Because you omitted any city under a million. And how did you choose to sample the way you did? And you have to have 300 surveys per hospital to be valid, so is that part of your decision?

DR. TOOMEY: So I think what you're referring to is the qualitative work that we did during the formative period. In terms of the national field test itself, it covers 34 states. It's actually very diverse

in terms of the size of the cities that are represented for the field test itself.

In terms of the formative work, we really were striking, were trying to strike two different factors, one of which was geographic diversity, so LA, Boston, St. Louis, and then Miami, and also looking at some differences in regards to some, particular with the Spanish population with the cognitive interviews, doing some different groups, so LA and Miami being two very different sort of cultural groups for Latinos.

To be frank, a lot of it has to do with the realities of wanting to be able to get enough participants for something like a focus group at the same time. And so from that perspective, some of the larger cities, like St. Louis for instance, had the capacity, had the people that were able to help us recruit patients, or parents in this case, to be able to participate in the field and the focus groups and had the facilities to allow

us to do the focus group in a reasonably efficient manner.

CO-CHAIR MERLINO: Lisa?

MEMBER MORRISE: I want to echo that it would be great to eventually develop measures or testing of adolescents. As a parent who spent more nights in the hospital than the Marriott, I think that these are excellent.

As a patient and family center care leader in a hospital, we had a youth advisory council. And our youth were very vocal that too often providers ignored them and did not speak to them at all and only spoke to their parents. And so we taught to that, especially with our house staff, and the feedback from the rest of the staff, the nursing staff, and the feedback from the parents of the children was that it made such a difference when we actually taught them how to talk to the child.

So I am so glad to see that as a

measure. And I think it will go a long way toward making the hospital experience less traumatic for children.

CO-CHAIR PARTRIDGE: Sara, one of our long-term concerns, for those of us who have been deeply committed to improving maternity care, is the fact that a number of the teens are in the hospital because they're giving birth. And because HCAHPS applies, adult CAHPS applies only to 18 and over, we don't capture the hospital experience of the 16 and 17-year-old woman who gives birth. I assume they're in your universe.

DR. TOOMEY: So, actually, obstetric care is excluded from our survey. I think there were two main rationales for that, one of which is that, almost by definition, obstetric care is not occurring within the pediatric realm of the hospital. And then I think the second point is, although I hear what you're saying, that there might be special considerations when it comes to teen

pregnancy, when you look at how they're distributed over the course of the country, etcetera, they're a very small portion of any obstetric unit and that we were hopeful that the overall experience of the women who deliver at this institutions would have a positive effect on the overall care that's being received for all of the women, including those that were under 18.

CO-CHAIR PARTRIDGE: I wish I thought you were right on the latter point. I think the experience of the 16 and 17-year-old woman probably can be quite different. But I understand why you did what you did, and thank you.

CO-CHAIR MERLINO: Any other questions or concerns for high priority? You sure? Okay. Let's vote on high priority. We only need 16 this time.

MS. ALLEN: We're voting on high priority, addressed in a specific national health goal or priority or data demonstrated

a high-impact aspect of healthcare for PRO target population values and finds meaningful. One high, two moderate, three low, four insufficient. Voting starts now. Results are in. Sixteen high, zero moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: Okay. Moving to reliability. Karen?

DR. PACE: Okay. Jim asked me to at least introduce some things for your discussion. And remember, under reliability and validity, we also would get measure specifications. So in the submission, they did list the measures, as we asked, and then also the items that comprise those measures was not in the form itself but was in the data dictionary Excel file.

So there's a statistical model for case mix adjustment and the variables include child age and respondent report of the following: child health status, relationship to child, age, education level, and language.

And the coefficients for that, for the case mix adjustment were provided in the data dictionary.

There are sampling instructions and survey instructions. And as someone already noted, they recommend 300 completes.

So getting under reliability testing, would you pull that up? So they did provide information on testing of the patient level scales. They did internal consistency reliability testing. And if we go down to 2A 2.3 there's a table with the box alpha for the scales. And we may ask the developers to comment on -- three of them had internal consistency reliability below 0.7. Communication about medicines, there you see is 0.43. And go down a little bit lower, the stakes and concerns 0.26 and child comfort 0.63. So we'll just ask --

DR. TOOMEY: I'll speak first, and then if Alan wants to add something he certainly can in this case. So internal

consistency and reliability is trying to look at sort of how well, as you say, that elements of this scale come together.

With that said, it is possible that the items themselves are conceptually related but might not be as empirically related as you might think because they're different processes of care. So a great example is the mistakes in helping you report concerns. So for those two items, conceptually speaking, we felt as though they were very strongly related. They're looking at whether or not somebody is checking a wristband to confirm their identity before giving medicines and also whether or not a hospital staff tell you how to report any concerns you might have about mistakes you have in your child's healthcare.

And so, conceptually speaking, they're very, very related in our minds. However, you could imagine that the processes that go into whether or not those two things

occur are quite different.

Alan, did you have anything to add?

DR. ZASLAVSKY: I think I have a view or we have a view that maybe a little heterodox from a psychometric perspective that I think is more relevant here, which is that what we're really most concerned about in reliability is that the results you're seeing are results of systematic differences among the units, in this case hospitals, rather than due to random variation in the individuals we have as a sample.

So the internal consistency and reliability is essentially about whether the different items that are being combined into a composite are giving you the same information, so that it's just some random variation, and that this is a very appropriate thing for a situation where the items are random and the individuals are fixed. But here it's actually the individuals who are

random because we're sampling people out of the stream of patients coming through the hospital. And the items are fixed in that we've elicited in the preliminary phases of developments the things that are important to people and that cover the different aspects of care. And so we definitely think that the inter-unit reliability, which is a measure, essentially, of the reproducibility of the results if you had a new sample of patients, is the primary criterion.

Now, the combination of items like the two measures that Sara just referred to is really based on a conceptual relationship of the items from the point of view of summarizing the information. Those two do go together. The usability testing shows that people do understand those as being part of a common characteristic, even though they are not empirically that strongly related.

And so that's really the key criterion there. We do find that for most of

the measures the items which are really more representing the same process with slightly different questions do have higher alphas.

DR. PACE: Okay, thank you. And just to remind everyone, for NQF, we asked for the reliability at both levels. And let's just do a quick look at the unit reliability that Alan referred to, and then we'll come back to Chris.

So these on the computed performance scores, the next table, four, these are the inter-unit reliabilities. And you can see all of these. There's only one that's below 0.7, and that's involving teens and care, but it's at 0.62. So this is about being able to distinguish, you know among the units or hospitals from this data, and this is with sample sizes of 300, at least 300.

So, Chris, did you have a -- okay.

CO-CHAIR MERLINO: Lisa?

MEMBER MORRISE: Tell me if this is the wrong place to bring this up, but I

noticed that in one place it says that respondents will be selected based on if there had been an overnight stay. And in another place, it indicated that outpatients would be excluded. However, in today's world, you can be an outpatient and have an overnight stay.

So, in fact, many patients who used to be considered inpatient now are put in for a supposed less than 24 hours but it involves pretty much all 24 hours. So I'm wondering about that, how that is actually screened for.

Also, in my experience, the patients and families that I worked with did not understand the difference between the terms outpatient and inpatient. If you were in a bed in the hospital, to them, you were inpatient, even if to your insurance company you were a short stay.

DR. TOOMEY: Thank you for the question. So in regards to the second point you made, let me answer that first. The

decision about consent to survey is made at the hospital level, so parents aren't having to differentiate between whether or not their child did or didn't have an inpatient stay.

We're using the same basic HCAHPS principles in regards to sort of inclusion criteria and having it be an overnight stay. I would agree with you that, as time goes forward and as there are more outpatient surgeries, for instance, that are happening, that we might need to revisit sort of what is considered to be an inpatient stay. But right now we're using the CAHPS guidelines of it having to be at least an overnight stay.

So in that regard, we also allowed for our field test -- this was a voluntary participation in regards to the 70 hospitals that participated. We're really fortunate that we had as many as we did. We gave them guidelines in regards to what we were looking for, and then they worked through their vendors that they usually used for patient

experience surveys.

So, unfortunately, we don't have good quality assurance. It's just sort of how some of these definitions were actually operationalized, to be quite frank. With that said, we had over 17,000 sort of completed surveys that go into sort of this testing.

MEMBER MORRISE: So just as a follow up, could they then operationalize that question differently from facility to facility based on how they view it? Because we've also had the benefit of being in different facilities and find that they define things differently.

DR. TOOMEY: No observation stay was supposed to be within the survey. So I would hope that that did not occur, that it was pretty clear, and, as I said, is a guideline that gets followed in the context of other patient experience and patient surveys. But as I said, I have to acknowledge that we were unable to do quality assurance at the

actual hospital site to see who they actually included or not.

DR. PACE: I think that may be something to add to our list because I know, I don't know if it was you or someone else brought it up yesterday with HCAHPS about the observation stays and, because those are increasing so much and probably have some implications for experience with care in terms of what patients experience as an observation stay versus an inpatient, I don't know how that could be addressed but I think maybe it's something to add to your list.

CO-CHAIR MERLINO: Carol?

MEMBER LEVINE: It's really important for the adults, as well as the children, because -- and I will say that, based on our experience in New York, not even people at the hospital know what status this is because the nurse on the floor doesn't know and the doctor may have recommended something but it's, you know, the people who pay that

make the decision. So it does affect the experience because if you know you're going to be admitted and you're a real patient, you have a different experience from sort of they're being observed, what does that mean, who pays? It's a very different experience.

CO-CHAIR MERLINO: Further observation is a gap for both adult and now peds that will have to be addressed at some point. Chris?

MEMBER STILLE: Yes. I think it's sort of an open question, the experience of kids and families with observation status. I'm not aware of any real differences, but maybe that's a state-specific thing, especially with Medicaid. So maybe it's something that needs to be looked at, but my impression is that it's not as much of a problem. I don't know if your hospitalists have perceived much. So maybe not as bad in kids as adults, bu worth looking at.

CO-CHAIR MERLINO: Katherine?

MEMBER BEVANS: Without the reliability for the -- I can't tell if it's a composite or a single item, the involving teams in care looking a little bit different than the other measures. It appears that there's a response proportion of only 20 percent --

DR. TOOMEY: But it's because -- so, actually, thank you for bringing that up. We're actually pleased, to some extent. So this is hospital-level unit reliability at 300 completes at any hospital. So of those 300, only, on average, about 20 percent of those would actually be teens, and so they would be the only people who would be eligible to answer those items. And even with, on average, their only being 20 percent of the 300, we still have a reliability that's very close to 0.7. So there actually is quite a bit of signal to noise within those items.

MEMBER BEVANS: Okay. And so I'm trying to understand how that -- is it the

reduction in sample size that compromises or the portion of --

DR. TOOMEY: No, it's basically -- so it's the fact that what this is looking at is it's looking at a hospital having 300 completed surveys for which those 300 completed surveys have a distribution of age, right? So in any -- like at Children's Hospital, if you were to pick 300 random surveys, on average, only 20 percent of them would be teens who would be eligible for those items.

This is looking at the reliability of taking a 300 knowing that there's only 20 percent who would be eligible for those items. So I actually think it's actually quite good, given that that's the case.

CO-CHAIR MERLINO: Any other comments about reliability? Concerns? We're ready to vote? Let's vote on reliability.

MS. ALLEN: We now have 17 votes that would be tallied. Now we're voting on

reliability, and this includes precise specifications and testing. One high, two moderate, three low, four insufficient. Voting starts now. All votes are in. Results: 14 high, 3 moderate, zero low, zero insufficient.

DR. PACE: Okay. We'll move on to validity. And this is where I'll need a little bit of clarification from the developers on the things that they submitted. Typically, I generally see item-to-composite correlations under reliability, and also you repeated, I think, some of the internal consistency reliability. But from this table six -- would you go to table six, the composite-to-composite correlations? Is that the patient-level scale? Because it looks like table seven is probably the performance score.

So, again, we asked to see validity information at the scale level and then at the performance score. So I just want

to make sure we understand what you provided.

DR. ZASLAVSKY: Everything in that section is at the level of the hospital.

DR. PACE: Hospital level. So did you do any validity at the scale level, the patient level, scale level?

DR. ZASLAVSKY: We do have some.

DR. TOOMEY: This is the correlation with the overall reading, individual level items composite.

DR. PACE: Everybody should have three. And I think for -- okay. You want to just quickly explain which each of these tables is talking about? So the ones that you have in front of you, the handout, is at the patient-level scale.

DR. ZASLAVSKY: Right. And because of the fact that they're also structured skips, which are the main source of individual level missing in these items. We had to impute the missing items in order to get a complete covariance matrix, which this

is based on. So the ones on the separate pages are all individual level, and everything in the materials is performance scale level.

DR. PACE: So let's just quickly, I think probably -- okay. So let's look at this one first: individual level composite and single-item correlation with the overall rating. So, basically, this is the composite that you see in the first column, so I'm looking at -- you all have it? The first column are the 18, in this case, patient-level scales and it's looking at a correlation with the overall rating of the hospital.

And so, again, this is similar to what we saw yesterday. The idea is that these are all some aspect of the overall experience with care and rating of the hospital, and so you would expect to see some positive correlation with these. And it probably makes sense that recommending the hospital is the one that has the highest correlation with the overall rating, but these are, I assume, in

the direction you expected. I don't know if you want to make any other comments about it.

DR. ZASLAVSKY: No, I think that's the main point. The reason we didn't include this in the main submission is that we really think these are less informative than the performance scale --

DR. PACE: I understand, and I'm just --

DR. ZASLAVSKY: But they do seem reasonable, at least, so we should go in that direction.

DR. PACE: Right, right, right, right. Okay. And then I don't think we'll necessarily need to look at the item-to-composite correlation that really gets at, you know, getting down to the question level which is not, is certainly important for constructing the scale but not something we need to look at. And then the composite-to-composite correlations that look like this.

So the idea here again would be,

again, because they're part of the overall experience, that you would expect to see these correlated positively but that they're not redundant, meaning if they were very high correlation then you would question do you need both of the scales. So these look reasonable. I don't know if you want to make any other comment?

DR. ZASLAVSKY: Just that.

DR. PACE: Okay, all right. Okay. So now what is in the submission form, table six and seven are along the same lines. And let's mainly look at table seven. So this is if they actually computed the hospital scores on these 18 scores and then correlated it with the overall rating, again with the idea that they expect that these should be correlated. And so I guess there's quite a bit of variation here, and I guess the ones that I would ask you to maybe comment on are the ones that are fairly low or even, like, cleanliness that's negative 0.07, quietness that's 0.02,

if you have some comments to make about that.

DR. TOOMEY: Well, I think this got brought up yesterday by Liz, you know, the point of looking at the correlation between these composite and single items and overall rating is to get a sense of how much, in this case, parents are evaluating those aspects of care. And I think that some of the lower values represent more that they're just not being prioritized in the same way to sort of influence their overall care.

And we heard a little bit about that, frankly, on the end user testing where if they were to rank what was most important to least important, you know, quietness and cleanliness, they weren't the most important things that were going into their overall experience. So for us, I think that's the explanation for why it is. I think they're still important, and there's a lot of reason for why we chose to keep them in, even though they weren't as highly correlated with overall

experience. But I think that's the main reason.

In regards to being informed with the emergency room, we actually asked -- that's actually a little bit of an internal check to some extent. We asked parents early on in the survey whether or not they were informed in the emergency room, and then we very explicitly asked them not to consider their emergency room care in the rest of the survey itself. So, in theory, they really should be thinking about their inpatient stay, rather than the emergency room, so it might be the case that it isn't as well correlated with their overall stay because, frankly, as we know, there are differences in experience with the emergency room, versus with their inpatient stay itself.

DR. ZASLAVSKY: Also, remember that the emergency room is not a very large share of the total admissions. So the quality of the experience in the emergency room, even

if for individuals it had an impact on the overall experience, a lot of those individuals are not going through the emergency room and their experience doesn't really have anything to do with what's going on there.

MEMBER BRADLEY: I guess my question is kind of a general question. When you find elements like this in a survey that don't seem to be a high priority, I know those two items are prevalent in the other CAHPS surveys, but at what point do you decide that they're not important for this survey, and take them out? Because with a 57-item survey, I guess at some point you have to question, you know, the length of the survey.

DR. TOOMEY: I think it's a valid point. I think, generally speaking, from a hospital perspective, which is another user of this survey, these items have been core items, in thinking about the care that they're providing for patients. There have been some studies that have linked cleanliness, for

instance, to safety. And so from that perspective also, there seems to be value from those types of work that's been done to say that there probably is a relationship. And that relationship, frankly, parents wouldn't be aware of, necessarily, that there would be that link.

So I think we felt as though -- and also for the perspective of harmonizing with the adult HCAHPS measure. For all those reasons, it seemed to be important to keep in at this point in time.

MEMBER LOEB: I was going to actually echo what you said. Cleanliness is very important, related to safety and quality. I mean, if you have a dirty hospital, your infection rate is going to skyrocket. And while you're not going into the hospital to have a quiet, you know, hotel stay, it does affect your healing, your getting better. And so there are ways to cut down.

And what's interesting is what we

have found, and this is not published and not specific, but the patients who have been educated as to what to expect in, you know, appropriate cleanliness, like they should come in and clean your room everyday, and there should be some reasonable amount of quietness, they're scoring the hospitals lower who aren't meeting those specifications, than the parents who come in with no education at all as far as, you know, well, do they even come in our room everyday and clean?

They don't expect it, so they're rating it higher because they don't know what to expect. So I think these absolutely need to stay in the survey. There's no way you can take out cleanliness and quietness from a survey like this.

CO-CHAIR MERLINO: Any other comments on the validity or questions?

MEMBER STILLE: Just real quick. I'm hoping this is related, because I waited before. One of the exclusions is psychiatric

primary diagnoses. Any rationale for that, given that mental health is so important?

DR. TOOMEY: Thanks for the question. I think there were two reasons why it was left out, two main reasons, one of which was that we thought that the experience of inpatient pediatric psychiatry stays, particularly from a parent perspective, is extraordinarily different than on a medical floor, as they're often inpatient, locked units, etcetera.

It's not to undervalue. If anything, I think our goal would be, once again, in addition to having a child-reported survey at some point, would be to focus a patient experience survey on, in particular, psych admissions, which is actually, in the adult world, what's been done.

So for CAHPS, the adult HCAHPS, sort of the second reason it's focused on non-psychiatric admissions, and they do have a psychiatric sort of CAHPS echo survey for

which, once again, would have a lot of value in developing, and probably would be different in regards to at least some of the aspects of care. I'm not saying that there aren't, I'm not saying that communication isn't important across the board, but one of the key principles in developing a survey like this is that there have to be things for which the person who is responding to the survey is observing.

And, you know, at least speaking from my own anecdotal experience of inpatient psychiatric care at our own hospital, parents aren't observing a lot of what actually is occurring.

MEMBER STILLE: Okay. I think we're discussing one of those later on, as a matter of fact.

CO-CHAIR MERLINO: Becky, did you have a question? No?

DR. PACE: So the other thing that we look at under validity, of course, are the

threats to validity and the case mix adjustment, and you brought up the exclusions, which is good. We didn't really receive any other exclusion analysis. I guess there were no other exclusions that were significant.

DR. TOOMEY: So, once again, I think, as with when you look at the exclusions, it's very hard to do an analysis, because we're not privy to who gets excluded at the hospital level.

DR. PACE: So could we go to their case mix adjuster table, table eight? And maybe you could just run us through the items across the top, or the things that are included in the case mix adjuster, is that correct?

DR. TOOMEY: All except for the last two. We gave two examples of case mix adjusters that we considered but didn't end up including. Once again, as you all know, one of the key tenets to having a good case mix adjuster is that it's associated with the

outcome. We obviously have 18 outcomes in the context of this measure, or even more if you look at the individual items. And so given that that's the case, what we tried to do is to summarize how we approached choosing our case mix adjusters.

So the first, which is probably the most important for the purposes, is to look to see how important each of these different characteristics were, in regard to their strength of association, with the number of outcomes that we have. So as an example, patient health. So this is the respondent report of child's patient health. All 39 of the sort of key items that go into sort of the composite and single-item measures had a very strong association with patient health, and that is very different.

If you go over to the right side of the table to patient gender, 36 of the 39 were not statistically significantly associated with the outcome. So this helps

guide us in thinking about what characteristics are important.

And then the other two analyses that we did was to look to see what the effect was or how much difference there was based on those across hospitals. And here, although that is a traditional way of thinking about, sort of, the importance of those for case mix, what you have to understand also is that, if there isn't a lot of variation among those characteristics in different hospitals, we're not going to see a lot of response.

So the fact that, statistically speaking, there wasn't a huge effect is not necessarily a bad thing about the case mix. It's just saying that the patient mix is actually pretty similar across the hospitals.

DR. PACE: So just one question. Why did you focus on the individual items versus the scale, in terms of looking at the effect of the case mix factor?

DR. ZASLAVSKY: This goes to the

way that we calculate the summaries. We actually analyze each item separately and then put them together at the hospital level, rather than creating composites at the individual level. And we're forced to do that because, within the same composite, there might be items that are answered by different subsets.

So maybe there's one item that's answered by 95 percent, and another one is answered by only 70 percent because it doesn't apply to them. And so you wouldn't go to create the individual composite to do the regression, so we actually calculate case mix adjustments in each item separately and then put them together. That's standard procedure for all the CAHPS surveys.

CO-CHAIR MERLINO: Any other comments on validity or questions? Are we ready to vote? Okay, let's vote.

MS. ALLEN: We are voting on validity. One high, two moderate, three low,

four insufficient. Voting starts now. All votes are in. Results: fifteen high, two moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: Moving on to feasibility. Anybody want to comment about feasibility?

CO-CHAIR PARTRIDGE: If those of you who looked at this in-depth said you're satisfied, just for the record, it would be better to say that before we vote, so that there's something that says we looked at it and it was fine.

MEMBER STILLE: It seems fine. It's not unduly long. You know, there's good understandability.

CO-CHAIR MERLINO: Anybody else from the peds world? Katherine? Any comments? Lisa?

MEMBER MORRISE: I have had several parents, knowing that I was involved in this work, suggest that the length of the survey is actually very long. And we've also

had parents suggest that they only answered if they're mad about something. They only answer it if they're mad about something.

CO-CHAIR MERLINO: Do you guys want to comment?

DR. TOOMEY: Sure. I guess I can comment. One is there have been studies done that have shown that response rates don't vary based on the length of the survey itself and that we are definitely in the realm of the length of many other patient experience surveys that are out there.

In addition, we actually, the last item, which you might or might not have seen, is getting to both free text to write stuff in, and we had extremely positive responses for many, many hospitals in regards to their care. And if you look, I mean, there certainly are a lot of people that are reporting, overall, a very positive experience with their care. So it would seem that our testing would suggest that there are people

who have had positive experiences that are also responding.

MEMBER MORRISE: Just as a follow up, the parents that I work with have chronic complex children and are frequent fliers. And both for the adult survey and I believe this one, the more often you have care the more likely you are to rate them lower. And so I think that plays into that.

Also, they don't have as much time as other normal parents because of the complexity of their children's care.

CO-CHAIR MERLINO: We were also one of the pilot sites, and I think that we were using the standardized vendor survey before we did the pilot. And it's pretty long, as well, and I didn't think it was much different. And I think if you look at pediatric hospitals across the country, I'm certainly not an expert, but I think most of them deploy some type of survey.

MEMBER STILLE: Yes. You actually

brought up a thought. We were discussing yesterday whether eventual case mix adjustment for complexity might be an interesting idea, and I don't think too many of the existing surveys have that. But as complexity measures get better, we might want to think about that for round two.

DR. TOOMEY: Definitely, thank you.

CO-CHAIR MERLINO: Any other comments, questions on feasibility? Let's vote.

MS. ALLEN: We're voting on feasibility. One high, two moderate, three low, four insufficient. Voting starts now. All votes are in. Fourteen high, three moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: Moving on to usability and use, again, I think the same comment applies. I think most pediatric hospitals are using some type of survey, so it's just a matter of plugging this in where they're already using something.

DR. PACE: So this is a question, because there was nothing in the submission form that indicated the plan for this being deployed or required. And so, you know, as has already been noted, a lot of hospitals have their own, so what's the plan that this will be used, or is there a plan yet in terms of --

DR. TOOMEY: So I think there's several pieces to that. I can speak to our own hospital, and they are using it now in one of their contracting with one of the major insurance companies at our hospital. When you go beyond that, as I was saying, all of our materials are being prepared for the AHRQ CAHPS website, and they'll be available and up and running. And I know that several of the vendors are waiting for those materials to be formalized so that they can start to develop sort of support materials around that.

In regards to the actual submission, so we submitted to AHRQ and CMS.

They are coming up with a process for which they will be evaluating it in the context of whether it gets adopted for the core measure set, which, you know, for our population, obviously CMS or Medicare isn't as important as Medicaid. And so what the core measure said is is it's a set of measures for which the CMS strongly recommends that states use in their state Medicaid programs.

As was mentioned, nearly every hospital around the country that services kids in any volume are doing some type of patient experience survey. And from our perspective, you know, many of the hospitals that have participated in our field test are continuing with that, and there's certainly many steps that are moving forward, in regards to adopting and uptake.

CO-CHAIR PARTRIDGE: I just want to add a postscript. The partnership, the National Partnership, and I personally was involved in the development of the legislation

that much of the funding for this project, which is part of the CHIPRA re-authorization of 2010. And I believe that legislation, going forward this year perhaps, we hope, will continue that effort and the updating of the core set of Medicaid-recommended measures will incorporate this product. We're very excited about it.

CO-CHAIR MERLINO: Any other comments, questions? Let's vote on usability and use.

MS. ALLEN: Voting on usability and use. One high, two moderate, three low, four insufficient information. Voting starts now. All votes are in. Twelve high, five moderate, zero low, zero insufficient information.

CO-CHAIR MERLINO: Okay. Moving on to overall. Any comments overall? Let's vote on overall suitability for endorsement, yes or no.

MS. ALLEN: We're voting on

overall suitability for endorsement for measure number 2548, Child Version CAHPS. One yes, two no. Voting starts now. All votes are in. Seventeen yes, zero no.

CO-CHAIR MERLINO: Thank you.

MS. DORIAN: Okay. Now we are moving on to 0725, the Validated Family-Centered Questionnaire for Parents' and Patients' Experiences during Inpatient Pediatric Hospital Stay from the Children's Hospital of Boston. And so could the developers come up to the table? Great. So we have Sonja Ziniel. Do you want to just introduce yourself and the measure briefly, please?

DR. ZINIEL: Good morning, everyone. My name is Sonja Ziniel. I'm a senior survey methodologist in the program for Patient Safety and Quality at Boston Children's Hospital and I'm also an instructor at the Harvard Medical School.

We started to develop this survey

in 2008 at Boston Children's Hospital out of a situation where we used a previous survey that was also developed at Boston Children's Hospital by Charles Homer, called the Picker survey. And if you're in the realm, most of you will know that. And we weren't able to really show improvement with regard to quality initiatives anymore. We literally had ceiling effects on most of our measures with 80 percent or more that strongly agreed to said always to certain questions.

So we decided to basically try and develop a survey that was more sensitive to be able to measure change. So we did -- very similar to the Child HCAHPS, we had focus groups at Boston Children's Hospital only. We did cognitive interviews. We developed the English survey. We have a Spanish translation, that is not validated, though. The survey was validated first at Boston Children's Hospital as mail and phone survey, so we randomly assigned the data collection

mode to whoever got the survey to be able to estimate the effects.

Once we had validated the survey and shortened it from 90 items, like 90 content items to about 38 items, we validated it at 22 hospitals, only in the mail version due to funding across the U.S. Thirteen hospitals of those were freestanding children's hospitals, and the other were pediatric units in adult hospitals.

The survey includes eight composite measures and five individual overall rating questions. In the application, I split exactly out how they fall in this survey, as well as a number, of course, of demographic items.

The survey was also designed to be used in the modular approach with this survey to be a core. It will be continuously administered and then, having modules such as the ICU, the emergency department, surgery, depending on the applicability for each

person, to rotate these modules to provide more detailed information for each of the services while still have an overall measure of patient experience in this shorter main module.

So I mentioned a few of these modules that we have started to develop. One module that we had planned, and I recently received internal funding for is actually an adolescent module, so I'm very pleased to hear that you and me both think that that's really important to get, really, the feedback of the adolescents themselves.

We are using it right now at Boston Children's Hospital for our internal measures. We also report it out to the Children's Hospital Association.

CO-CHAIR MERLINO: Comments? Evidence.

DR. PACE: So I think there wasn't a lot put in the evidence submission form, especially correlated to each measure. Some

general information but, again, kind of the situation we've been in on several of the submissions, you know, for you to think about whether these are measures that the hospital can influence. And based on the categories that we've seen, that probably seems reasonable. But any comments or thoughts about that?

DR. ZINIEL: I'm happy to provide more specifics during the public comment period, if that's desired.

CO-CHAIR PARTRIDGE: I wonder if it would be helpful, before we go through it step by step, just to talk for a minute about to what extent is this survey distinct from the pediatric Child HCAHPS version that we've just been through.

DR. PACE: Yes, if you would just maybe make a brief comment now because, basically, just for everyone to kind of -- because we didn't end up doing this yesterday, but, in terms of our competing measures and

harmonization, we first look at each set of measures individually, and then definitely we'll need to, if they're both recommended, then come back and look at if they're competing, if one has superiority for one reason or another, but maybe make a brief comment now and then we'll come back to that.

DR. ZINIEL: Yes. I mean, it's obvious that they measure the same construct with regard to patient experience. There are slight differences in terms of, for example, our survey doesn't have any questions that ask parents about what their teens or children, basically, were thinking. We have some questions in there that we call emotional satisfaction that are derived off the Six Sigma concept.

So there are, like, slight changes. But, in general, it's obvious it measures the parent experience from the parent point of view from a pediatric inpatient stay.

The main differences, I think,

beyond that is that it has a modular approach which allows really to or provides the opportunity for hospital to rotate modules in and out, which gives services the opportunity to add questions on a fairly quick basis, and basically provide more information and still have, at the same time, information about the overall stay.

The other thing is the response scales in the HCAHPS are generally four point, staying with the HCAHPS survey concept. Our goal was really to break out of that because we could not measure our hospital's improvement with that type of scale. So our goal was really to try and break that, to have sensitive measures that actually allow to measure improvement.

CO-CHAIR MERLINO: Chris?

MEMBER STILLE: Yes, I spent a lot of time sort of taking a look at both of these, and I think they're just different. There's more detail in some of these, the

areas on this survey, for example partnership with nurses and partnership with doctors. So I think it could be more useful, in some ways, potentially.

MS. DORIAN: Just to note, we do have an agenda item at 10:45 to discuss these --

MEMBER STILLE: Okay. So we will spend more time on that. I just wanted to do open that up to people's thinking. Okay.

CO-CHAIR MERLINO: Any other comments on evidence? Okay. Let's vote on evidence, and then we can get more granular on some of the other topics. Lisa?

MEMBER MORRISE: I just want to say that I think that the rationale exists for implementation of both because they would be used differently within the context of how the facility operates.

DR. PACE: Right. And those are the things we'll discuss when we talk about them together, but we really need to focus on

this one --

MEMBER MORRISE: I guess what I'm saying is I think there's value in this one specifically because it addresses two very key areas, nurses and doctors and their communication and relationships with their patients.

CO-CHAIR MERLINO: Okay. Let's vote, and then we can --

CO-CHAIR PARTRIDGE: I was just going to tie that into this particular vote. I think Lisa's comment, in a way, addresses the evidence issue. Okay.

MS. ALLEN: So we're voting on evidence. One yes, two no. Voting starts now. Sorry. Please vote again. Perfect. All votes are in. Sixteen yes, one no.

CO-CHAIR MERLINO: Okay. Let's move to performance gap. Comments about performance gap?

DR. PACE: So let's go to the submission form. I don't know that we were

provided any information about the performance on this measure.

DR. ZINIEL: Can I comment on this? So we provided a table with regard to the hospital level that's called performance measure score validity testing, and it's in the testing supplement and it shows for each of the domains the scores of the different hospital facilities that had at least 30 surveys and the range across the facilities. We also provided, in an Excel sheet, data from nine quarters from Boston Children's Hospital only because we have only the data across nine quarters from our own hospitals, including improvement initiatives we had and the impact we saw on the scores.

DR. PACE: Nadine, can you open up the measure testing -- okay. It's under the facility level. Okay, I see it.

DR. ZINIEL: 2B 2.3.

DR. PACE: Okay. It's in the measure testing attachment. Those of you who

are looking at this online -- yes. So good, okay. So here you see the facility coded by different letters, and these are the scores for those facilities on the eight of the thirteen measures.

DR. ZINIEL: Basically, the composite is correct.

DR. PACE: Right, okay.

CO-CHAIR PARTRIDGE: The emotional satisfaction lines got a lot of variation.

CO-CHAIR MERLINO: Any comments about performance gap? Dawn?

MEMBER DOWDING: Could I just ask for you to talk through the sample on which this was carried out? Because I went through some of the detail and it seems like -- is there any ethnic disparity? Because your sample is predominantly white, non-Hispanic, so are there any disparities that you've identified in this small group of patients who aren't white?

DR. ZINIEL: With regard to the

overall scores?

MEMBER DOWDING: Yes.

DR. ZINIEL: So there are measures and we, again, submitted an Excel spreadsheet that provides all of the details by domain. There are measures that show ethnic disparity. There are measures that don't.

So across time in Boston Children's Hospital, there is also not a consistent trend in terms of if, for example, Caucasians compared to non-Caucasians rated better or worse. It can actually even change across the quarters.

MEMBER LINDBERG: I'm sorry. Could you just clarify that? Are you talking about it could vary between the different elements of the questions that we just had up there, the eight examples? Are you saying some non-Caucasians might score higher in one area and lower than Caucasians in another?

DR. ZINIEL: Yes. So there is not consistency across the different domains, and

there is also not consistency across time. So for example, I'm just giving an example made up, like one quarter it could be that Caucasians scored higher in partnership with nurses than non-Caucasians, whereas in the next quarter it could be, you know, the difference could be less or even slightly reversed.

CO-CHAIR MERLINO: Any other comments on performance gap? Should we vote? Let's vote.

MS. ALLEN: Voting on performance gap. One high, two moderate, three low, four insufficient. Voting starts now. All votes are in. Results show nine high, six moderate, two low, zero insufficient.

CO-CHAIR MERLINO: High priority? Comments about high priority?

MEMBER STILLE: This seemed to be developed, sort of, from the ground up through parent focus groups, rather than a priori with any other stuff, so I thought that was a good

thing about it. Any emphasis in the number of questions seems to be along those lines, as well, so --

CO-CHAIR MERLINO: Any other comments?

MEMBER BEVANS: I generally agree with that, but I may be missing some information. But it seems like there were only ten families involved in the focus groups, is that right? In the initial development?

DR. ZINIEL: That's correct. In the initial development, we had a committee formed at the same time that included parents, physicians, and other stakeholders at the hospital to ensure that, from a parent point of view, it was questions they could observe but, from a stakeholder point of view, the questions were such that there actually could be action taken to improve the performance and make the measurement more sensitive.

MEMBER BEVANS: Okay. And prior

to asking about or debriefing on the specific questions, is it true then that you asked folks to, sort of, help to conceptualize the key elements of high-quality patient experience?

DR. ZINIEL: Yes.

MEMBER BEVANS: And all of this was done at Boston?

DR. ZINIEL: Yes.

MEMBER BEVANS: Thank you.

CO-CHAIR MERLINO: So you're currently, this is currently in place at Boston? You use this for all discharges?

DR. ZINIEL: Yes. So far, we were validating HCAHPS at the same time, so, basically, our discharges were split between going to HCAHPS and going to the survey, but we kept the survey throughout, because we had implemented it as our new survey after the Picker survey.

CO-CHAIR MERLINO: And you used this for improvement? You actually saw

process improvement as a result of it?

DR. ZINIEL: Yes, we did. So I outlined some improvement initiatives we had with regard to, for example, identifying the attending physician, which was pointed out by parents, a big problem in teaching hospitals or, basically, in our hospital. So we had some improvement initiatives, and we saw increase of scores.

CO-CHAIR MERLINO: Any other comments about high priority? Dawn?

MEMBER DOWDING: Just following on from my previous comment, if you only included ten families, how can you be certain that the issues that they raised as important are relevant for families across the board? So for instance, in those ten families, did you include anyone who was a non-native English speaker, for instance?

DR. ZINIEL: So we had two non-native English speaker among those that spoke, though, enough English to participate in the

focus group. Again, we have a Spanish translation, but we have not validated that. And the main reason for that was, basically, funding because we funded it internally. So, basically, we had to sort of focus the number off of patients we could recruit to provide estimates for the English version.

CO-CHAIR MERLINO: Lisa?

MEMBER MORRISE: It almost seems to me as if it's a patient and family advisory council that was like your focus group and that some of the measures that you introduced were the kinds of things that may come out of that, versus across-the-board quality measures. Things like the parents in an advisory council may say they don't know who their physician is that is coming into the room. They also don't know what a pharmacist is. I mean, there's a lot of things that can come out of talking to them and then measures that can be implemented. I'm not sure it's the same thing as quality measures across the

board.

I do see it, as we suggested earlier, as something that helps in terms of the physician relationship and the nurse relationship. But I'm feeling like somehow it's not exactly getting at the quality areas that are important in a hospital setting. It's more a communication type of piece.

DR. ZINIEL: So to clarify, the families were recruited from the floors. They were not part of the family advisory board because the family advisory board was part of the kind of stakeholder group, together with physicians and nurses that were also on there to then kind of select the questions and get feedback.

What we heard in the focus groups with regard to the attending physician was we didn't call it, necessarily, attending physician but we asked them if they knew, like, who the physician in charge was. And especially people who had children with

complex chronic diseases complained that they had problems knowing who the go-to person was.

MEMBER MORRISE: I'm not sure, honestly, if the physicians who are working on a child in a complex chronic case know who the go-to person is either.

CO-CHAIR MERLINO: Becky?

MEMBER BRADLEY: Yes. I guess I'm just a little curious as to why you limited your research to Boston if the goal is to address a national health issue. Why were you so limited in the population that you chose to --

DR. ZINIEL: So when we developed it, we used only Boston Children's Hospital due to the funding situation. Again, it was internal funding. We then validated it on a national level, recruiting hospitals through the Children's Hospital Association.

MEMBER BRADLEY: Okay. And then also some of those hospitals that you recruited, though, didn't stay in the study,

they didn't actively participate. Do we know why they dropped out or why they --

DR. ZINIEL: Yes. NRC Picker decided to force their clients to a four-point scale in anticipation of the implementation of HCAHPS, and that's why clients who would have liked to continue on PIES ended up not using PIES anymore.

MEMBER BRADLEY: Because they were already using another tool or --

DR. ZINIEL: No, because they were forced to use the four-point scale in anticipation of the implementation of HCAHPS.

MEMBER BRADLEY: Thank you.

CO-CHAIR MERLINO: Any other comments on high priority? Let's vote.

MS. ALLEN: Voting on high priority. One high, two moderate, three low, four insufficient. Voting starts now. Please vote again. Voting starts over. Thank you. All votes are in. Results show nine high, three moderate, four low, one insufficient.

DR. PACE: Okay. In terms of reliability, you know, we also look at specifications, are they precise? And in this case, just to also keep on the table a difference is there's no case mix adjustment on this particular set of measures. One question I had maybe you can clarify. Your sampling instructions say random sampling or census. So what do you mean by census?

DR. ZINIEL: So, basically, if you have a small hospital that doesn't have a lot of children, in order to get a number of surveys back that is sufficient to actually provide some data, you might need to send the survey --

DR. PACE: To total all --

DR. ZINIEL: Yes.

DR. PACE: Okay, all right. Thanks. Okay. So now we'll get to the testing, and let's go to the testing form. So testing was done at the parent level instrument, at least submitted, and we have,

if you look under 2A 2.3, there's a table that gives the Cronbach's alpha. And we'll just have to clarify, because you also have an ICC reported, but that's a test-retest. Is that also parent level?

DR. ZINIEL: Yes, that test-retest was only done at Boston Children's Hospital. We did not administer the survey twice on the national validation level.

DR. PACE: So here we have -- Nadine will bring this up in a minute. If we look at the -- so this is a good example here, just for people to understand, is that when you have a single-item measure you can't do a Cronbach's alpha internal consistency because there's only one question. And we saw some measures in the CAHPS group where they just didn't report any patient level reliability. So here test-retest is a way that you can get at reliability of a single-item measure, and we see the scales.

So we can look at the -- can we

get to the 2A 2.3? There we go. Okay. So if we scroll down, I think these are all reasonable Cronbach alphas. So the question would be about the communication about medications. That internal consistency is 0.55. Do you have any thoughts about that?

DR. ZINIEL: So the value of Cronbach's alpha is also dependent on the number of items that are within a domain. So the more items in a domain, the higher Cronbach's alpha, automatically. The communication about medication domain has only two items, and the two questions are about if they were explained what the medications were for and the side effects. So while they are conceptually related, they might not necessarily get at the same exact thought. So that's why I think the Cronbach's alpha is 0.55.

DR. PACE: So we didn't see any report of reliability at the computed performance score level, so do you have that?

DR. ZINIEL: So we basically did, on the national validation, a confirmatory factor analysis that basically showed that exactly these domains --

DR. PACE: Right. So the factor analysis just kind of, again, like you said, shows these domains. What we're looking for is some type of signal-to-noise analysis, inter-unit reliability, so that when you look at those computed hospital scores that you can distinguish signal from noise or differences versus within hospital --

DR. ZINIEL: Yes, I'm happy to provide that. I can definitely provide that.

DR. PACE: Okay. All right. Dawn, do you have a question?

MEMBER DOWDING: Yes. I just have a question about response rates because, it seems to me, apart from the exception of one facility, your response rate for the questionnaires is way below 40 percent. You gave out 2,500 surveys in one hospital and got

221 back, which is a response rate of 8.7 percent. So I wonder if you could just comment on why you think the response rates are so low, and then what effect that would have on the reliability of calculating differences between hospitals or units.

DR. ZINIEL: So most of the hospital, like the problem we ran into, which HCAHPS ran into to a certain extent, as well is that the pediatric population is limited. In terms of -- we have, for example, at Boston Children's a rule that if you send out a survey to someone, that family cannot get another survey for six months. So at one point, the population really shrinks down and people are over-surveyed because they continuously get these surveys, especially, of course, the one with children with complex chronic diseases that are in the hospital at the same time.

So this was one of the problems, basically, that we faced where hospitals said

they still were administering their old survey and put leftover sample into our validation. So I'm not very surprised about these response rates. If you look at surveys in general, for mail surveys it's a very normal response rate, unfortunately.

CO-CHAIR MERLINO: Any other comments? Is that --

DR. PACE: So where we're at right now is similar to some things we encountered yesterday is that we just have the testing at the one level, though Sonja says they can provide that. So according to our scale, actually we don't know what the reliability says. So to be consistent with where we were yesterday, that would be insufficient information. Is that -- any analysis -- you don't have it handy. It's something you would have to do?

DR. ZINIEL: Yes.

DR. PACE: Okay. So it is something that you could do within our comment

period?

DR. ZINIEL: Yes.

DR. PACE: Okay. So what's -- we should have the --

CO-CHAIR PARTRIDGE: I think probably follow the procedure we did yesterday and -- well, first we should probably vote. And if we conclude that four or three and four seem to have the majority of support of the Committee, then it would be deferred.

DR. PACE: All right. Any other thoughts about that? And, Sonja, I don't know if you listened yesterday, and I know we've mentioned this on some of our calls that the guidance that came out of our PRO project several years ago, and that the reason we asked for reliability and validity at both levels is that for patient-reported outcomes, experience with care being one of them, that we ask for reliability and validity of the patient-level or parent-level instrument, as well as the computed performance score. And

so that's --

DR. ZINIEL: Per hospital then?

DR. PACE: Yes.

DR. ZINIEL: Yes. So, I mean, I can tell you that we were able to distinguish between hospitals on a number of domains. I'm happy to provide all of that.

DR. PACE: Okay. So what the Committee will do now is to vote on this just so that we have it for the record. And then you will have an opportunity during the comment period to submit that for the Committee to take a look at to proceed. And why don't we vote on this then?

MS. ALLEN: Voting on reliability. One high, two moderate, three low, four insufficient. Voting starts now. All votes are in. One high, three moderate, one low, twelve insufficient.

DR. PACE: Okay. And before you go, I know that this would normally end where we're discussing, but I think it might be

worth to just look at what they submitted for validity of the patient level just so we know that she can submit the performance score level. But let's just take a look at this just to see if there are any questions.

So there's a couple of things that they did. Let's see. They did content validity of the parent-level instrument. And then, in terms of testing, the table -- I think you had it up a minute ago -- of the construct validity where you did the correlations of the composite level parent-level scales to the overall. And I don't know if you want to mention any of these. It looked like this identification of attending physician one, if you look at that row, fairly low correlations to the overall, if you want to make any comment about that. And then I guess the admission one, there was some low ones.

DR. ZINIEL: Yes. I mean, I think what, for us, was really satisfying was to see

the high correlation with regard to the emotional satisfaction, which looks at, if you looked at the item, kind of the attitude of stuff and people feel the hospital delivers on its promise, which is sort of kind of this emotional level, and basically the high correlation with that and the various overall outcomes.

DR. PACE: Right. And what about the, do you have any thoughts about the identification of attending physician in terms of its low correlation with the global items? So 0.26, 0.23. Okay.

DR. ZINIEL: I'm not . . .

DR. PACE: Okay.

DR. ZINIEL: I believe that's what it is.

DR. PACE: Okay. And are there any questions for Sonja about this or any concerns so that, when she does bring back the performance measure level, that she can --

MEMBER LEVINE: I just have one

question, a general question. In pediatric hospitals or pediatric units, are hospitalists as prevalent as they are in adult centers? Is that part of the problem of identifying who the attending is?

DR. ZINIEL: I'm not 100-percent sure. Based on the parent feedback that we got, it's really kind of the attending versus resident problem. Or fellow.

MEMBER STILLE: There are two issues. One is, like you said, attending versus resident or fellow, and sometimes how old they look. But in addition to that, many of the hospitals, I'm guessing, tertiary care hospitals where there's a number of different doctors, all of whom may appear to parents to be running the show at one point or another.

CO-CHAIR MERLINO: Any other comments or questions? All right. Thank you, Sonja.

CO-CHAIR PARTRIDGE: Well, I was just going to say, Chris, since you did a

careful look through of the two surveys, are there any other questions? While Sonja is here, are there any other questions or issues that you want to raise?

MEMBER STILLE: I think they've pretty much been raised. You know, the two little problematic content areas have been addressed. I think it's just a matter of getting the complete psychometric data that are needed for this, really, and then we can talk about harmonization a little bit later on.

DR. PACE: I think we'll probably still, after our break, have a brief conversation about competing measures. And before you go, I think one of the key things, in terms of NQF endorsement, is under usability and use. It's being used primarily in the Harvard Pilgrim payment program, and it's not publicly reported.

DR. ZINIEL: So we reported to Children's Hospital Association. They have a

whole system measure where the member hospitals report out their scores, and that's not publicly available but it is available to all members that submit these scores.

DR. PACE: So, I know I went to the website, and there's no way you can --

DR. ZINIEL: Yes, you have to be a member hospital because there is the agreement that, basically, there is benchmarking among the members but that it's not officially or publicly reported out.

DR. PACE: All right. Okay. Any other questions? And then we'll, I guess time for a break and then we'll come back and we'll have at least -- oh, go ahead, Brian.

MEMBER LINDBERG: Yes, just to clarify that, if I would. I mean, are you saying that won't change, that this won't be publicly reported? You have no intention of making this a publicly-reported set of data?

DR. ZINIEL: So we have discussions at our hospital level to publicly

report the data on our hospital website, so that is actually ongoing.

MEMBER LINDBERG: Thank you.

MEMBER STILLE: So with the benchmarking within the Children's Hospital Association, is that reported on their website? Because that's a pretty big group of hospitals.

DR. ZINIEL: So it's only reported for the members. So, basically, the agreement that they have is that we share data among the members --

MEMBER STILLE: Oh, so it's only within CHA? Okay.

DR. ZINIEL: Yes, exactly. So, basically, all the members within CHA can see the data but not any one outside CHA.

MEMBER STILLE: And then with Cincinnati Children's, do you know if they report that publicly? Because they tend to be a pretty transparent bunch.

DR. ZINIEL: No, I'm sorry, I

don't.

MEMBER STILLE: Okay.

CO-CHAIR PARTRIDGE: I'm not quite clear on the answer to the previous question. Does the Children's Hospital Association publicly report the national benchmark?

DR. ZINIEL: They calculate a benchmark --

CO-CHAIR PARTRIDGE: They calculate a benchmark --

DR. ZINIEL: -- data but --

CO-CHAIR PARTRIDGE: That's right. And they don't identify what each individual hospital's scores were, but I wonder if they make public the benchmark?

DR. ZINIEL: I don't think so.

CO-CHAIR PARTRIDGE: Okay. Because sometimes associations do. They'll make the benchmark public but not the underlying data.

DR. PACE: So, basically, I mean, and we'll have this discussion, at least a

brief discussion, even though we don't know exactly where this will end up while we're here and have these both fresh in your minds to have some discussion about the differences and things to consider. I mean, basically, neither one is publicly reported at this point.

But why don't we take a break?

MS. DORIAN: Why don't we take a break until 10:50 and meet back here?

(Whereupon, the above-entitled matter went off the record at 10:36 and went back on the record at 10:52 a.m.)

MS. DORIAN: Okay. We're going to go ahead and get started again so if you could take your seats, please.

So although the last measure -- oh, if the developers could come back to the table, that would be good. You can be part of the conversation.

DR. PACE: Yeah, from both --

MS. DORIAN: 2548 and 0725. Although the last measure isn't officially recommended, we're still waiting on information. We thought it would be good since you're all here to have this conversation anyway.

Just some background on related and competing measures. This is a difficult and complex area for NQF. We've been trying to update and improve our processes.

One of the big changes that has occurred within the last year and a half, I think, is that NQF initially reviews the measures portfolio and identifies measures inside the related or competing.

And related measures are measures that have the same measure focus or the same target population, but not both. And competing measures have both the same measure focus and the same target population. So we asked for related measures for the sake of end users so results are as comparable as possible

for the specifications to be harmonized.

In other words, if two measures are measuring a similar area and one is 18 and up and one is 16 and up or something like that, we would want the measure developers to harmonize those specifications or explain why that wasn't possible.

Competing measures, which come to us less frequently, but these measures we have identified as competing because we consider -- but we would like to hear from you whether you agree. We consider that they have both the same measure of focus and the same target population.

Usually in our process if both measures are reviewed individually and both are recommended, at that point we would ask that you compare the specifications and the differences and choose a superior measure or that the measure developers really explain why again both are needed and that you agreed to that.

I don't know if you want to add anything.

DR. PACE: I'll just say it's not just a matter -- I mean, we start with looking at the specifications in terms of the differences but there are some similarities. But it's really looking then through the criteria.

Generally they are not going to be different on the importance criterion because if they are really targeting the same basic concepts, that will be similar. But are there differences in reliability and validity? Are there differences in feasibility? Are there differences in use and usability?

So to the extent possible we ask the steering committee to identify which competing measures should move forward as a recommendation for endorsement. It is something that there's a couple ifs.

First of all, if on this last measure they submit the testing of the

performance measure level and if you end up recommending -- you know, saying that measure meets the criteria, then we would have another conversation with you about whether you could selected one over the other, thinking about the various criterion and how they met the criteria and, again, thinking that we're asking you to make recommendations for national consensus standards and how to measure performance in a particular area.

We thought with both of the developers here, if there were any particular questions that you had that you wanted to bring up, we'll take a few minutes to do that but kind of we'll have to -- we'll take a few notes but just thought this would be an opportunity if you have any questions for the future if we get to that.

MS. DORIAN: And just to note in terms of process, another change, because this used to be done quite haphazardly, we do now reach out to developers prior to the in-person

meeting and request an initial sort of response, and so the developers have sent those to us. They are comprehensive. They are on your SharePoint page. But maybe before we open it up to questions, if you could both briefly describe your response to these being identified as competing.

CO-CHAIR PARTRIDGE: We'll start with HCAHPS because you presented first.

DR. TOOMEY: Great. Thanks. So I think that one of the key things just to mention about Child HCAHPS is that we started from the beginning to the end with the focus of developing a measure for national use.

All of our testing from the very beginning of doing a Federal Register Notice and redoing surveys, et cetera, focus groups, cognitive interviews, has been done throughout the country both in English and in Spanish.

If you look at the statement that we provided, I think we tried to highlight some of what we think are the key distinctions

between the two surveys. The first one, which it sounds like Sonja will be providing, is looking at hospital level reliability.

From our perspective when thinking about a performance measure, it is really important, and perhaps the most important, to be able to identify that the signal that you're hearing in terms of differences that you're seeing across hospitals, is related to the qualities of the signal rather than the noise, or within the hospital sort of differences that you're going to find so we were able to provide that information.

A second point of difference for us is the case-mix adjustment. From our perspective, once again when you're trying to compare hospitals case-mix adjustment is critical and ours has a case-mix adjustment model that we have thoughtfully tried to develop. The other measure does not include a case-mix adjustment model.

In terms of performance

measurement itself, and from what we could find, we were able to demonstrate that hospitals do statistically better or worse on the measures and provided that information, referred to it in the measure testing form, and then provided additional information in our appendix.

In terms of some other issues -- then I guess one other thing in regards to the development itself that was actually brought up during our talk is the end-user testing component of our measure development process, which we found extraordinarily beneficial in being able to get the input of parents on both our composites and on our labels and our groupings.

We also have highlighted in our document some of the differences in regards to the surveys themselves when you look at the survey development. First of all, in regards to screener items, there's been some extensive literature looking at whether or not it makes

sense to have screeners or have a question for which you then enter into answering other questions.

An example would be we have in our survey, did you push the call button? Before you answered did people respond to the call button in a manner that was -- I'm not getting the question exactly right, but the notion being that there is an item for which you enter into the item and only at that point are only the people for whom that experience was had are the ones that are answering the item.

There are other ways of doing it which are called sort of non-applicable skips and/or through embedded skips which are options within the item itself and CAHPS Consortium among others have done extensive work looking at whether or not those are as good of a way of having people answer so it does cut down on the number of items.

But what they find is there's actually more people that don't answer

appropriately the question because they either don't see the embedded skip or they see the embedded skip and are misreading it and think it might apply to them.

I guess I'll just say in regards to response scales, Sonja did point out that we are harmonized with the adult HCAHPS and use a four-point response scale almost throughout most of the survey. We have one additional response here that we often use which is yes, definitely yes, somewhat, and no.

And we feel from a survey development perspective it's better to have fewer response scales, rather than more, because of the cognitive burden to the respondent. Our survey in comparison to the other has many fewer response scales that are used uniformly throughout the survey.

I guess the last point I'll make is that when you compare sort of the domains at a domain level what domains we include in

our survey versus what's included in the other survey, they are very similar. There are three particular domains that the patient experience survey has that we do not.

In response to those we have written, but we did attempt in regards to the issue around having a main doctor to have an item regarding that in our survey. After extensive cognitive interviewing, we were never able to ask the question in a way that we felt confident that parents weren't misattributing, knowing who was in charge.

A great example is that parents would say they knew who was in charge of their care and when we were able in cognitive interviewing to ask questions around that, it was very clear to us that they were talking about the resident rather than the attending.

Because one of the tenets of creating sort of a survey development tool like this is that you want to make sure that the questions are uniformly understood and

that they are questions for which people are responding in similar manners. We never felt comfortable that we could assure ourselves that people would not misattribute who they thought the main doctor was.

In regards to admissions, we agree that the admissions process is something that is very important in the context of the processes of care. However, once again, the start and end of admissions is very difficult for parents to understand, and we did not find that was a concept that parents uniformly understood in the same way.

DR. ZINIEL: Thanks so much for providing the opportunity to give a statement. Sara has pointed out, elaborately, the various differences. I would like to focus on two that I think differentiate the PIES from the Child HCAHPS.

The first one is the reason why it was developed. We developed PIES because we could not show any improvement anymore for

quality improvement initiatives. Our scales, amongst which are yes, definitely, yes, somewhat, no, a three-point scale.

We had ceilings effect of like 80 percent that checked yes definitely. It is really hard to improve on 80 percent and that is not necessarily a reflection of the people implementing -- designing or implementing the quality improvement, but an issue of sensitivity of the response scale. So that's my second point.

The response scales that we implemented were matched to the questions. That's why we have a number of different response scales because from a survey development perspective, it is more important that the response scale actually matches the question, compared to keeping a consistent response scale throughout the survey. If the questions are yes/no questions, it's really bad to provide a five-point answer or vice versa.

So, with that in mind, I would like to tell you a little anecdote when we developed our survey. We tested the questions Courteous and Kindness with Nurses. In cognitive interviews we asked them to think out loud how they would get to the answer which is a normal process due to cognitive interviews.

We provided them with a scale that was never, rarely, sometimes, usually, always. We asked them to think out loud and we frequently got the answer, well, you know, generally the nurses here are great but there was this one time the nurse must have had a really bad day.

On and on you get the whole story and then you say, what response option would we choose? The person would choose always, which doesn't reflect what they just told us. Right? They just told us that there was this one nurse.

From a quality improvement

perspective and we talked to these parents, why did you give always? Well, you know, you've been at Boston Children's for three times and, you know, in general, so I give you the benefit of the doubt.

Quality improvement initiatives do not respond to benefit of the doubt so what we added was an almost always. And when we did cognitive interviews with this new scale, we actually saw up to a 20 percent difference in people who checked always. We can improve on 20 percent. That's something where we really can show if a quality improvement initiative works or not.

So when we did that during our validation in Boston Children's Hospital, we implemented an experiment in the national validation and we used the HCAHPS scale for half of the people in our scale for the other people and we randomly assigned these scales.

Table 1 shows that the main scores of the different questionnaire versions, if

you scroll down the tables are down at the end, and you can see that there are some differences. Since then, we have also done more theoretical research.

Dr. Ozonoff from Boston Children's and myself on how response scales with more response options theoretically improve the sensitivity of the scale. We have, right now, implemented several different experiments in terms of the number of response scales, the number of response options, and the labeling of response scales.

If you go to Table 2, which is after Table 1, you can see that we had an experiment of the response scales to the question, how would you rate the overall quality of care your child received? We have a five-point response scale and a six-point response scale from poor to excellent on the five and poor to exceptional on the six-point.

If you'll look at the percentage of respondents randomly assigned to check the

top box, you can see that for the five-point response scale, 69 percent checked the top box for the six-point response scale 45.2, which is a difference of 23.8 percent.

For quality improvement measures, we feel that this will provide sensitive scales that allow people to actually measure if a quality improvement makes a difference.

That's why we think given that HCAHPS right now doesn't have any data available to show that their scales are as sensitive with regard to quality improvement and it basically has not been implemented. It's right now premature to consider them as competing. Thank you.

CO-CHAIR MERLINO: Comments?

MEMBER PARISI: I have a few comments. I have a preliminary comment, Karen, if you can clarify. What is the position as it relates to the regulatory requirement to implement a performance measure, because that does enter into the

feasibility and the usability of the instrument.

DR. PACE: It's actually one thing to consider in the mix. It's really to look at these measures across the criteria, but as far as we know right now, there's no definite plan to require the CAHPS and there's no definite plan of using the other measure in an accountability application, though it's currently being used in Harvard Pilgrim.

DR. TOOMEY: And ours is being used in the Blue Cross/Blue Shield contract.

DR. PACE: In what way?

DR. TOOMEY: In Boston Children's similarly in the development process and now sort of ongoing as we are moving into sort of more of an accountability phase.

MEMBER PARISI: Great. So I have two more questions and I'll be brief. The second one is in response to the various CAHPS surveys.

One of the things that continually

surfaces, in my experience, is that the person completing the survey frequently confuses the provider, be it the nurse, be it the CNA, be it the home health aid, the LPN. There's a lot of confusion. They see someone in the uniform and they respond to the nurse question or the physician question.

Is there any thought as to how that is going to be addressed? Particularly as we --- at some point I'm hopeful that we'll be evaluating patient experience across the continuum rather than in the silo, as that is the way we're moving in terms of care delivery. Any thought to that, or any way that's being addressed currently?

DR. SCHUSTER: For adult CAHPS attribution has been a continuing criticism of the process, especially with multiple adult physicians treating the same patient in the hospital. As far as I know there's nothing in place right now that they are looking at to modify the program but it is a problem.

DR. TOOMEY: The only thing I'd add for us is although we have the core questions for communication that do mirror the adult HCAHPS that are focused on nurse and doctor communication, interestingly we do get different responses, so they are giving two different groups of people that they are responding to.

The rest of our questions are actually about the provider more generally, in part for that very reason, that it was very hard for us to think that in a busy hospital setting that people were going to be able to distinguish necessarily between the nurse practitioner or the nurse or the doctor in coming in, so we do have a lot of questions that are based on providers more generally for that reason.

CO-CHAIR PARTRIDGE: Chris?

MEMBER PARISI: One last one. I need some statistical guidance on this.

Sonja, if I may call you Sonja,

what you had referred to is the ability to initiate a performance improvement initiative related to your data. Is it because there is more differentiation between the scales? Is that the major difference? Can you help me with that?

DR. ZINIEL: That's correct. So basically if you think about the distribution if you have a three-point scale, the distribution is much more skewed than if you have a five-point scale and the labels, the response labels which seem to play a significant influence, as we found out in our research, basically widens that distribution.

MEMBER PARISI: So it's more sensitive?

DR. ZINIEL: Correct.

MEMBER PARISI: Okay. Thank you.

DR. ZASLAVSKY: I would add that really what we're talking about here is liability. It's way after you see the consequences of liability. We don't know

whether statistically it's helping to distinguish among units to have those broader scales.

MEMBER STILLE: Yes, I had a couple questions for Sonja about the use and the testing of the PIES. You mentioned that -- I just need to get closer. Okay. A couple questions for Sonja about the use and the testing of the PIES.

You had mentioned that you see one of the unique uses of it as being able to be done modularly, with one module at a time. Can you talk a little bit more specifically about sort of how that's been implemented and how that would differ from it being used as a whole instrument?

DR. ZINIEL: We have the modules -- most of the modules developed. Some are still in development. At the same time, validating HCAHPS at the hospital the leadership decided to not field the modules at that point in time. What we have is we have

data on the core module but the way it was designed to be implemented was to basically -- - depending on characteristics in the medical records.

For example, if the person had an ED stay, that throughout the year a subsample of people would get this ED module, so that you still would have, throughout the year, answers for the ED module.

You could correlate with the overall survey but, at the same time, if each person, for example, only would get two modules, you would be able to hone in on specific questions that are related to the ED without overall burdening the respondent.

MEMBER STILLE: Okay.

DR. ZINIEL: Instead of having the respondent answer about the ED, the ICU stay, the surgery they had, the cleanliness of the hospital, they would randomly be assigned based on their hospital experience to one or two of these modules to keep the survey short

overall.

MEMBER STILLE: Okay. Great. And then, during the break we had talked a little -- a couple of us had talked about some of the validity testing in the other hospitals and the remarkably low response rate.

I realize that resources probably dictate a lot of what you are able to do in terms of getting a higher response rate, but are there any plans for more complete validity testing in some of these other hospitals and/or trying to figure out if there is a difference between respondents and non-respondents, that kind of thing, just to --

DR. ZINIEL: So I've started doing some non-response bias analyses for our hospital. I don't have access to data from any other hospitals. I would love to do end-user testing or additional focus groups as was recommended during the previous call at other hospitals. At this point in time, it's basically a question of funding.

MEMBER STILLE: Okay thanks.

CO-CHAIR MERLINO: Sherri.

DR. TOOMEY: Can I just add just two quick points about some of these topics, one of which there is actually a recent publication that came out from members of the CAHPS consortium that sort of compared head to head a four versus six-point response scale.

In that analysis they concluded that the four-point scale was -- that there was no significant difference in regards to the responses that they were receiving in those two, and that as a result, they are sticking with the four-point scale in terms of what their recommendations are.

It's certainly an area for which there has been active conversations and for which there is ongoing work in this area from that perspective. The only other thing I'll add in terms of the modular issue is that child HCAHPS, just like other CAHPS measures, has the ability to add in extra items.

It's done so in a uniform way so they are done always after the mean set of core items in the survey so that there isn't any issue in regards to when you change up the order of the survey, et cetera. Sometimes that can change a little bit how people respond.

There is no sort of problem at all including additional items in the survey and we actually do have some additional items that we will be eventually sort of hoping to get out there for supplemental items.

MEMBER LOEB: I was just going to echo as far as being able to say are you aware of who your main provider is, although there are tons of women physicians these days, they are still not accepted as much as men.

My daughter goes into the room numerous times, introduces herself as the resident, and the phone will ring and the patient will answer it. I can't talk now. My nurse is in the room with me. So, you know,

I'm not sure how accurate that question is, who is your main physician. Unfortunately that's going to take years and years to change.

CO-CHAIR MERLINO: Katherine.

MEMBER VAN ZYL: I know that the PIES survey doesn't excluded -- doesn't have as many exclusion criteria as the child HCAHPS, so I'm wondering if you got any data on child psychiatric admissions that the HCAHPS survey would not have and whether that was something that you stratified out.

DR. ZINIEL: I would have to go back to the data and link an identifier from if they were discharged or if they had a psychiatric stay, but I think I might be able for Boston Children's because that's only the access -- that's the data that I have access to to see if I can differentiate between the two.

MEMBER VAN ZYL: I'm just curious because right now nobody covers that, and so

one of the strengths of your survey might be that you are the one survey that captures psychiatric admissions in children where the HCAHPS does not. It may eventually, but right now it does not.

CO-CHAIR MERLINO: Katherine.

MEMBER BEVANS: It occurs to me, as you were presenting, that it seems to me, correct me if I'm wrong, that the intended purposes of these two instruments and the way you're thinking about using them in the future, are really quite different where the HCAHPS is, you know, designed for quality monitoring on a national level.

It seems to me, Sonja, that you've talked a bit about quality improvement and the initial development of your instrument really took place within the context of Boston. Are you intending -- are you thinking that the purpose of the instrument is more to be able to gauge change within a specific segment of your -- like within the hospital over time?

This purpose is different. It's kind of a quality improvement purpose as opposed to a quality monitoring on a national level. If so, I just want to comment about a couple of implications of that if that's right.

DR. ZINIEL: Absolutely. So we developed this survey prior to the funding call coming out from HCAHPS. Due to the way it was structured, we actually -- PIES was actually included in the application to HCAHPS. Correct me if I'm wrong, Mark.

So basically at that point for us --- the most important thing while we had the initial attention for PIES to be the child HCAHPS, based on our hospital experience and other experiences, for us the key was really to be able to measure change.

One comment I want to make with regard to the response scales. A six-point compared to a four-point response scale is not the same. It really depends on the labels.

That's like one thing we really clearly found out in our research. If you don't stretch where the people cluster with response labels, you won't see a difference. That's really from a cognitive response answering process the key to this. We know by whom child HCAHPS was funded so for us as a measure developer, we really want to provide people who want to measure patient experience and want to measure if their initiatives make a difference. Give a measure that they actually can use and show differences.

MEMBER BEVANS: Right. And -- I'm sorry. Go ahead.

DR. ZINIEL: Go ahead.

MEMBER BEVANS: It seems that, aside --- the issue of a four-point versus six-point response scale is one thing but then also the use of the top box scoring approach may reduce sensitivity to change.

I want to make a point that we are entering this era of big data and wanting to

multi-purpose data. Right? To use data for multi-purposes for, if anything, to reduce the burden that we are placing on people as we are over-serving them. That comment has been made a few times.

I guess I'm wondering what NQF's role is in this, because we are charged with making a recommendation for potential endorsement of the PM, including the specification of use of the top box approach for scoring for performance measures.

At the same time, that doesn't mean that the data are there. Right? The use of a multiple response category coded four times are there. Right? So could the instrument be double-dipped here? Like used for purposes of quality improvement using the four-part response scale.

I know that is not quite desirable to you, but certainly better than the top box approach, to be able to be more sensitive to change. Also the top box approach being used

for the kind of performance measure side.

I guess the question is really more to the committee is what do we see our role here in making recommendations about varying uses of the same data that has to do with the specification of how the performance measure is actually defined. Does that make sense?

CO-CHAIR MERLINO: Can I comment about HCAHPS and then you can comment about the role of the committee. I think we can go to the adult HCAHPS survey to learn a lot. This debate happened when that instrument came out as well. How can you possibly use a four-point scale for performance improvement?

I think there's a lot of people across the country that are involved in hospital operations that wish they could go back and change one thing about HCAHPS. They would have made it a five-point scale.

Having said that, we now have five years of experience using the HCAHPS survey to

actually drive performance improvement. That's reflected in Medicare's benchmarking database.

I can tell you on an anecdotal level what is reflected in my organization. I think you can use it to drive quality improvement and you don't have to get into a lot of extraneous metrics or questions. That history, I think, is important for this.

The second thing is, and this is my opinion as a member, and not as the co-chair, is that we probably have an obligation to really pick the instruments and metrics that we think are going to have the greatest impact to drive change.

I applaud the work that all of you have done because you are clearly setting the standard for measuring pediatric experience of care, which needs to be done.

I think we need to really ask the question where should we put the effort, what should we focus on this that would have the

greatest impact. To me, personally, it's the instrument that really mimics what the national agenda is.

DR. SCHUSTER: Can I jump in on this topic a little bit? So we explored different response scales, in terms of the literature, which is known, and the CAHPS consortium has a long history of studying number response scales and the actual items in those response scales.

The very strong consensus, among that consortium, is that the larger number going up to five and six is too cognitively challenging. We have a wide range of parents and educational levels and switching out --- I mean, I think there are just philosophical differences here.

The experience to be gained from the CAHPS group which is going from poor to excellent, from poor to exceptional, to very poorly, to very well, is confusing to people. They stop paying attention and they start just

getting confused by it.

We had a lot of discussions on this and aspirations and there's a lot of pressure on us to limit ourselves to a primary scale of four and then for certain items, because we do have to tailor it somewhat to the items, a three-point scale for some. But this wasn't in any way a haphazard decision.

In terms of quality improvement, our measure --- we designed for national use in many ways. One is public reporting and paper performance, if it gets used for that, but it's designed knowing that is a possible use. Another use is very much quality improvement. Again, I think we just disagree.

I get all the quality reports for the hospice list and out-patient, all of the out-patient experience reports, and I have to manage in our hospital trying to improve. We do not find that a four-point scale or hitting 80 percent in the top box means you can't improve to 85, to 90, to 95.

Our response is we do have room for improvement. I think there are just different experiences here. I just want to make it clear it's not that we're just doing public reporting. We are designed for quality improvement and that is very much a part of it so that this survey can be used for both.

CO-CHAIR PARTRIDGE: I want to thank all our guests from Boston for working on this issue with us. I don't think at the moment we can devote any more time to it. We have 45 minutes between us and lunch to tackle yet another CAHPS measure which is Clinician and Group. We will excuse you and thank you again. We'll be talking to you more.

MS. DORIAN: Thanks. Great. As Lee just said, our next measure is the CAHPS Clinician and Group Survey from AHRQ. Let's just check to see who we have on the phone.

Carla, are you there or any of your team?

DR. ZEMA: I am. Chris Crofton is

going to kick us off from AHRQ, and then we also have a number of consortium members with us as well.

MS. DORIAN: Okay. Great. Go ahead then. Thanks.

DR. CROFTON: Well, earlier this morning Carla mentioned reconciliation that we're doing across all the surveys and we received some changes both on the Clinician/Group and the Health Plan Survey resulting from that.

There are also some changes in items that we've known that we've needed over the course of the past several years in administering the surveys and you will see those changes, too.

Other than that, it's the same set of core items and additional items, so the structure of it will look the same as the versions that you've seen in the past. To talk about it, Julie Brown from the RAND CAHPS team is on the phone, I believe.

MS. BROWN: I am. Thank you, Chris.

DR. CROFTON: And there other members of the CAHPS team. I don't have the whole list in front of me but will probably be speaking up to voice their opinion on particular topics. Julie may refer to them as she speaks.

MS. BROWN: Good morning everyone. I realize that it's almost noon there and afternoon there, but it's certainly morning here. I apologize that I didn't get to sit in on the earlier session today, so I'm not sure what's most helpful for going forward.

I can certainly give you an overview of the revisions that we've made since CG-CAHPS was last reviewed. If there are particular questions the committee has, we are happy to answer them. Ron Hays is also on the phone. Ron and I participated in the quality group meeting, so it would be helpful to hear from Karen or Lauralei or Sara as to

what would be most helpful in going forward.

MS. DORIAN: Sure. Thanks. If you could give -- many of the people on this committee weren't here when this measure was last reviewed so if you could give a brief synopsis of the measure and you can include any changes.

You might want to mention that article that was sent around as well, just to reference it, and we can bring it up on the screen later. If you could keep that brief to about two minutes, that would be great.

MS. BROWN: Okay. That's a lot of information to put in a few minutes.

MS. DORIAN: Put the measure information at the top of the forum.

MS. BROWN: No problem. So the Clinician and Group Survey is designed to provide information on patient experience of care to inform decision making and quality improvement with regard to care delivered by individual clinicians, care delivered in a

range of settings, from individual practices to group practices to larger entities.

The qual measures are used by CMS to assess experience with ACOs. They can be used to assess medical home. While the instrument references a specific provider, often referred to as a focal provider, it's really measuring experience on multiple levels depending upon the sample design.

Across the CAHPS instrument there are a set of common core measures that you'll see in this survey. We measure access to care, communication with a provider, experience with office staff. Always the hallmark of any CAHPS survey is the zero to 10 reading of provider.

There has been evidence that patient reports and ratings of care are correlated with clinical qualities so we really view these patient experience measures as companion measures, the clinical quality measures that may exist out there.

There are the core measures and there are a host of supplemental questions that aren't included in this submission so I'll just focus what I'm saying on the core.

Chris mentioned refinements and improvements. Due to changes over time in the care delivery system, feedback from users, and kind of the best survey science within CAHPS, we made some small refinements to how we frame questions for patients, and that's reflected in the revisions. It's a minor wordsmithing here and there to improve the clarity, but also promote the translation of instruments.

AHRQ provides instruments in English and Spanish but many users are translating them into multiple languages, so testing in other languages has created a feedback loop that helps us understand how best to frame questions in English so they are easily translated into other languages.

One aspect of that report is the response scale. Earlier there was some

discussion about a four versus six-point response scale.

I think a key change between CAHPS prior submission and the current submission under review is that we are proposing our four-point lever to always response scale. Previously the committee reviewed a six-point response scale that went from always, or almost always, to never.

We found that the four-point response scale is easier for people to keep in their minds, introduces less difference in patterns of response across different modes that are interviewer administered versus self-administered, and results in sufficient variation of response to capture meaningful and measurable difference in patient experience whether it's at the clinician level, the group level, or some larger practice system level.

I think the other thing that's important if committee members are new to

CAHPS is CAHPS avoids abject title scales. That is, scales that use excellent to poor. We do that for several reasons.

One is that when the data is reported to other consumers, they do those kinds of ratings as subjective and it's not very clear to them what they mean, whereas it's very clear to people what it means when they understand that someone sometimes has to wait more than 15 minutes for an appointment to begin.

Additionally, those kinds of scales present some challenges in translation. Not all languages can be translated into a scale that kind of represents the ordinal ranking of that kind of scale so CAHPS goes with reports and ratings because they are more objective and we are able to ask about discreet experiences that are able for people to understand cognitively across a range of education levels, experience levels, and across multiple languages.

I suspect I took more than two minutes there and hope that I've touched on the things that you'll find helpful.

CO-CHAIR PARTRIDGE: Before we begin, I just wanted to clarify one thing about the way this is labeled. It says adult primary care, pediatric care, and specialist care surveys. Are they three separate surveys?

MS. BROWN: I want to be very clear. The adult measures, the adult core measures, work in primary care and specialty care settings.

CO-CHAIR PARTRIDGE: That should be clear to everybody.

MS. BROWN: Thank you.

CO-CHAIR PARTRIDGE: You've really got two surveys but --

DR. PACE: So this really, the child is not part of the adult so you really need to probably think about getting that separated out. It's confusing this way.

DR. ZEMA: So that is a change also from the last time we submitted it. We used to package the clinician group survey as a primary care survey and specialty survey when in reality they were the same core survey. They differed in some supplemental items.

It caused a lot of confusion and because that concept of a core survey is so important, we clarified and repackaged so that the CAHPS Clinician/Group 12-Month Survey is the core survey that is in front of you that is applicable to both primary care and specialty care.

DR. PACE: Right. But you've also included the child.

DR. ZEMA: Correct. So there is an adult 12-month survey and a child 12-month survey.

DR. PACE: Right. We'll need to get those separated but we'll talk about that off line so thanks. As you go through you'll

see that they do provide different data.

DR. ZEMA: Just a quick follow-up from this morning's conversation. One of the fundamental differences in CAHPS surveys, CAHPS surveys are divided into facilities surveys which is like the hospital surveys that you've talked about already.

This is part of our ambulatory surveys. One of the key differences that you talked about this morning is we never ask people to really focus in on a particular provider on our facilities surveys because of all the difficulties that Sara and everyone described to you.

But on the ambulatory side we do ask respondents to zero in on what we call a focal provider so that is one of the key differences between our ambulatory surveys and our facilities survey.

CO-CHAIR MERLINO: Okay. Discussion about the evidence?

MEMBER PARISI: I have a question

about the changing wording to provider actually. I'm doing a 180 in my own head as you're speaking and trying to sort it out for myself.

My disclaimer -- I should say my conflict of interest is I'm a registered nurse. Clearly I'm interested in understanding the differences between the scope of practice of a physician and a nurse practitioner.

I'm wonder in this particular instance are you able to ascertain what will be needed to improve performance, communication, etc. just by putting in as a provider rather than differentiating that. I don't know if I have a preference. I want there to be actionable initiatives as a result. I'm struggling with that content. Maybe you can help clarify that.

MS. BROWN: Hi. This is Julie Brown. I'll make a response and then welcome input from Karla or Ron or Chris. One of the

reasons we changed to this provider language from this doctor language was to recognize the changes in care delivery. Especially in primary care settings, but also in specialty care settings can be delivered or managed by a physician, a nurse practitioner, a physician assistant, a clinical nurse specialist.

We wanted to be responsive to the realities of healthcare. By using this provider language it allows the user to survey experience referencing a provider that is important in selling it to the patient, but not limiting that provider to being a physician. I think that is very important. That data is meaningful and useful and does inform quality improvement.

I'll pause there.

CO-CHAIR MERLINO: Any other comments about evidence or questions?

DR. PACE: So I think we're in the same position as we were with a lot of the submissions. There is some general

information versus specific for each of the measures submitted in terms of things.

I think the survey questions kind of point to the things that the measured entities can do to affect the experience with care but something again that you'll all need to think about in your own mind in terms of are these things that healthcare clinicians can affect.

CO-CHAIR PARTRIDGE: One of my comrades on the work group want to say anything about evidence before we vote?

Excuse me. Carol, go ahead.

MEMBER LEVINE: It doesn't really -- I share the concern about this kind of lumping everybody together as a provider. Not a doctor but a provider, but doctors are providers too, right?

I think from what I'm feeling, and we heard it this morning, is people are very confused about what happens in healthcare. Sort of putting all of these people together

in one category doesn't help to sort out who is able and responsible and accountable for doing what.

I don't think if affects this but I think it is something that really needs to be addressed as we go forward in healthcare. It doesn't help people to make everybody the same. Thank you.

DR. ZEMA: This is Carla. I wanted to add to Julie's explanation of, in case the reaction is that we are lumping providers. We actually don't.

This is an ambulatory survey so the very first question confirms the very specific provider you saw, whether it's Dr. Jones or Mary Smith, and then orients the respondent to say, "Okay, that person is this provider." We use the terminology "this provider" through the rest of the survey to mean a very specific person.

That is the difference with our ambulatory survey versus our facilities

surveys is we are talking about, we are orienting them to one specific provider. While you and I as professionals might think of the term provider differently, because of that question one, that does very specifically define what we mean by "this provider."

MR. SHALLER: Carla, this is Dale Shaller, also a member of the CAHPS team. I wanted to just make a further point that most of the health systems have used the CG-CAHPS survey for collecting information for internal improvement do sample at the individual provider level, and can know specifically what individual practitioner, be they the physician, be they a nurse practitioner, or other mid-level, is actually accountable for the results that are being collected.

That actually does inform and drive very specific targeted improvement strategies that many health systems are actually using.

CO-CHAIR MERLINO: Okay. Any

other comments on evidence or questions from the committee?

Carol, are you still -- okay.

Why don't we vote on evidence and then we can move forward.

MS. ALLEN: You're voting on evidence, one yes, two no. Voting starts now. All votes are in; 17 yes, zero no.

DR. PACE: So we're going to go on to performance gap and I just want to mention that there is no information provided in the form requested but there is some in the data dictionary. I think this meeting just brought up the Excel file and you all have access to this. There is a tab for both the adult and the clinician.

CO-CHAIR MERLINO: Any comments on performance gap?

Let's see. This is where we talk about disparities.

MEMBER THOMAS: So I understand that 90 percent of the respondents were white

and disparities weren't really addressed. I have a note here that I made to myself. The questioner says that the lack of variability makes this, put in my own words, non-critical.

Is that -- I note that there was a heavy concentration in the adult survey, at least in Maine and Washington and I just wondered if you could talk a little bit about that.

MS. BROWN: Sure.

Ron, do you want to respond to that or --

DR. HAYS: Well, I think Dale might be best but it's whatever we get our data from. I mean, these are voluntarily submitted. I don't think it's the widest distribution that we could possibly get for sure. It's a large sample size but definitely we would like more diversity.

We know there is more diversity out there. Historically we've been able to look at race, ethnic differences shown in

several published articles that they exist but this data set has it's limitations.

MEMBER THOMAS: It's about 90,000 adults patients. Is that right? I think I read that in the packet.

DR. HAYS: I was just going to ask a clarifying question. Is this a question directed to the actual results that were obtained in the State of Maine?

MEMBER THOMAS: No. I thought you said it was a large sample. I think in Maine it was 50,000 and I think it's a total of about 90,000 for the adult survey if I'm not mistaken. I'm reading that in the submission, page 41.

DR. ZEMA: Right. This is based on the 2012 CAHPS database and there was a large presence by Maine in that year of the database.

MEMBER THOMAS: Thanks.

CO-CHAIR MERLINO: Any other comments on performance gap? Questions?

CO-CHAIR PARTRIDGE: I don't have it in front of me but, as I recall, we got different results. We got different tables for the adult and pediatric.

MS. BROWN: I think you might be referring to Table 1.6, the descriptive characteristics for processing patients. I'm not sure.

DR. PACE: We're looking at what you put in the Excel file for 1(b)(2), the performance gap information.

DR. HAYS: Well, there is adult and child data separated. The question related to variation in scores or --

(Simultaneous speaking)

DR. HAYS: It depends on the particular data set and we know in different collections in different parts of the country and different states that there is actually a quite wide variation in performance along the different domains measured in this CG-CAHPS instrument.

You see different levels of variation depending on the community. For example, in Minnesota there are two state-lead implementations of CG-CAHPS now, quite a large variation from their top two lowest scores and then the distribution between those.

Are there gaps in performance at the clinic level, at the group level, and the individual clinician level? The answer is yes. All of that data that supports that assertion I don't think were submitted as part of the submission but they can certainly be obtained and forwarded to the committee.

MR. SHALLER: Yeah, the Excel spreadsheets do show you scores, means, and median at different percentiles. If you look at that relative to the standard deviation, you can see that there's substantial differences in terms of affect sizes across sites.

CO-CHAIR PARTRIDGE: We have it, Dale.

MR. SHALLER: Okay.

CO-CHAIR MERLINO: I think we're good.

Any other comments about performance gap? Let's vote on performance gap.

MS. ALLEN: We're voting on performance gap; 1 high, 2 moderate, 3 low, 4 insufficient. Voting starts now. All votes are in. Results, eight high, nine moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: Moving on to high priority. Any comments about high priority?

People on the call?

Any questions?

CO-CHAIR PARTRIDGE: This measurement is fundamental to the model of the patient-centered medical home and to core aim.

CO-CHAIR MERLINO: Let's vote on high priority.

MS. ALLEN: Voting on high

priority; 1 high, 2 moderate, 3 low, 4 insufficient. Voting starts now. All votes are in. Sixteen high, one moderate, zero low, zero insufficient.

DR. PACE: Okay. We're going to move on to reliability. This includes precise specifications if there are any questions about that.

Basically the measures the questions that comprise them were provided in the Excel file data dictionary so you can access that. Then I'll just make a few notes about testing. We'll need to bring up something here. Just a second.

So in the submission there is a question I have for the developers. The testing appears to be done for practice sites but the specifications say individual clinicians that it could be used at either level.

Have you tested reliability in terms of being able to get reliable at the

clinician level? Let me just clarify. Is the testing that you provided for practice sites versus individual clinicians?

DR. ZEMA: The testing that was specified in the submission were practice site level. And then the article that I forwarded to you does have physician level results as part of that published article.

DR. PACE: All right. So we'll come to that when we get to performance score levels. The first thing at the patient level instrument that was individually submitted was sent as an article that we'll bring up that has the composite and level Cronbach's alpha. Let me see where that's reported.

DR. ZEMA: You did hear from Allen this morning that we typically don't calculate that at the CAHPS level and perhaps Ron can comment more. I sent an article where we actually did do that level of calculation because of the data set that we had.

DR. HAYS: Yeah. I would just say

that we will do both. The most important indicator of reliability is at the site level or, if you're interested at doctors, at the doctor level, whatever the unit is you're trying to compare.

DR. PACE: Right. We understand that and NQF agrees but our current criteria are to submit both for the evaluation to have a reliable and valid instrument, as well the computed performance score. Thanks for submitting this.

I think -- can you just orient us where this -- is this on page S16, the Cronbach's alpha data?

DR. ZEMA: Right. So the table that you're looking at, this is actually an article where we were discussing the development of the HIT supplemental item set. But because of the concept of the core survey, results for the core survey are also included.

Items that are not marked with HIT are actually our core survey items and those

are items that are most relevant for you in your discussion today.

DR. PACE: Right. What I'm looking for is if you could point us to in this article, since we're just looking at it, the Cronbach's alpha for the scales versus the item level information.

MEMBER BIERNER: If you look at Table 4, physician level reliability, they have an intraclass correlation co-efficient.

DR. PACE: That's the physician level score.

MR. SHALLER: I think you just jumped over -- there was some text that said co-efficient alpha. If it says that, that would be the individual patient level.

MS. BROWN: I think it said on page 16 the co-efficient alpha was for various composites.

DR. PACE: I think it's not in the table. It's just the text here, reliability.

MS. BROWN: Right.

(Simultaneous speaking)

MR. SHALLER: There it is.

DR. PACE: All right.

MEMBER THOMAS: So then most of them are over .70?

DR. PACE: Yes, it looks like that.

MS. BROWN: And this is the rest of that group just pointing out that in the measure testing form that we submitted we did, in fact, provide the patient level Cronbach's alpha right above the site reliability table. You've got both the individual level and site level in this submission on pages 7 and 8 of the measure testing form.

DR. PACE: Okay. Thank you.

MS. BROWN: That's it.

DR. PACE: Okay. So I think we're okay on that. Let's go to the measure testing form then for the practice site level, 2a2.3(c). Here we have the -- those were the Cronbach's alpha. This table has the site

level reliability. You see the first two columns are adult and you see the reliability statistics there.

Then for the child you see the -- and this is for the computed performance score at the site level. You said that you also did reliability testing at the physician level which is in the article that you submitted, Table 4.

DR. ZEMA: Correct. That's Table 4 in the article.

DR. PACE: Okay. That seems fine. Any questions?

CO-CHAIR MERLINO: Any comments about reliability? The staff rated it moderate to high overall.

MEMBER DOWDING: I was just looking at the table in the paper. I wonder if you could just comment on the reliability for the shared decision making scale which seems to be rather low.

MS. BROWN: Shared decision making

is not part of the core survey so it's not one of the measures that's being considered for you today. It's what we consider a supplemental item.

MEMBER DOWDING: Okay. That helps.

CO-CHAIR MERLINO: Any other comments?

MEMBER THOMAS: Since this is the patient committee, I'm going to bring just my own perspective to this. This isn't about evidence. This is a question for the developers that may be pretty basic.

I've been to plenty of doctor's offices and waited plenty of time and have been exposed to some pretty rude people in health care, yet I'm not sure I can say that impacted the quality of my outcome in terms of what is really important: my health status. I'm just trying to correlate that. Is that even a relevant observation or not so much?

DR. HAYS: No, it's relevant but I

think we would like to have both and we want good outcomes and good technical quality of care, but we also don't want our providers to be rude. It's still something that is important to patients.

MS. BROWN: And there have been studies that look at communication and then things like adherence and whether or not you comply with your treatment plan and things like that. There definitely are associations there.

(Simultaneous speaking)

MEMBER LOEB: I have a question and a comment. So are you referring to the office staff being rude or the doctor being rude?

MEMBER THOMAS: I was referring to the office staff in my personal experience. Again, I appreciate there's a connection there. I'm just trying to get to the tie between health status outcome and these factors. I think it would be great if people

could treat you better and well and courteous, but I'm just trying to make sure --

DR. HAYS: It's related to patience adherence, for example.

MEMBER THOMAS: Okay. That's fair enough.

MEMBER LOEB: I'm coming from the opposite side in that I have refused to see doctors at times because going to the office was so painful because of the staff and because of their lack of competency that I will go to another physician.

MEMBER THOMAS: Just because of that?

MEMBER LOEB: Because of that.

MEMBER THOMAS: Okay. That's fair.

MEMBER LOEB: Yeah.

MEMBER THOMAS: Thank you. I appreciate that.

MEMBER LEVINE: Or not go at all for treatment there because it's so awful.

MEMBER CROSS: I would second that and add a little bit to that conversation that a lot of times it's the office staff or others who are giving test results back to patients occasionally, or answering the phone when patients are calling to ask for that. Office staff can certainly impact the willingness of patients to continue to see the providers in the office, so I do think it's important.

I want to just kind of add a little bit. I know part of this falls under usability in the future. I'm from a large healthcare organization. We do use this survey often, constantly, and we have implemented multiple quality and process improvement initiatives based on feedback that we've gotten from these surveys.

It's really invaluable for us and our organization. I would ask the developers if they could just make one comment about under the endorsement maintenance section.

I think someone mentioned this

earlier as well that there is kind of a new part that's been added regarding overall mental or emotional health. If you could comment on that, I would like to hear your rationale behind that.

DR. HAYS: That's primarily for case-mix adjustment because we know that is related to what patients say about their care in a way that is not necessarily reflecting the quality of care. I mean, it could be used in other ways but the CAHPS team uses it to adjust scores to make more fair comparisons between plans.

DR. ZEMA: Just to add to provide some history, we have always kind of known that it's been a very strong case-mix adjuster but we were actually asked by stakeholders to take it out the Health Plan Survey because of concerns with the way to improve and mental health status so we took it out of the survey.

Recently as we talked to different stakeholders, I think that stigma and that

fear has kind of gone away so we thought this was the perfect opportunity with this version update to add it back in.

MEMBER MORRISE: I just want to make a couple points. One is I speak to clinician groups regularly about patients and families in case. We talk about touch points relative to marketing as identified in the marketing concept that the total experience is impactful upon how one rates the overall situation.

One aspect of the touch points of that total experience can make it impact one's ability to like the entire situation. They may rate, for example, the physician five but the poor treatment in the office may make the overall situation be rated lower.

Indeed, physicians in a group local to me are being paid based on their satisfaction and they're frustrated because they realize their satisfaction is impacted by the office staff over which they have no

control.

Still, all of that's important in the mix. Indeed, if a patient gets into a room for the actual encounter, which is the important part of the visit, that they are so wound up by all of the factors that led up to that, their ability to hear and interact with the provider will be significantly impacted.

DR. PACE: Okay. So basically we do have the reliability information for the measures that are based on multi-hilum scales. We have the inter-unit reliability for the computed performance scores. Both of those were provided in the form. The article for validity was reasonable.

CO-CHAIR MERLINO: Why don't we vote on reliability.

MS. ALLEN: Voting on reliability; 1 high, 2 moderate, 3 low, 4 insufficient. Voting starts now. All votes are in. Sixteen high, one moderate, zero low, zero insufficient.

DR. PACE: Okay. So we'll move on to validity. This is actually the one where they had the practice site level in the form. Then if we go to their article -- you can bring that up -- I believe Table 5 is your validity of the patient level measures. Is that correct?

DR. ZEMA: Yes.

DR. PACE: So here they did a correlation with those composite measures to the overall rating of the doctor.

Karla, or one of your team, want to run through any of these results?

MR. SHALLER: Well, the one thing that stands out when we look at the global rating is always that the doctor communication is the main driver of that. But you can see that there's significant associations, at least bivariately, for all the composites that are shown here including office staff so that they are all somewhat important.

When you do the multivariate

results, then because of correlation among the different measures, you do get some things that stand out. Again, it's doctor communication that is always the main driver.

DR. PACE: And these HIT ones are not part of what is being submitted. Correct?

DR. ZEMA: Correct.

DR. PACE: Okay. And then in the submission form --

Nadine, if you want to go to 2b2.3 for the performance level validity testing.

They did the same type of correlation. Here you see the adult global with the three measures. Then the child. Wait, no. I think we'll just look at the child global with the child measures. Maybe you could comment on the two low ones, the office staff and the child prevention.

MR. SHALLER: I guess in this case it doesn't seem to make a difference in these global ratings because they are so dominated by communication anyway for children's care.

I'm not exactly sure why it's different, why the office staff is less important in that case but someone else might have an idea.

CO-CHAIR PARTRIDGE: I think they're -- Nadine, can you move this up a little bit? In the child there is a prevention one, too, I think.

DR. PACE: At the end. Right there.

CO-CHAIR PARTRIDGE: Yes. As I read this admission, some of the rationale behind those measures came from the development team -- excuse me, came from the provider community as you were working on refining the child version. I wonder if you could talk a little bit about the extent that you had any parent involvement in those, the development of those particular questions.

DR. ZEMA: So, again, I can give you a little bit of history. The actual impetus for the development or the extension of the child composites actually came out of

the first NQF review where some of the pediatric representatives said it is not sufficient if you're talking about what should be in a course survey and you're talking about a pediatric survey to not have things that are on development and prevention.

We had one item at that time that kind of broadly was intended to capture it. We went into development of these particular topics in partnership with the American Academy of Pediatrics, as well as a number of other stakeholders. But the development of these went through the typical CAHPS process which involved extensive cognitive testing with input from parents. The process for development is very similar.

CO-CHAIR PARTRIDGE: Thank you.

MEMBER STILLE: I have a comment. This is as much speculation as anything else but discussion of preventive care and development tends to be a subset of visits. I mean, it's an important subset of visits but

it's all health maintenance visits as opposed to sick visits and other things so that may have some impact on it.

Also being a parent when I look at the global rating of how I feel about my kid's care, you know, development and prevention is fine if they are not sick, but what I'm really worried about is if they do get sick how good is everything and how well does it work. That may be why they load it a little bit less.

CO-CHAIR PARTRIDGE: Actually, in terms of looking at whether or not you would choose a pediatrician, you would look as a parent at prevention and child development.

MEMBER STILLE: Right. You have to.

CO-CHAIR PARTRIDGE: Because you want to be sure they are paying attention to it.

MEMBER STILLE: Right. So it's important but it may not load as much on the retrospective grade point.

CO-CHAIR MERLINO: Lisa.

Any other comments on validity?

DR. PACE: Before we move on we should at least mention as part of validity, remember we also look at case-mix adjustment.

Lee, I think you may have had a question here.

CO-CHAIR PARTRIDGE: I think I'm a little confused. Are we doing case-mixed adjustment on these or not?

DR. ZEMA: In general we always recommend that in the CAHPS database load case-mixed adjustment on age, self-reported health status, and education.

CO-CHAIR PARTRIDGE: But for purposes of the measure, are we incorporating the protocol that includes those recommendation?

DR. ZEMA: Yes.

CO-CHAIR PARTRIDGE: Okay.

DR. PACE: Right. So we definitely need to have a standard of what's

endorsed. It sounds like you are submitting for endorsement a measure that would be case-mixed adjusted. Correct?

DR. ZEMA: Yes.

DR. PACE: Okay.

CO-CHAIR MERLINO: Any other -- I think we're good on validity then. Any other questions or comments? Let's vote on validity.

MS. ALLEN: Voting on validity; 1 high, 2 moderate, 3 low, 4 insufficient. Voting starts now. All votes are in. Eleven high, six moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: Feasibility. Comments about feasibility.

MEMBER BIERNER: Can the developers comment on the length of time it's average to take this study? Have you collected any data on that?

MS. BROWN: Sure. This is Julie Brown. The adult core survey takes on average

less than 15 minutes to completes and the child's version is slightly longer, closer to 17 or 18 but that's because there are more items with those domains Chris was referencing earlier.

MEMBER BRADLEY: In reading this, this is a voluntarily reported instrument or survey. I think there were some really good comments in the information about how sometimes you can't pick your providers anymore and, you know, there's a lot of insurance companies and payers are kind of directing.

I'm just curious as to what is the -- maybe the HCAHPS people can tell us -- what do you foresee with this survey and how it's to be used given some of the concerns that were raised in the feasibility section? What is really the intent on long-term use of this survey?

MS. BROWN: This is Julie Brown. I think Chris and others have commented that

the mission was to put this forward. As Dan and others have mentioned, the database is voluntary and there is a whole host of different types of users that Dale can speak to that this tool has been picked up for statewide initiatives in multiple states, among them Minnesota, Maine, and others.

CMS uses the tool for several initiatives. There are individual health systems, whether they are health plans or multi-site specialty groups, or other types of arrangements who use the tool for measuring patient experience and quality.

I think while the uptake varies with different groups, I think the key message is the tool is out there, that the tool is used, and that based on differing initiatives and differing entities, it has different levels of uptake.

MEMBER BIERNER: I can tell you that in our large public hospital we've been looking at this closely for over a million

ambulatory visits a year and throughout our system looking at this.

DR. CROFTON: I think this might be a good time to also clarify the different roles that AHRQ has as a federal agency versus CMS. AHRQ is really kind of the developer. We do not implement the survey. We do not have that role that CMS has as a payer.

As Julie mentioned, while we make the instrument available, our real mission and goal is to put a very rigorously developed standardized survey out there that can be used by various users. As Julie mentioned, many of the users that have picked this up to implement it.

MEMBER BRADLEY: I guess it kind of goes back to the first question of the national priority or the national goal. Is there any indication CMS is looking to make this available or mandatory for Medicare or Medicaid?

CO-CHAIR MERLINO: Oh, clearly.

It's current mandatory for ACL participation. I think it's --

DR. ZEMA: Correct. And it's also the tool used for the physician quality of reporting system initiative within CMS so these data will appear in physician compare and be publicly available.

CO-CHAIR MERLINO: Yeah, it's currently on the march.

Any other questions about feasibility? Let's vote.

MS. ALLEN: Voting on feasibility; 1 high, 2 moderate, 3 low, 4 insufficient. Voting starts now. All votes are in. Results; 15 high, two moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: Usability and use.

CO-CHAIR PARTRIDGE: I think we just answered that in the previous discussion so we're ready to vote.

MS. ALLEN: Voting on usability

and use; 1 high, 2 moderate, 3 low, 4 insufficient information. Voting starts now. All the votes are in. Results show 15 high, two moderate, zero low, zero insufficient information.

CO-CHAIR MERLINO: Finally, overall suitability. Any comments? Should we vote? Let's vote.

MS. ALLEN: Overall suitability for endorsement for measure 0005 CAHPS Clinical/Group Survey; 1 yes, 2 no. Voting starts now. All votes are in. Results show 17 yes, zero no.

CO-CHAIR PARTRIDGE: Thank you, CAHPS team. We'll move onto public comment.

MS. DONIAN: Yes, indeed.

Operator, please open up the lines for public comment.

OPERATOR: At this time if you would like to make a comment, please press * then the number 1 on your telephone keypad. There are no public comments at this time.

MS. DONIAN: Okay. Is there anybody in the room who would like to make a comment?

All right. Well then it is time for lunch. We are about five minutes late so let's reconvene at 12:35. Oh, then we'll take until -- all right, sorry. We'll take until 1:00.

(Whereupon, the above-entitled matter went off the record at 12:20 p.m. for lunch and resumed at 12:59 p.m.)

MS. DORIAN: Okay. Operator, if you could open the lines back up, please.

OPERATOR: All lines are open.

MS. DORIAN: Thank you. Okay. Welcome back from lunch, everybody. I hope you enjoyed it. We are about to consider Measure 0006, CAHPS Health Plan Survey, Version 5, Medicaid and Commercial. And I'll just check to see if we have the developers on the phone or in the room.

DR. CROFTON: Yes. This is

Chris Crofton. Julie Brown will lead this discussion and there are a number of people: Carla, Ron Hays, Dale Schaller and Joan Germay (phonetic) from Westat to fill in and respond to questions.

MS. DORIAN: Great. Welcome back. And, Julie, if you wanted to go ahead and get us started by introducing the measure?

MS. BROWN: Sure. Well, hello, again, everyone. As with the measure we just reviewed a short time ago, the CAHPS Clinician and Group Measure, this measure is comprised of some core domains that are common to all CAHPS instruments at measures of access, measures of doctor communication.

Because this is a health plan instrument, this measure has some additional measures about health plan customer service, some more detailed information about ratings of personal doctor, ratings of specialty care, rating of healthcare in general, and rating of the health plan.

This is part of the ambulatory CAHPS instrument suite that Carla referenced earlier this morning, and is actually the first CAHPS ambulatory care instrument.

In part of our packet for consideration and approval, we detailed some updates and revisions to the measure. Again, it's refinements of wording for improving the measure, some movement of items from one domain to the other, that is, you know, focusing from all providers to a focal provider that we call a personal doctor or nurse.

Again, this instrument is designed for use with commercially-insured and publicly-insured patients. And I'll pause there and see if Carla or anyone would like to add anything or if there are questions from the group.

MS. DORIAN: Okay. Great. Well, we'll start with evidence then.

CO-CHAIR MERLINO: Any questions?

Comments? Becky? Now you have to ask a question. Any thoughts?

MEMBER BIERNER: I just have a quick question, on the question that talks about specialists. I realize this is being administered at a higher level like a health plan. How did they identify or are they trying to identify who that doctor refers to, I mean if the question about specialists or their personal doctor?

MS. BROWN: Great question. Because, as you said, this is administered at a higher level such as a health plan, in this instrument, we've referenced the name of the health plan to orient the patient to reporting on the right plan and their experiences with that plan, the personal doctor, which is a provider asked about in the instrument, and any experience with specialty care reference providers identified by the patient.

That is, the patient is given a definition of specialist care and then asked

if they've visited that provider or physician who provides specialist care.

CO-CHAIR MERLINO: Chris?

MEMBER STILLE: Hey, Julie. Chris Stille. Good to talk to you over the phone. I'll see you in October. Kind of naive-ish kind of question but I just want to orient myself. I was wondering why, in health plan level surveys, there are more detailed things about how well your doctor communicates with you. And I also saw that that doesn't correlate quite as well to the local-level measure. But what sort of a rationale for putting those specific-level questions in there?

MS. BROWN: The same questions are in both the health plan instrument and the clinician and group instrument. And, actually, I think clinician and group has two more items in their communication composite. And that was driven by the early development of CAHPS, what we saw in the literature.

But, in some respects, more importantly, the feedback we got from patients as to what made for positive and negative experiences with their health plan. And really the interpersonal communication with a provider was a really important aspect of the whole health plan experience for patients.

MEMBER STILLE: Okay.

DR. PACE: So, I think --

MS. BROWN: And I, too, look forward to seeing you in October.

MEMBER STILLE: All right.

DR. PACE: So, I think, Chris, that probably gets at, you know, the central question here that we asked is --- because the health plan is the measured entity. What can the health plan do about the provider communication?

MEMBER STILLE: Yes.

DR. PACE: I think that's what you're getting at.

MEMBER STILLE: They can not have

doctors on their panel. But, yes, other than that, I don't know.

DR. PACE: No, no, no.

CO-CHAIR PARTRIDGE: A health plan can and they often do encourage some kind of in-house training or workshop.

MEMBER STILLE: Okay.

CO-CHAIR PARTRIDGE: No.

CO-CHAIR MERLINO: Well, and they're also starting to tie reimbursement to performance. So, clearly, they have tools to be able to enforce improvement.

MEMBER STILLE: Yes. I guess it's sort of what level of detail.

CO-CHAIR MERLINO: Yes.

MEMBER STILLE: Okay.

CO-CHAIR MERLINO: Any other comments about evidence? All right. Let's vote on evidence and then we can move on. Go ahead.

MS. ALLEN: We're voting on evidence: 1) yes, 2) no. Voting starts now.

All votes are in: 15 yes, zero no.

CO-CHAIR MERLINO: Performance gap?

DR. PACE: And I think, like the last measure, this information wasn't in the form but it's in that Excel file, the data dictionary. So, you can look at it there, if there were any questions? You need to enlarge that some and is there a tab that says 1b2? Yes.

So, I think the mean performance generally was in the 50 to 70 percent range. No, 1b2 is what we're on. And the inter-quartile range for most was ten points or less. That's between the 25th and 75th percentile. So, any questions for the developer regarding this?

CO-CHAIR MERLINO: Shall we vote? No.

DR. PACE: Yes. They provided the adult and the child. If you scroll down, there's the child ones. Okay.

CO-CHAIR MERLINO: Any comments? Let's vote on Performance CAHPS.

MS. ALLEN: Voting on Performance CAHPS: 1) high, 2) moderate, 3) low, 4) insufficient. Voting starts now. All votes are in. Results: eight high, seven moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: High priority. Any comments?

CO-CHAIR PARTRIDGE: In the world of the ACA, when more and more people have to make choices among health plans on their own, as opposed to obtaining through your employer, I think this measure is very important.

CO-CHAIR MERLINO: To the developers, what was the most significant finding out of the focus groups you did that patients or families were concerned about?

MS. BROWN: There were so many. I think wait time was something that still resonates with me from the early focus groups. I welcome Lee or Dale or anyone else's

reactions. Kind of the importance of having someone that the patients defined, the survey reference was personal doctor. That's a term that came from some of the focus group work.

And, so, it was really the importance for the patient of having this provider with whom they could really establish a relationship and have continuity of care. And kind of the importance of that person in how they experienced the health plan and their ability to navigate the plan.

MR. SHALLER: This is Dale. I would support everything Julie just said. And we've done numerous focus groups over the years for CAHPS survey development and communication consistently rises to the top of the aspects or domains that patients and consumers seem to be most interested in and how that relates not only to the personal provider like Julie was just describing but in the context of the health plan survey, getting information and communication support with the

health plan itself, which, you know, kind of distinguishes this from the CG-CAHPS instruments.

CO-CHAIR MERLINO: Any comments about high priority thoughts? I think we can vote.

MS. ALLEN: Voting on high priority: 1) high, 2) moderate, 3) low, 4) insufficient. Voting starts now. All votes are in. Results: 14 high, one moderate, zero low, zero insufficient.

DR. PACE: All right. So, this includes reliability. We talked about measure specifications. Is there any questions or comments on that and, then, we'll look at the reliability testing. So, I think, just in terms of the specifications, this has come up before. But in a couple places the specifications say recommend and, so, we need to be clear on what you are asking to be endorsed.

So, you indicated recommend top

box scoring. But is that the way you're suggesting this be specified in your testing results? I'll ask the others, too, because then there's an area where you say some users exclude proxy responses. So, the question is, are proxy responses allowed or not? And, then, again, recommending case mix adjustment.

So, in terms of a standard that you're asking NQF, that you're wanting NQF endorsement, what are you suggesting as the standard?

DR. ZEMA: So, this is Carla. We are recommending top box for scoring. Proxy responses are not --- will be excluded and case mix adjustment will be, you know, for our submission for this measure.

As you talked about what's the trial in each CAHPS, one of the things that's unique about CAHPS is we always do reports-label testing or, you know, they called it end-user testing.

And, so, a lot of that, in

thinking about public reporting, drives a lot of what we do. So, there certainly is a rationale for wanting, you know, there are advantages for using mean scoring and things that you see throughout that as well.

But given that CAHPS measures are so frequently public reported and we know that top box reporting is more meaningful to consumers and patients for which these audiences are, we are recommending top box scoring at this time.

CO-CHAIR PARTRIDGE: Okay. So, the answer to all three is yes. And the case mix adjustment?

MEMBER THOMAS: I don't quite understand the concept?

CO-CHAIR PARTRIDGE: Okay.

MEMBER THOMAS: We recommend top box scoring. I just don't understand that. Was that your question? I'm sorry.

CO-CHAIR PARTRIDGE: As I understood the response, what they are asking

is that we endorse that measure with the specification of top box scoring, no proxies and incorporating case mix adjustment. Am I right?

DR. ZEMA: Correct.

MEMBER THOMAS: Okay. Thank you.

DR. PACE: That's their terminology for basing the performance measure on the highest rating. Like, if it's a scale of four possible responses, the performance measure is based on the top response or the most positive.

MEMBER BIERNER: I wanted to ask about the response for global on the rating of specialist. It's substantially lower. It looks like it's low for child as well as adult. Is that due to just a smaller response, the numbers of respondents was smaller or why?

MR. SHALLER: You're talking about reliability I am assuming, right?

MEMBER BIERNER: Yes.

MR. SHALLER: Yes. Fewer respondents, because the reliability is driven by the number of responses you get, at the health plan level.

DR. PACE: So, let's continue on talking about the reliability and validity at the patient level instrument. The Cronbach's alphas were provided for those measures that are based on multi-item scales, in two tables. And for the adult, there's three of them below .7: getting needed care composite, getting care quickly, and health plan info and customer service composite.

And, then, for the child, three of them, also. So, if you want to make a statement about that, in terms of the patient-level instruments?

MS. BROWN: I believe Carla sent a couple of follow-up articles to get at patient level of reliability and validity.

DR. PACE: Well, you provided the patient level in the submission form. That's

what I'm referring to. If you're on the webinar --

MS. BROWN: Yes. I see it now.

DR. PACE: Okay.

MS. BROWN: Lee or Dale, anything?

DR. HAYS: Do you want us just to comment on the size of those?

DR. PACE: Yes, just I mean, you know, a rule of thumb a lot of people use is .7 or higher. And, so --

DR. HAYS: A rule of thumb is really, if you wanted to know the individual score, again --

DR. PACE: Right.

DR. HAYS: -- CAHPS is not an individual measure. It's a plan-level measure in this case. So, this is useful but it's only preliminary and the most important thing is you have enough responses to get reliability at the health plan level.

DR. PACE: Okay.

DR. HAYS: So this -- you know, we

typically will find some composites, because we have so few items, are going to have reliability that's not .70. But we're not using them for that purpose. So, that rule of thumb is really not something you should follow strictly.

DR. PACE: Okay. So, then, we can move on to the table, where they provided the performance score reliability at the plan level. And you see the adult and the child. And I think the one that came up on the work group calls before was the rating of the specialist for the adult and the child.

Wait. Did you move? Yes, there it is. So, you reported a plan-level reliability of .45 and .33 for the rating of specialists?

DR. HAYS: Yes. You would definitely want a larger sample to get reliability that's adequate there than we have in these data. So, we can Spearman-Brown up what the sample size needs to be. But, you

know, with 173, you're not getting reliability that you'd really like.

DR. PACE: Okay.

CO-CHAIR MERLINO: Any other questions on reliability? Becky? Sorry.

MEMBER BRADLEY: I was curious as to, in one of your exclusions, you mentioned if another member of the household has already been sampled then that would be an exclusion. And it just seems like they could have a very different experience and even see different providers. So, I was curious as to why you made that decision to exclude members of the same household?

MS. BROWN: Yes. Some of our developmental work, we found that there was a high correlation between the information provided by multiple members of the same household. In particular, if you were asking a parent to report on their own experience or an adult to report on their own experience and, then, also asking the household to

complete a survey about the experience of a child, that's one example but similar examples were found when we asked for information from two adults within a household.

CO-CHAIR MERLINO: Any other questions or comments?

DR. PACE: I think that, on the rating of the specialist, when you recommend the 300 sample, correct, for the survey is that --

MR. SHALLER: As a minimum, yes.

DR. PACE: Right. So, when you have a situation where, you know, one of the measures is less frequent, do you break that out in terms of how you report or what the recommendation is? Is it measure by measure or it is for the total?

MR. SHALLER: You would report it separately. In this case, you would typically have a note about the reliability. If it turned out you have this sample size and this level of reliability, there would be a

cautionary note about that.

CO-CHAIR MERLINO: Okay.

DR. PACE: Thank you.

DR. HAYS: And this all goes back to, you know, the choices that individual sponsors of public reports would make on their own. You know, I think it's noted in earlier discussions, the CAHPS team does make recommendations related to guidance on reporting.

But what's actually posted in any given website or report, you know, on the performance of comparative health plans, is really the decision of the reporter. And, so, we would hope that they would abide by this 10.70 we are referring just to, you know, assure the accuracy or the comparability of the information. But those are decisions that are made outside of the CAHPS consortium.

CO-CHAIR MERLINO: Okay. Any other questions?

MEMBER BIERNER: I just want to

ask, since you're explanation about this specialist issue was number size, if you look at the top of the box there for health plans, on customer service, you had fewer in but still had substantially higher numbers. So, it's not just the number of respondents.

MR. SHALLER: No. That's one factor. The other factor is how much patients are agreeing and what they say about the thing they're rating. So, they're agreeing more about the customer service than they are about specialty care, on average.

DR. ZEMA: There's greater variation and experience with specialists than with customer service.

MR. SHALLER: Yes, within a plan though.

DR. ZEMA: Yes.

MEMBER LINDBERG: Yes. I wanted to get at that same point and just ask you, Karen, if you could just say a little bit more about the other reasons that that number may

be low for reliability and for that particular question and, if you have any particular thought about why it is, aside from the sheer number.

DR. PACE: Right. Definitely sample size and variability between and within plans affects the reliability number. And I think, you know, they're right that, you know, greater numbers would make that more reliable and that's something that they recommend in terms of using it, using the measure.

So, you know, this is the kind of information we would want reported for your evaluation. And, unfortunately, with NQF endorsement, we also have limitations of implementation.

So, NQF endorses the performance measures but we don't say in what way they can be used. Though, obviously, all these specifications would go with this endorsed measure, which indicates, you know, the sample sizes to get adequate reliability in those

kinds of distinction.

Just one question though. I'm curious of why the health plan info and customer service, there would be fewer respondents. It seems like that would be one that people would be interested in responding to.

MS. BROWN: I think one of the things you may have heard during the discussion of HCAHPS or something that's important to remember is that CAHPS uses screening questions that ask about specific experiences.

So, within the prior 12 months, if the patient had no reached out to customer service to request information or to ask for help or had an interaction with customer service, then they wouldn't have experience to report on interacting with customer service.

CO-CHAIR MERLINO: Any other questions about reliability?

MEMBER BEVANS: Just a note about

the process or a question about the process. Given that it seems that the sample size may be contributing to this lower indicator reliability for the rating of the specialists, I mean is this an instance of insufficient information here?

Because, you know, I guess it also gets at these are separate measures. We are being asked to endorse the measure, at-large, but there is one that, you know, for which there is not potentially sufficient information. So, I'm wondering how you recommend we move forth with that?

DR. PACE: As we talked about yesterday, you know, if the Committee wants to pull the individual measures out for separate consideration, you can. I think the explanation that was given, that there are ways to estimate what the reliability would be if the sample size were up to the 300 recommended.

And I don't know if the developers

have done that or could do that. But that makes sense that I think it would be adequate reliability. But I'll ask the developers if they want to make any additional comments on that.

MR. SHALLER: I was just going to say that's right. We often will have that information, number of responses needed to obtain adequate reliability. So, if people want to report these measures like incorporating specialists, they need to make sure they get enough sample to do that.

DR. ZEMA: And I think also because CAHPS surveys are so dependent in the development process on things that here enrollees have told us and frequenters have told us is really important, sometimes we make tradeoffs on what we see on the psychometrics because this is just such a critical area that we've been told absolutely needs to be in the survey.

So, we put it in the survey. We

put the caveats around. You know, if you really want to report this measure, you may need to increase your sample sizes.

DR. PACE: But given that, it really is totally up to the Committee, if you want to pull any of these out.

CO-CHAIR MERLINO: Anybody else?

MEMBER BIERNER: I feel, if you look at your table 2b2.3, your global rating of specialists numbers are insignificant. So, I mean my worry is this is going to be used by health plans and it has potential penalties or potential adverse effects to healthcare providers in their system.

So, it seems like the specialists global rating or any of these specialist ratings don't hold up as well as a lot of your others. So, in my opinion, I don't see why it should be included in that survey. Because I don't think the health plans are going to go to all the statistical trouble to outline that they could do. I don't know that they will.

CO-CHAIR PARTRIDGE: If I were the CEO of a health plan, I would certainly be concerned about the extent to which my members were happy with access to or with the specialist to whom their primary caregiver referred them. So, I'm not sure, Sam, that they would disregard this one. I think what you're concerned about is that they might get bad information.

MEMBER BIERNER: Right. Exactly. I'm afraid that they will use this and that it will have an adverse impact on specialists. But it's not really that reliable or useful for that purpose, and they're not going to go to a lot of statistical trouble to tease it out for us.

MR. SHALLER: Well, the end result, if they use it, is that they probably will not see differences, because the standard error is so large, compared to the desired level. So, the problem is more that it just won't have any discrimination between plans.

Like, for example, Medicare, when they do it, you know, you do get a statistical test of whether a plan is different from other plans and you'll just have a lot of plans that are not different if you have low reliability.

CO-CHAIR MERLINO: Chris, is there any insight from cognitive testing or any sort of other qualitative work about why the specialist questions didn't go so well with that?

MS. BROWN: Well, I think, and Ron can correct me if I'm wrong, this is Julie. This is a function of the sample we had available to us at the time that we did the submission. So, I think something to keep in mind is that, depending upon the part of the population, you're going to see differences in the proportion of the respondents who have specialist experience to speak to.

So, one example is, if one is dealing with a population of individuals with chronic conditions. They tend to have more

specialist experience to report to. Or older populations, such as Medicare, they tend to have more interaction with specialists to report on.

In terms of the formative work, you know, access to specialists was something that was important for patients when we were doing the developmental work for the health plan and the extent to which the health plan promotes or inhibits someone's access to specialists was an important aspect of experience.

In terms of consumer testing, we have a good sense that the patients are accurately identifying the types of providers that one perceives as specialist care. And, again, you know, not related to positive testing I think as Ron touched on, the overall reliability may not be high depending upon the plan and the sample that's drawn.

So, one may not see differences between plans but the top box scores are still

there and are always there and I think those provide some very useful information to inform improvement and outreach.

CO-CHAIR MERLINO: Sarah?

MS. SAMPSEL: So, I'll just make a couple of comments because I was with WellPoint for a number of years and, then, was also with NCQA. So, understand how plans are using this. And this is more globally about the CAHPS overall. But, then, when you get into the specific questions and, you know, I think the data that's being provided certainly is from a smaller sample than you're typically seeing across the nation, when NCQA does their public reporting of these metrics.

And, in that case, what happened with the health plan was they would contract with a vendor to do their CAHPS survey. In order to report publicly on any of these results down to the measure level, they have to have a certain sample size.

So, if they had a 138 or a 173 or

those low numbers, a plan would not report that publicly. But, to the same degree, another plan would. So, you would have Blue Cross the Blue Shields, the others that would.

So, there might be some variability on the number of plans who then report it. But I would say the plans are using this information and they do do statistical testing as well as NCQA does before releasing any results publicly for the health plans.

CO-CHAIR MERLINO: Any other thoughts on reliability? I think we should vote.

CO-CHAIR PARTRIDGE: Sam, are you comfortable with not pulling this out for a separate vote?

MEMBER BIERNER: Yes.

CO-CHAIR PARTRIDGE: You are? You're sure? Okay.

MEMBER BIERNER: I don't like it, but, you know, I'm willing to leave it in.

CO-CHAIR MERLINO: Okay. Let's vote.

MS. ALLEN: Voting on reliability: 1) high, 2) moderate, 3) low, 4) insufficient. Voting starts now. Please vote again. All votes are in: three high, 11 moderate, zero low, one insufficient.

CO-CHAIR MERLINO: Validity.

DR. PACE: Okay. So, on validity testing, we'll go to the 2b2.3. These are plan-level correlations of the composites in global readings for the health plan. And you'll see that there's adult and child within here.

So, this is the plan level, and I wasn't sure if this composite inter-correlations was your patient level composite validity testing or if that was somewhere else. So, let's look at the plan level first and, then we'll come back to the question of whether they had anything on the patient level.

So, I think, if you look at this, as Sam pointed out, the global rating of specialists is lower. On the adult, it's just in the one area correlated to health plan service, .2. It's in the child one that it's low and non-significant. But that's probably even smaller numbers. Sam, did you want to say anything else about that?

MEMBER BIERNER: No. I think I already stated why I was concerned about it earlier.

DR. PACE: So, CAHPS people, do you want to point out anything about any of these other low numbers? The global rating of health plan seems to be low correlation with getting care quickly or doctor communication, mainly in the child I guess. Do you think that's mostly a function of the numbers?

MS. BROWN: Ron or Dale?

DR. HAYS: I wouldn't think it's necessarily related to the numbers.

DR. PACE: Okay.

DR. HAYS: The global rating of specialty care, again, in a child, those are non-significant correlations. Those are the only ones I'd really think that I'd be thinking about, you know, why that's the case. And it could reflect some of the unreliability of the measure.

It also could reflect differences in child care. I'm not the one to say but whether specialty care is more important to adults and that's why we seem to consistently see global rating of specialty care as more strongly related to the CAHPS composites in adults than children. But this unreliability could be part of it.

DR. PACE: Right. And just in terms of some of the discussion you had earlier about the areas of interest, this getting care quickly and doctor communication are low correlations to the rating of the health plan at least in the child. Any thoughts about that?

DR. HAYS: Well, we always see doctor communication most highly related to the global rating of the doctor.

DR. PACE: Okay.

DR. HAYS: And that, actually, is something that we would hypothesize that provides kind of support for construct validity. I don't know which correlation you're on right now, in terms of saying it's low because I think we're somewhere else. I can't see the heading here.

DR. PACE: Would you go now to the child, global health.

DR. HAYS: Which one's the child, which number are you looking at?

DR. PACE: The last row of the 2b2.3, global rating of health plan. And, if you look at the correlation with getting care quickly, it's 0.17. Correlation with doctor communication is 0.17.

DR. HAYS: Well, I mean in a way it's discriminate validity because it's

significantly related to access and to health plan customer service, which are the two that you would hope you'd have strong relationships with.

DR. PACE: Okay.

DR. HAYS: So, the fact that it's not significantly related to the other two, that may be a little surprising. But, at least, you know, there's the differential association you'd expect. I mean getting care quickly could be more of an office function. So, global rating of the plan itself should be most related to plan-related functions.

DR. PACE: Okay. And did you provide anything on the patient level instrument on these validities, Table 2d1.2, those intercorrelations. Is that at the health plan level or was that at the instrument level?

PARTICIPANT: This is the Westat crew. That is at the plan level. Table 2d1.2 is at the plan level.

DR. PACE: Okay.

MEMBER STILLE: Yes. I think I can maybe provide a little insight as to the differences with the child plan, especially with specialists. I was looking at this. It's a Medicaid sample.

Most pediatric subspecialists are located within academic medical centers. So, I think the difference in access to care for kids between primary care and specialty care is probably not as great because most academic medical centers accept Medicaid.

So, I'm just thinking that that might have something to do with it, that the relationship between the specialist and the plan isn't quite as strong. It's mostly speculative, but I'd be surprised if there wasn't some truth in it. It doesn't make the measure any less valid.

DR. PACE: So, CAHPS team, do you have anything to say about the instrument level validity?

MR. SHALLER: Patient level?

DR. PACE: Yes, patient level. Yes. Sorry.

MR. SHALLER: I also submitted that I know we do have some other documents that were sent by email that do have patient-level analyses.

MS. BROWN: Yes. This is Julie Brown. I mentioned this earlier but at the wrong point in the discussion. We started the session or shortly after we started I believe Carla Zema or, perhaps, the Westat team circulated two articles.

DR. PACE: I thought we only got one article.

CO-CHAIR PARTRIDGE: Just one.

MS. BROWN: That was for the last one. But I just recently emailed to Lauralei the two articles or the health plan submission.

CO-CHAIR PARTRIDGE: I do see --

MS. BROWN: One is by Zhang and

one is by Hargreaves.

CO-CHAIR PARTRIDGE: Okay.

DR. PACE: Okay. So, can one of you kind of summarize for these for us, so that we can actually have the Committee vote?

DR. HAYS: Well, is Lee on the call?

MS. BROWN: I don't believe he is, Ron.

DR. HAYS: Well, in his article, there's a Table 5 that's a regression of the CAHPS global rating items on the composites at the individual patient level. This is from the National CAHPS Benchmarking Database, which is what it was called when this paper was written.

And, so, you see standardized regression coefficients. And the largest predictor of the global rating of the doctor or nurse, you know, the provider is communication, just like we see consistently, whether we do it at the patient level or the

plan level.

And that communication scale is also the largest predictor of the global rating of specialty care and of all healthcare. And, when you look at the health plan, what you see as the biggest predictor is customer service and second is getting needed care.

So, I think, overall, they kind of are consistent with these results here at the plan level, in terms of associations. And the other document I think is also consistent. It reports correlations among the composites and the global ratings and, again, doctor communication is most highly correlated with things about healthcare and the provider's care, global assessments.

DR. PACE: Okay. Does anyone want to delve into this further? Should we try to bring this --- Table 5 you said?

DR. HAYS: Yes.

DR. PACE: We'll bring it up.

MEMBER BEVANS: This is for adults only.

DR. PACE: This is the --

MEMBER BEVANS: Adults.

DR. PACE: CAHPS group, is this adults only?

DR. HAYS: Yes.

DR. PACE: Okay. So, could you just orient us to this table again? In the first column we have the --

DR. HAYS: Yes. The composite there, in the first column, the global rating items are along the top, starting with the personal doctor, then specialty, then all healthcare, then plan. Those are the four global ratings that were in this analysis.

So, the bigger the number in there, in those four columns that are referring to the global rating, those are the standardized regression coefficients. So, the bigger the coefficient, the higher the association uniquely with that global rating.

So, it has .29 for doctors' communication with a global rating of the doctor or nurse. And, then, if you go over across, .17 is the highest coefficient in the column for specialty care. Yes. And, then, if you go over one more, .38 is the highest standardized regression coefficient.

So, communication is very important to anything that has to do with care. And, then, when you switch to the plan, the biggest coefficient is .42 for customer service and, then, .28 for getting needed care or access to care.

So, that's pretty consistent with what we're seeing at the plan level and everything else that we've ever looked at.

DR. PACE: Okay. Yes. So, under validity, we also talked about threats to validity, whether there's issues with exclusions, case mix adjustment, et cetera.

CO-CHAIR PARTRIDGE: I just wanted to go over, so that we're sure we know what

we're endorsing here, that the risk adjusters include your health status, your age, your educational level and, also, mental health status. Am I correct?

MS. BROWN: Correct.

CO-CHAIR PARTRIDGE: Okay. Katherine?

MEMBER BEVANS: I'm sorry if I misunderstood. But I don't think we've seen the individual level validity indicators for children.

CO-CHAIR PARTRIDGE: That's correct.

DR. PACE: That's right. Are the child measures in that same article or in the other ---

MS. BROWN: The information that we sent you was based on the adult surveys.

DR. PACE: Okay. So --

CO-CHAIR PARTRIDGE: Julie, do you have the child?

MS. BROWN: I apologize and,

Westat, correct me if I'm wrong. I think we can probably identify something after the call. I think it kind of speaks to our not fully understanding when we submitted this application that those were needed and how CAHPS is used in general.

MEMBER BEVANS: I think we have some accruing evidence here that there are some real differences here between --- at least with respect to validity between the adult and the child measure.

Currently, we're being asked to review this as both, right? Is there a way to break them out and, you know, suggest that we, you know, perhaps vote separately on the child and adult measure?

DR. PACE: Yes, that's possible and we can have a discussion about that, in terms of if people want to do that. In terms of the validity information, you know, I think it's not as critical that we don't have the scale level, if we have the performance

measure level.

It's when we had the reverse situation of only having the patient level and not having the performance measure. But, when we look at the table of the performance measure level, that's where you've had some concerns. So, do you want to propose that to the group and see what others think about that?

DR. HAYS: Chris?

MEMBER STILLE: I think it would be good to try and take a look at them separately. I don't see it as a huge threat, but it wouldn't hurt to have a little bit of separate information.

CO-CHAIR MERLINO: Anybody else?

DR. PACE: Why don't we maybe just do a hand vote to see if people want to vote on them separately? And, then, we can proceed. Would that be okay?

CO-CHAIR PARTRIDGE: I suggest we split the measure into two parts, adult --

DR. PACE: Right. In terms of your voting, right.

CO-CHAIR PARTRIDGE: Yes.

DR. PACE: If we do it on this one, then we will carry it through.

CO-CHAIR PARTRIDGE: Okay.

MEMBER STILLE: Are there any concerns other than reliability of validity?

CO-CHAIR MERLINO: Not that anybody raised, no.

DR. PACE: So, I guess, without validity, you're right, it's probably not an issue for feasibility and usability. We've already done reliability. So, the question is whether you want to break them out on the validity question?

MEMBER BEVANS: Yes. I mean my concern I guess is with respect to the global rating of the specialists, in particular, and the global rating of the health plan. I feel like no one, so far, has been able to provide a compelling reason as to why those

correlations would be so different in the child sample as opposed to the adult sample.

If there is a reason and it seems justified, then I think that would be a fine indicator of validity. It's just that I'm not quite sure if anyone has a proposal as to why they expect a hypothesis about why they might expect that to happen, then, I think we should discuss that.

MEMBER STILLE: Other than my speculations, which are based on no evidence I know of other than personal experience.

CO-CHAIR MERLINO: Okay. Let's break it out.

DR. PACE: So, yes, why don't we just see, those who would like to vote on validity separately for the adult measures versus the child measures, indicate by raising your hand.

We'll proceed with voting on validity separately for the adult and the child measures. So, why don't we use this for

the adult? We just have to figure out the logistics here, and then we'll just reset it. We'll just have the hand report. So, let's go ahead. This would be the validity for the adult measure set.

MS. ALLEN: We're voting on validity for the adult measure set: 1) high, 2) moderate, 3) low, 4) insufficient. Voting starts now. All votes are in: seven high, eight moderate, zero low, zero insufficient.

DR. PACE: So, now, Nadine, we'll reset this. We're going to reset this and we will now vote on the child measure set under CAHPS survey.

MS. ALLEN: We are voting on validity for the child measure set: 1) high, 2) moderate, 3) low, 4) insufficient. Voting starts now. All votes are in: one high, two moderate, six low, six insufficient.

DR. PACE: Okay. So, those do not cast validity and we can work with the CAHPS team to see if there's anything additional

they can submit during the comment period that you may want to consider this.

But we'll move on then to discussion feasability and usability and we'll figure this out when we have a talk with the CAHPS folks.

CO-CHAIR MERLINO: So, CAHPS team, I don't understand how this gets implemented exactly.

DR. PACE: Well, you know, this is the first phase of recommendations. So, this will go out for public comment. During the comment period, the CAHPS team can come back to us, if they have some additional data for us to consider that we can take a look at.

Oh feasability, you mean, how to go forward, why don't you --- I think that people said they didn't think there would be that much difference between the child and adult on feasability. I don't think we need to separate them out. Okay?

PARTICIPANT: What is the

question?

CO-CHAIR MERLINO: How does the survey get used?

MS. BROWN: Sure. The NCQA uses the core measures as part of their accreditation of health plans. CMS requires all Medicare Advantage and Medicare Advantage prescription drug plans to implement the survey nationally once a year.

In addition, CMS implements the survey for all original Medicare beneficiaries to measure experience with Medicare fees for service. And the data generated by the survey is publicly reported on Medicare Compare, and also NCQA uses it to generate reports. Those are some uses I can speak to and Dale or others feel free to remind me if I overlooked something.

DR. HAYS: Yes. I think of quite an important one. Those are exactly true and I think CMS Medicaid is responding to legislative requirements in the CHIPRA law

that now, many state Medicaid agencies, about half of them, do use the child health plan survey to survey the managed care plans to serve their enrollees.

It's been in use for a long time and the stakes in using it are growing. So, I think that it's an important application that is driven by the individual states, but we're also aware that CMS is launching a national survey of all states to look at performance. And I believe that's adult Medicaid though.

DR. ZEMA: And this is Carla. One last use is that this also is the foundation for the Qualified Health Plan Survey that is part of the health insurance exchanges that CMS is implementing.

CO-CHAIR MERLINO: Thank you. Becky?

MEMBER BRADLEY: Just as an observation, it's interesting that there is some concern about the information on the

hospital survey related to physicians, like who's the attending physician versus who is the specialist and primary care physician. And it's kind of showing up in these surveys, too.

And I'm just curious as to whether the developers think that the general public or the people filling out these surveys may not be able to distinguish between who is their primary personal doctor versus a specialist.

For instance, if you're taking your child in and you're seeing a pediatrician, would that be a primary doctor, a personal doctor or a specialist? I'm thinking that there is something about the consumer being able to distinguish between these levels of physicians that's showing up in several of these surveys. And it might just be worth looking into again.

MS. BROWN: I had a little difficulty hearing you because you broke up in

some respects. But I think what you were saying, communicating is the concern that the consumer, when they are answering on the survey, the child version fo the survey, the parent or guardian may not be able to distinguish between the personal doctor and a specialist doctor, which they're reporting on different experiences with care.

So, let me try and touch on that by first addressing the definition of the personal doctor. While one tends to nominate one's primary care provider as personal doctor, a parent can nominate a specialist. It's really the person who knows most about the child's care.

It's the person that the parent reports that they would take the child to visit if the child were sick or ill, needed a check up, or whom they would contact if they had a question about the child's care. That does tend to be a pediatrician when dealing with children.

In terms of the specialist section, again, there's a definition of specialist and parents are asked to report on their experience with specialists. And there's also a question about the adult and the child versions that capture whether or not the same provider is being reported on in both sections. We do recognize that someone could nominate a specialist as their personal doctor and capture that so it can be used analytically, if appropriate.

CO-CHAIR MERLINO: Sherri?

MEMBER LOEB: I think it sometimes can't be answered. I believe it's also in-patient, too, because I mean, if you're admitted, your primary care doc doesn't see patients in the hospital, you're seen by one person on Sunday, as a hospitalist, who then is off on Monday. And you're seen by another person who's off on Tuesday. So, you don't have a primary care doc to rate for your hospitalization.

MS. BROWN: In this instance, we're just talking about the health plan survey, which is an ambulatory care instrument and that's what I used --

MEMBER LOEB: Right. I understand that but I can see it can be confusing for any of these surveys.

MEMBER BRADLEY: And I think that was my point. Maybe through some more research or focus groups, they could --

DR. PACE: We'll put it on the list.

MEMBER BRADLEY: Yes. Thank you.

CO-CHAIR MERLINO: Any other thoughts on feasability?

DR. ZEMA: Yes. I just want to clarify that respondents are given specific direction to not include hospital stays when they're assessing care here.

MS. BROWN: Right. And I want to clarify that our qualitative work, you know, hundreds of cognitive interviews have shown us

that people are able to parse out their ambulatory care experience when responding to the survey, from any in-patient experience they may have had.

CO-CHAIR MERLINO: Okay. I think we're ready to vote. Any other comments? Feasability.

MS. ALLEN: Voting on feasability: 1) high, 2) moderate, 3) low, 4) insufficient. Voting starts now. All votes are in. Results: 11 high, four moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: Use and usability or usability and use.

CO-CHAIR PARTRIDGE: Again, I think in our discussion we've identified a number of current and proposed uses.

CO-CHAIR MERLINO: Any other comments? Okay to vote? Use and usability.

MS. ALLEN: Voting on usability and use: 1) high, 2) moderate, 3) low, 4) insufficient information. Voting starts now.

All votes are in: 14 high, one moderate, zero low, zero insufficient information.

DR. PACE: So, just a reminder for overall suitability for endorsement, this is where this will be specific for the adult measures now, because we'll need to come back and look at the child measures on validity.

CO-CHAIR MERLINO: Any final comments? We'll vote on overall suitability.

MS. ALLEN: Voting on overall suitability for endorsement of Measure 006 CAHPS. And we're only voting on the adult version: 1) yes, 2) no. Voting starts now. All votes are in: 15 yeses, zero no.

CO-CHAIR PARTRIDGE: Moving on to our last measure.

MS. BROWN: Just to clarify, we can accurately run that information on the child survey but, if you could just confirm the process for us. So, we submit that during the public comment period?

CO-CHAIR PARTRIDGE: At any time.

DR. PACE: Yes.

MS. BROWN: Or at any time. Okay.

DR. PACE: Right. We'll follow up with you on that. But, yes, you will have through the public comment period, so that the Committee will have it when they review all comments. And thank you for helping us out and joining us.

MS. DORIAN: Yes. Thank you.

MS. BROWN: All right. Thank you.

MS. DORIAN: So, yes. Now we are moving onto our final measure of the day, last but not least, 0726, The Patient Experience of Psychiatric Care as measured by the in-patient consumer survey. I believe you have Lucille. Welcome. If you like to, just introduce yourself and introduce the measure. Just push the speak button and just speak into the microphone.

DR. SCHACHT: Yes. I'm Lucille Schacht. I'm the developer with the NRI. So, I'll be here today. We also have

Glorimar Ortiz on the line. She's the one who ran a lot of the analysis that we'll speak about, if you have questions.

So, the in-patient consumer survey was developed initially back in 2000. And, at that time, we used a couple different task groups involving consumers, researchers, hospital staff.

And we went through a development phase of looking at specific items and getting feedback as to what are the important items to the consumers for the in-patient experience. We really wanted to target to the in-patient experience.

And we ran our analysis back in 2000/2001. In 2002, is when we released our final version of that survey and we were dropped down to 28 items. And, during that process, we went back to those groups and, as you heard from other developers, there are items that we kept in our survey because the consumers felt them to be important, even if

they didn't load to a particular domain or scoring group. So, they stayed in the survey but we dropped it down to 28 items.

And also, we talked with those groups. We had a couple different groups that we used, about the concept name and whether these items that were in that cluster were appropriate, if it covered enough of the dimension of like dignity, rights, outcome, participation, environment and, now, empowerment.

So, we also redid our analysis twice since our initial study in 2002. We did a study in 2008 and, then, we did another study in 2011. And a lot of the material that we presented for this submission are based on the most recent 2011 analysis.

And, so, I think, when we submitted our materials, we left out some things that had been in our earlier materials that are what you were looking for. So, I do have some of that to fill in for you from a

lot of the analysis that we did actually in 2008.

CO-CHAIR MERLINO: Any comments?

MS. DORIAN: Let's start with evidence.

CO-CHAIR MERLINO: Comments about evidence?

DR. PACE: So, again, the question of what actions of the facility? Are there actions of the facility that will influence these particular experience with care measures?

That wasn't exactly what was provided but I think, from the items that go into these, you can get a fairly good idea. But, if anyone has any questions, you can bring it up.

CO-CHAIR MERLINO: Comments? Sam?

MEMBER BIERNER: I just want to ask so I understand the target audience. These are both adolescent and adult patients that have been in-patients in some type of

psychiatric unit, whether it's free-standing or part of a larger hospital?

DR. SCHACHT: Yes. That's correct. It's designed for a in-patient setting, so, both a psychiatric unit or a free standing psychiatric hospital. It has been tested with both adolescents and adults and it's not appropriate for children. Their surveys are designed very differently. So, we don't recommend being used with children.

MEMBER LEVINE: Excuse me. What age is adolescent?

DR. SCHACHT: 13 to 17.

CO-CHAIR MERLINO: Lisa?

MEMBER MORRISE: Sadly, we have also had in-patient psychiatric experience, and I will attest to the fact that this is desperately needed because too often, the feedback from these patients is ignored, both immediately and, then, through feedback-related channels.

And I have mental health medical

power of attorney and it just was so frustrating to get people to talk to me and share information around my child's needs, who was an adult. So, I see this as many other measures, as something that will develop standards that are not currently being met in many, many, many situations. So, I absolutely see that this is something that is needed.

CO-CHAIR MERLINO: Any other comments about evidence? Peter?

MEMBER THOMAS: I just want to suggest that this is a big issue in the disability community, in particular the mental health community, because the very decision as to what treatment plan to pursue is perceived often to be thrust upon patients, rather than having them participate in those decisions, sometimes by virtue of the fact that the provider's questioning their own ability to make those very decisions.

It just makes this that much more important. Do you have anything to say

related to that? It's not a question but I mean it is an important issue that I've heard a lot about in the circles that I travel.

DR. SCHACHT: Yes. We hear a lot about the difference in the perception of what was helpful, what was useful, what's important, when you ask the patient perspective versus the clinician's perspective.

And this really does ask, from the patient's perspective, what was helpful, what was important, how did you feel about that quality of that interaction, because that is probably one of the strongest things in terms of recovery is the quality of interaction. And it really asks for that from the patient's perspective.

MEMBER THOMAS: If the patient actually is not suitable to answer these questions, what happens? You understand what I mean? If they aren't of appropriate capacity, at that point, to answer these

questions, what happens?

DR. SCHACHT: It's a voluntary survey. It can be read to a patient, for patients who can't read. They can be assisted and the patient can be provided some key definitions, if they need something explained to them. It is voluntary.

Usually, when it's administered at the time of discharge, people are at a competency level where they can respond to this kind of a set of questions.

MEMBER THOMAS: But there's no situation where you'd have a caretaker or a family member or someone along those lines answer instead of the individual?

DR. SCHACHT: No. It's not set up as a proxy. There are other tools that you can use for proxy. It was not tested as a proxy. It would have to be retested that way.

MEMBER THOMAS: Okay. Thanks.

CO-CHAIR MERLINO: Lisa, do you have another comment? Sherri?

MEMBER LOEB: I think this just defines the whole name of our Committee. This defines person-centered care.

DR. PACE: And so, the question here with evidence, it sounds like everyone agrees that this is something the psych facility can influence. So, maybe we can go ahead and vote on this.

CO-CHAIR MERLINO: Yes.

MS. ALLEN: Voting on evidence: 1) yes, 2) no. Voting starts now. All votes are in. Results: 15 yeses, zero no.

CO-CHAIR MERLINO: Okay. Performance gap. Any comments from anybody on the call?

CO-CHAIR PARTRIDGE: Yes. I thought this data was very interesting and I was particularly struck by the tremendous gap where I suspect many of us expected it to be, which is on the three questions that relate to empowerment. I don't know where this is but --

DR. PACE: It's in 1b2, Measure Number 6, Empowerment. There we go.

CO-CHAIR PARTRIDGE: You've got a spread. Whoops. We lost it again.

DR. PACE: Measure 6. There. Stop.

CO-CHAIR PARTRIDGE: Right. It narrows, 71 to 82, between your 25th and your 82.

CO-CHAIR MERLINO: Any other comments on performance gap? Questions? Let's vote.

DR. PACE: Did you identify any disparities on anything?

DR. SCHACHT: Yes. We went back and relooked at the data and, basically, tested it in the other direction. Are there differences by racial groups for each of the domains? So, we've run these tests more times than we count. So, we actually have this in probably the earlier submission. But we have age, gender, race, length of stay and

commitment level.

Gender was an element that was different for all domains except for rights. And length of stay and commitment level were the other two that had showed differences. Age only showed difference on one and that was on environment. So, there were no gender differences but there were race differences.

And it was not consistent where one racial group always rated all domains lower than the others. They actually flopped back and forth but they can be identified through the survey.

And we actually had to take a subsample of the survey to determine whether or not the findings that we have are valid because, statistically, it was significant but there was no difference in the numbers. So, we had to do a subsample to ensure that differences are real, and not just statistically because of a large sample.

CO-CHAIR MERLINO: Any other

comments?

MEMBER STILLE: Just one thing I particularly like about this measure. It probably has more variability than almost all the other measures we've been considering the last two days. So, I look forward to seeing it used for improvement.

CO-CHAIR MERLINO: Okay. Let's vote on performance gap.

MS. ALLEN: Voting on performance gap. Voting starts now. All results are in: 14 high, one moderate, zero low, zero insufficient.

CO-CHAIR MERLINO: So, next is high priority. I think we covered a little bit of this in evidence but do you want to comment? Did you do focus groups with patients?

DR. SCHACHT: In the initial development, there were patients involved in the design of the questions and, basically, generating the list of 43 items. And then

when we did the pilot, because we're a developer we don't run the environments where the tests are distributed, those pilot sites did do discussions with their consumers about what questions they found useful or not or wording, and those kinds of responses. And, then, we did have a consumer and others involved in the final renaming of our domains, when we did our analysis.

CO-CHAIR MERLINO: Any comments on high priority? Questions?

MEMBER BEVANS: Could you tell us a little more about the focus groups? How many people were involved? Was it representative of the population?

DR. SCHACHT: The groups that a facility might run, I just have anecdotal information that they do run them. So, I don't know a lot about the size, the scope, or any of that.

In terms of our development work group, there were a number of consumers. I'm

going to estimate three or four in a ten-member work group that were involved in the initial design of the questionnaire. It was actually before I started, so I'm going on the paperwork that I got at that time.

CO-CHAIR MERLINO: Shall we vote, high priority?

MS. ALLEN: Voting on high priority. Voting starts now. All votes are in: 14 high, one moderate, zero low, zero insufficient.

DR. PACE: Okay. I'm on. So, we're at reliability and this includes precise measure specifications. And, just to note, this measure has no case mix adjustment, no sampling. All patients are surveyed that meet the eligibility requirements.

And the survey instructions are that it's given to patients prior to discharge and, then, they mail it back. Is that correct?

DR. SCHACHT: They generally leave

it at the hospital before they leave, at discharge. And they can mail it back, if they take it with them.

DR. PACE: Okay. So, then, we go to testing. Tested in 68 state psychiatric hospitals in 23 states. Each measure was tested for reliability of the patient-level instrument, and with internal consistency and reliability of the scales, which range from 0.81, the rights scale, to 0.88, the outcome scale.

And, then, each measure was tested for performance for reliability using this signal-to-noise analysis with good reliability, ranging from 0.91 on the rights scale to 0.94 to empowerment. And then all the others --- Let me look at that. I think I wrote my notes wrong. Anyway, 0.91 to I think 0.94 or 0.95 on the performance score reliability.

CO-CHAIR MERLINO: So, it's really a feasability question but you brought it up.

Is there a concern, since this is a vulnerable population, that, if people take the survey before they leave, there could be some influence from staff?

DR. SCHACHT: That is one of the areas that you always have a concern about, when you're asking them their opinion before they leave. It's part of the instructions on the survey. It's part of our instructions to a facility, when they're going to implement the survey, that they assure the patient that this is not going to influence the decision about their discharge or their continuing care plans.

You get a much higher return rate when it's returned at the hospital, prior to the person leaving. People do not mail them back. The mail back return rates are really low. A lot of these patients do not have phones. You cannot call them up and ask them these questions and they would also find it very intrusive to be called after they've been

discharged to ask those kind of questions.

So, we actually have a pretty high response rate now. Many facilities are up above 50 percent on their voluntary response.

DR. PACE: So, just to follow up on that. They're handed it by a particular person. Then where do they go to complete it, and where do they turn it in? Is the person standing over them watching them complete it?

DR. SCHACHT: No. Most of the times it's done either as part of the discharge process, when other paperwork is being done, materials that they need to review. They can go fill it out, bring it back. There's a drop box that's sealed, so that information is kept confidential and that their rights are protected in that process of doing the survey.

DR. PACE: We can stick on reliability and, if anyone wants to, come back to this at another point. So, these are the performance score reliabilities. It's .91,

.94 and most of them at .95.

CO-CHAIR MERLINO: Any questions? We'll vote on reliability.

MS. ALLEN: Voting on reliability. Voting starts now. All votes are in. Results: 13 high, two moderate, zero low, zero insufficient.

DR. PACE: Okay. Then on validity, what was submitted was validity of the performance score. So, we can ask if there was data element validity. Could you tell us what you see as data element validity, did you submit it? --- the patient-level instrument?

DR. SCHACHT: Right. Well, we've done a number of things and I think we misinterpreted what was requested in the form. We actually provided it in one of our annual reviews. We did a confirmatory factor analysis, which is the patient-level response validity testing.

And, so, we did that back for 2008

and we published on that part of the psychometric properties. And our fit indices, there are like 11 different fit indices that you can use for the confirmatory factor analysis and all of our scores were well above the expected.

DR. PACE: Okay. So, just for the group because we haven't really had any of the other measures that have done confirmatory factor analysis and that is something that would be appropriate for the instrument level. There's a little bit of difference if you're doing exploratory factor analysis. And we won't get into that.

The item-to-total correlations relates more to reliability. But I think the confirmatory factor analysis, at the patient level, would be appropriate. So, what you're saying is that the domains that you have your measures were confirmed in your analysis?

DR. SCHACHT: Right. And we did that for the 2008 and 2011 data. I know she

did it for 2008. We just recently published on it. We've published actually three times in a row now. So, I'm not sure which one it is that she told me.

DR. PACE: So --

DR. SCHACHT: It's the 2008 for the confirmatory factor analysis.

DR. PACE: Okay. So, let's --

MS. ORTIZ: Excuse me. This is Glorimar. I don't know if you can hear me.

DR. SCHACHT: Yes, we can.

MS. ORTIZ: Yes. We did confirmatory factor analysis for the --- using the 2008 data and, then, at the beginning, when we developed those things for the first time, in 2000.

DR. PACE: Okay. All right. So, let's look at the performance level, which is --- again was provided. And, if we look at the performance measures score, Nadine's got it up there for us. So, basically, this is looking at a coefficient of these different

measures at the hospital level to the overall reading, correct?

DR. SCHACHT: Correct.

DR. PACE: Okay. Well, why don't you explain this table for us.

DR. SCHACHT: Sure. So, what we're looking at here is the correlation and looking at the domain with a general item on overall satisfaction of care. And what's important to note here is things like rights domain and the empowerment domain have very high correlations.

So, from a patient's perspective on their overall satisfaction with care, if they have a higher rating on rights or empowerment, they felt more satisfied with their service, in general. Even if their outcomes might have been lower, they had a higher dignity level, so higher satisfaction.

DR. PACE: So, I think we would, just to kind of complete the circle, like the information on the instrument level

confirmatory factor analysis. But I think we can proceed with the voting, unless anyone wants to have some questions about that.

MEMBER THOMAS: Just looking at that data, I don't know. It strikes me as very interesting that the outcome of care numbers are so much lower than the rights and empowerment. So, does that say that patients that feel empowered and feel that their rights are being respected, they value that more than the actual outcome of the treatment?

DR. SCHACT: Yes. That's what it's suggesting. It's a personal experience of the interaction that has a higher relationship to overall satisfaction than the outcome. The outcome questions are being able to deal with stress and being better at social situations.

And they may feel like they're doing slightly better at that, but if they have a higher rating on their dignity, they may have generalized better satisfaction with

their hospital experience.

MEMBER THOMAS: Thanks. Very interesting.

CO-CHAIR MERLINO: Any other questions on validity? Comments?

DR. PACE: Just one. You know, this is the area where we would talk about case mix adjustment. So, in this case, the question would be is there any concern about no case mix adjustment or any questions or issues.

MEMBER BRADLEY: All right. Well, I guess there's always a concern about lack of case mix adjustment in this kind of survey. But could you explain again why you all did not feel that was significant.

DR. SCHACHT: As a vendor or measure developer, we developed a survey and we suggest lots of ways for hospitals to do their domain scores and, then, to break them apart by the populations of interest to them.

So, when you do risk adjustment,

you sort of bury those things in the score and you don't know that you have an issue with a particular population, because it becomes buried in the way the score is calculated. So, we suggest that folks actually break it apart and do stratifications.

DR. PACE: So the question is, again, if this is being used in any kind of comparative performance assessment. And you had mentioned earlier about I think gender differences. So, if there is a systematic difference, then you have a variation in the population.

So, is this being used? I know we'll get to that in accountability. But, just in terms of your discussion about case mix adjustment, is it being used for accountability applications where facilities are being compared for public reporting or payment?

DR. SCHACHT: Based on your feedback as to the interpretation of public

reporting is, we're a measure developer. We cannot display a facility-specific information. We display aggregate, so that others who are using the survey have that aggregate benchmark.

Facilities can display their own rates and many publicly-operated facilities actually provide those rates in public reports available through their website, or to their legislature or to other governing bodies. It's not a core measure, so it's not reported by joint commission on its public website, although it was a noncore measure.

So, it's used in accountability in that way and there are many facilities who actually do post their rates publicly, and they will post it as an aggregate.

CO-CHAIR MERLINO: Any other comments? We'll vote on validity.

MS. ALLEN: Voting on validity. Voting starts now. All votes are in. Results: 11 high, four moderate.

CO-CHAIR MERLINO: Feasability. I still don't get the operational component. I mean, I get the fact that you have a high return because people are filling it out before they leave. I would expect that. But I don't quite understand how you protect patients from honest opinion.

I mean one of the things that the CAHPS team has always really pushed is that providers are not allowed to talk about the survey. They're not allowed to reference it and it has to be done in the house, to a certain numbers of days after they are discharged, to protect patient's autonomy. So, could you just address that a little bit more?

DR. SCHACHT: When patients are asked, when we do the development of the survey, how would you prefer it be distributed to you, do you want it distributed by someone who's not on your treatment team, that's actually their preference, so that they know

that it doesn't feel obvious to them that they're responding right back to their treatment team in a way that's identifiable.

And a lot of the patients in the public hospitals, which is where this was initially tested, do not have the same capabilities once they leave the facility to have someone show up at their door and say, can we fill out a mental health survey versus, you know, being in the hospital or getting a phone call saying, I know you were in a psych hospital. Let's do a survey.

They are very intrusive kinds of questions and, you know, there are a number of places who have experience in doing that. I, myself, when I worked in the state of Vermont, worked on a survey that was sent out to patients after they had been in mental healthcare.

And it was actually just mailed to them and we had a huge number of responses coming back, how do you know I had this care?

It's a very intrusive kind of feeling once a person leaves the hospital.

So, while that's still really a stigma issue, it's easier on the patient population that they're administered while they're still in the hospital.

CO-CHAIR MERLINO: Any other comments or questions?

DR. PACE: So, in the survey instructions, you have one statement. Anonymous or not, if the numbering system for the survey includes some mechanism for linking the survey back to a specific patient, then the survey is not anonymous.

What are the instructions? Is it supposed to be anonymous, or is that a user decision?

DR. SCHACHT: That's a facility decision about whether or not it's anonymous. They have to indicate on the survey whether or not it is anonymous. And, if it's not anonymous, they're also obligated to tell the

patient this is not an anonymous survey. We know you are ID Number whatever.

And that is something the facility has to work through, if they're doing an identified survey.

MEMBER BIERNER: I just want to ask you on the table, it talks about overall missing data by domain. Participation and treatment was the highest. Do you think that ties into this issue of the way its administered or what is the feeling about why that was so much higher? Participation and treatment was missing data and it stood out.

DR. SCHACHT: Well, that particular domain actually has more to do with transition of care from in-patient to out-patient. So, there are a number of surveys that are completed by people during annual review, or a hospital may be just doing an overall reassessment of their environment.

And, so, there are people who are not getting discharged. And, so, the question

is not applicable. And that attributes to the higher level of missing data there.

CO-CHAIR MERLINO: Anybody else? Can we vote on feasability? Let's vote on feasability.

MS. ALLEN: Voting on feasability. Voting starts now. All votes are in. Results: five high, nine moderate, one low, zero insufficient.

CO-CHAIR MERLINO: Usability and use. Comments? We're almost done. Two more questions. Do you want to comment on usability?

DR. SCHACHT: Yes. As the measure developer, we do get information from facilities who are using the survey and want to benchmark with another defined group. And we can post, through the nature of the contracts, an aggregate across all of those providers, so that anyone using the survey has a benchmark available to them without actually having to participate in the benchmarking

database.

Facilities can choose to self-disclose their numbers. It used to be easier to find stuff on the web. But I can still find Texas Departmental Health posting their materials, Colorado Department of Human Services is posting their materials. And Acadia Hospital, which is a privately-run psych hospital in Bangor, Maine is posting their materials.

Those are the first three that I could find. So, people can self-post that material and they can use it as noncore measures and accountability reporting with Joint Commission. But Joint Commission only posts core measures, so it wouldn't be posted through them.

People use it a lot for internal quality and improvement, and they do a lot of networking on how to break down these questions and work with their local consumers on how to really improve the care and be

consumer driven.

DR. PACE: You said Texas Department of Health?

DR. SCHACHT: Texas Health and Human Services Department of State Health Services it the department that actually posted.

DR. PACE: So, is that more than one facility or is that --

DR. SCHACHT: They have ten facilities.

DR. PACE: And those would be publicly reported?

DR. SCHACHT: Yes.

DR. PACE: So, that's --

DR. SCHACHT: That's ten identified facilities with their rates, with the national number that we post that they have then put on their report.

DR. PACE: Okay.

DR. SCHACHT: Colorado actually has two hospitals that they report.

DR. PACE: Okay. Thank you.

CO-CHAIR MERLINO: Any other comments on usability or use? Let's vote.

MS. ALLEN: Voting on usability and use. Voting starts now. I'm missing a vote. Okay. All votes are in: 11 high, three moderate, zero low, zero insufficient information.

CO-CHAIR MERLINO: All right. Overall suitability for endorsement. Any comments or questions? Carol has her clicker up already. She's ready to vote. All right. Let's vote.

MS. ALLEN: Voting on overall suitability for endorsement for Measure 0726, Patient Experience of Psychiatric Care. Voting starts now. All votes are in: 14 yeses, zero no.

CO-CHAIR MERLINO: Congratulations. You made it.

MEMBER LEVINE: Could I just make a comment now that we've voted? I'm really

intrigued by the importance of the rights element, not that it's surprising but how do these patients know their rights and what are the rights that they think are most important?

It would be really helpful, at some point, to know a little bit more about what's going on.

MEMBER BIERNER: They're posted. In the in-patient psych facilities, they're posted, you know, on the wall, so you can see them. And they're distributed or made available to the patients.

MEMBER LEVINE: Posted is one thing. Really understanding what these can be --- some of these are adolescents. And the other point is it's not at all surprising to me that outcomes are less important because these are people who have a mental illness that's not going to get cured in whatever the short time they are in in-patient.

So, if they see any kind of improvement, any kind of, you know, stability,

I would think that would be important. But the say they are treated and they are feeling that they've gained something in this experience I think is obviously more important to them.

DR. PACE: Do you want to make a comment on how people are notified of their rights and how that relates to the question?

DR. SCHACHT: No problem. The rights are things that are communicated through postings on the walls. Those are like requirements that they're posted. But, also, through the therapeutic interaction. What are your rights? Is it okay or how do you refuse medications? How do you decide which treatment group to go to? Those are rights about choice.

And, so, that's all part of the therapeutic interaction. And I think that's why it rates higher in terms of its relationship to overall satisfaction than outcomes might because of the dignity and that

personal empowerment that goes along with all of that.

MEMBER THOMAS: So, are we about to break up, because I have one thing that I'd like to suggest?

MS. DORIAN: All right. So, on to public comment. Operator, if you could, please open the lines.

OPERATOR: If you want to ask a public comment, please press *1 on your telephone keypad. There are no public comments at this time.

MS. DORIAN: Okay. Thank you. So, did we want to break and then come back?

DR. PACE: No.

MS. DORIAN: So, we touched upon some of this yesterday, but we did want to touch base again after the second day, just to see if you had any recommendations.

So, we were struggling with issues about submitting multiple performance measures in one submission form, the requirement for

testing at both levels and the requirement for information on how the target population identified what was valued and meaningful.

So, if you have any thoughts or feedback on any of those three things or anything else that could help us improve our process that we didn't discuss yesterday, we're open. Yes?

MEMBER THOMAS: I have a couple.

MS. DORIAN: Yes.

MEMBER THOMAS: I think the first one that I would suggest that NQF consider is having each one of these submissions undergo kind of a staff review to ensure that it's complete, and to ensure that the questions are answered and that the answers are in the right place and that it's organized in such a manner that you can intuitively go through a packet and see what the issue is that you're supposed to be looking at, and what the data is that correlates to that issue.

So, I can't tell you how much time

I spend just trying to find things that might be relevant to what I was trying to figure out because I didn't know enough to know what I didn't know.

And it just struck me that, if they were organized in such a manner that these would not even be before us until they were certified as being complete, that would save a lot of time and probably make the whole process a bit easier.

We've been getting things in spreadsheets and things sent in, you know, last minute. And I understand this is a work in progress. But that was one point. Could I continue?

The second thing is that I'd love to see the actual measures that we're looking at and examining right up front. Just these are the measures that we're looking at, because it oftentimes is buried, and sometimes they're not even included, which is really bizarre that you would be assessing a set of

measures that aren't even included in the packet that we receive. So, it would strike me that that should be up front and, you know, in bold letters.

The third is that I noted that a number of the developers didn't understand some of the questions and what they were actually being asked. And, so, they didn't provide the data to support that. So, I'm wondering whether some of the questions are either unclear or whether they were struggling with some of the things that I was struggling with, just understanding exactly what they were being asked.

So, I guess I'm recommending that you go back and kind of figure out are these questions as clear as they need to be for developers to understand what they're being asked?

MEMBER BIERNER: I think, as we kind of mentioned yesterday, instead of being prescriptive about it, maybe get some

illustrations. You know, some developers have used the following methods to establish reliability or validity, so that you're not saying you have to do it this one certain way but here are some examples that have worked, you know, for a developer coming to the Committee.

MEMBER THOMAS: I agree. I also wanted to compliment you, Karen, on what I presume was your drafting of the staff review of these, because I don't mean to be pushing this onto NQF staff to do our work, but that was really, really helpful to me. That organized me. That kind of gave me a sense of what I needed to focus on.

Again, I sometimes didn't know what I didn't know, and that's the worst position to be in. So, having that kind of laid out by someone who sees a lot of these and understands this stuff cold was really useful to me. So, I would very strongly encourage the additional development of those

prior to group discussion.

MEMBER DOWDING: Yes. This is in reference to the multiple performance measures. I'm not entirely sure that I want to see every single performance measure for every single CAHPS survey submitted separately. I think that would probably be overkill.

But I do think that it would be very helpful if, for instance, this afternoon we looked at the adult plan survey and the child plan survey together. And, actually, they should have been separated. The validity data was different. The reliability data was different. And there's a case for separating out those types of surveys.

And I think we had two where we were looking at adult and child together. And I think that we probably need to say they need to be separated out. But not the individual performance measures within the surveys because then we would be here all week. But

that would be my preference.

MEMBER STILLE: I was going to say, basically, what was said but I was trying to think of a way to do that. I don't know if there's any way to sort of say, okay, these two measures are the same for this, this, this, and this and, then, they diverge here. So, we talk about them separately. And, then, they come back together for the feasability and the other stuff, if there's a way to do that.

That would help save time and, also, orient people that they don't have to think about the same thing a million different times.

MEMBER BRADLEY: I actually see the survey tool as part of it. Because of the way the questions are worded, from my standpoint, since I'm not so statistically oriented --

DR. PACE: --- can I just. What we asked the developers to do is to identify the

measure and to write out the questions that went with each measure because, even when you see the survey tool, you can't tell necessarily which questions go with which measures.

There were a few that did that and, for me, that was much easier to follow. But we'll continue to work with that. But we also asked them to provide, either at a URL or in the appendix, the actual data collection instrument.

So, I think, you know, we'll have to continue working with the developers and certainly I think both are useful to you and to have them immediately available.

MEMBER BRADLEY: And some of them they did provide kind of a synopsis of the question. But it wasn't the way the question was worded on the survey.

DR. PACE: Right. Exactly. We asked for the detailed specifications to identify each measure and to write out the

questions that went with it.

MEMBER STILLE: You're also being a little charitable, right? From what you told me offline before, a couple of calls with some of the developers were very specific --

DR. PACE: Right.

MEMBER STILLE: -- about what to submit and they didn't listen?

DR. PACE: Right. We just continue to try to have discussions with developers and respond to their questions. And, so, we will continue to work with the developers to work on the submissions as you all have suggested. And we know that, you know, sometimes the questions are not that understandable.

In general, NQF, for our general measures, have put together what's called What Good Looks Like. So, especially for the evidence and measure testing, we've given specific examples, just as you were talking about, Sam, on illustrations.

We did a little bit of that for the experience with care measures but we didn't really get to every item. But we did try to provide some notes on the kinds of things. But we'll continue to work on our end and get some feedback from the developers on things that were unclear and that we need to clarify with them.

CO-CHAIR PARTRIDGE: At this point, I think a couple of times over these two days we have talked about making statements that say, this is what we will be looking for. And it isn't just the same person on the Committee saying that. It's coming from multiple Committee members.

So that I hope that helps you in the future, so you can go back and say to a developer, this submission, as it stands, will probably not get through this Committee because you haven't addressed this or haven't addressed this fully.

They are looking for that and I

think it's one of the strengths of having a standing committee. You establish a culture here, which then helps the developer community understand what they need to do.

DR. PACE: One other thing in terms of, you know, we came across a couple where they didn't submit the testing at both levels. And I think, from an NQF standpoint and how these measures are intended to be used, that the performance score, reliability and validity, in terms of what they're being used for, is essential.

So, I guess my questions to all of you is, you know, our feedback from the PRO Committee a couple years ago was they would still like to see that the, you know, instrument or scale that's being used had some reliability and validity testing. So, if you have any thoughts about that, whether we should dispense with the instrument level or what your thoughts are about that.

MEMBER BEVANS: I think it's

essential. I mean I really think that it gives you a very important view of how the instrument operates overall, what the factor structure is, what the concepts actually mean, you know? Because, to sort of just work at the scale level, where we would likely be for a lot of the performance measures, I think that, you know, results in some really critical missing information about the meaningfulness of those concepts.

So, my opinion is to retain the individual level reliability and validity information.

MEMBER DOWDING: I agree. I think that you can't have a reliable performance measure unless you've got a reliable individual scale. So, if we're endorsing them for national use, we have to be convinced that the data on which they're based is reliable and valid. So, it's essential.

And, as we said yesterday, there are ways in which we can be much more explicit

and directive about actually saying, unless you provide both levels of information, it goes no further. I mean I have no problem about sending it back to them and saying we won't look at it unless it's there.

MEMBER BIERNER: One other thing that's slightly oblique to that. I think that it's really useful that they explained the purported use and it was expected, how it will be used for some of these instruments.

For example, the one that had to do with healthcare plans, they have potentially far reaching implications. So, I'd like to know more, maybe somewhere in the worksheet that the developer fills out, the intended use, you know, the audience, so to speak.

Not only who the subject or patients are going to be but the audience for the results. Is it for, you know, federal government? Is it for health plans or hospitals, et cetera?

MEMBER LEVINE: I have one suggestion about the orientation or whatever we went through the first few times there were discussions. It was only today that I really understood what this was all about.

Honestly, I spent a lot of time. It was all too abstract. In my world, Cronbach's alpha and top box scoring are just not, you know, state of the art stuff. So, in the training or the orientation, if you took an actual proposal and then applied the concepts to it, rather than going through the concepts which don't mean anything to people like me, it would be a lot more meaningful.

But, I mean, I must say thank you. Today was a learning experience. I really felt like, oh, that's what they're talking about. Thank you.

DR. PACE: You know, I think this obviously will get easier as the Committee works together and you go through this again. But I'll just throw out something for you to

think about. And we're willing to kind of think about this. But to think back to the work groups and also this meeting, so, what if we flipped everything around where we met together first for the initial review and, then, you know, the voting may be online afterwards?

I'm just curious, in terms of what is the best use of our time together versus online or on conference calls, if you have any thoughts about that? I mean this is the usual process we've used. But, certainly, if you have any thoughts about that.

MEMBER BRADLEY: I think it would be hard for me to concentrate online and get the sense of the conversation with the developers. I mean there is just the tendency to want to do three things while you're on an all day conference call.

DR. PACE: Right.

MEMBER BRADLEY: So, I would recommend that we do the voting in person.

MEMBER BIERNER: I think being in person gives you a feel of the room, of how, you know, some people are feeling about one measure or another that you don't get on the phone.

If you listen into one of the previous calls that we did preliminary to this, you don't get a good sense of what other people are thinking or how they're reacting to things.

MEMBER LEVINE: I agree with that. I think that, if we're better prepared, if what we get ahead of time has all the elements that we've talked about, then, the coming together and feeling the sense of the room and the group is really critical, as a final step. I would prefer to keep it that way.

CO-CHAIR MERLINO: Yes. I think getting the information in an easier to use form: the abstract, the measures up front, summary of the key points, holding the developers to really the standard that we're

expecting and if they don't have it they don't present. Using that.

MEMBER BEVANS: I think the phone calls, the work group phone calls, at least for me, were really helpful to really begin to understand the instrument on a different level, because of the feedback that other members of the Committee were giving and things that I didn't think about, different perspectives I could use to evaluate those measures but also other measures that we were evaluating later.

I would say though that, at least, our work group had I think one measure that we reviewed for which the developer was not on the call. And I don't think that was especially helpful. So, I think that should be a requirement.

I was also wondering what was the process? After the call, in several instances, we gave, you know, some feedback that could have been addressed by the

developer. Did they do that or did they have an opportunity then to make revisions? I think that's another benefit of the call.

DR. PACE: Yes. We didn't give them specific directives but we did send a follow up, you know, with some of the general issues that we identified. And, also, some of them, you know, very much realized that there were --- something that was brought up in the call and submitted.

But one of the things that we've been trying to work out, our time lines, as you probably have identified, are very compressed. And, so, we really hear and appreciate your thoughts about the submissions.

It's always been a bit of a struggle of reopening these submissions and letting them add new stuff because generally it's a lot of stuff to look at. And, if you we tell you, oh, now there's a new one to look at, we have to try to balance that as well.

So, we tried to, you know, ask them specific questions and then we'll have a chance for them to really update the information. But it is a struggle that we have in terms of --

MEMBER BEVANS: Even if they don't do that in writing and they begin their presentation here in the in-person meeting --

DR. PACE: Right.

MEMBER BEVANS: -- here are the things the work group brought up, here is my response, that wouldn't --

DR. PACE: Okay. Yes. Right.

MEMBER BEVANS: -- add any extra time really.

DR. PACE: Right.

MEMBER BEVANS: I think that might be a good approach.

MEMBER BRADLEY: Is there a difference between a steward and a developer of a measure?

DR. PACE: Well, a lot of times

they're one and the same.

CO-CHAIR PARTRIDGE: Sometimes.

DR. PACE: Sometimes, especially with the federal agencies, the steward, for example, might be CMS but they contract with another group to actually develop the measures and do the testing.

So, we have both models where the steward and the developer are one and the same and, then, you know, especially with CMS and AHRQ, CMS and AHRQ would be the steward but they generally contract with other organizations to develop the measures.

CO-CHAIR PARTRIDGE: And the steward means, essentially, I'm going to keep track of this measure. The developer may have gone out of business. That sometimes happens, too.

And, so, someone else takes it over and is responsible for the maintenance, which means that, over the course of the period of time between the time it comes up

for initial review and the maintenance review, if something dramatic has changed, the evidence has changed, we shouldn't be treating people this way or there's a new drug or something like that.

MEMBER BRADLEY: Who would be the steward if that measures stays in the public domain and people start using it?

DR. PACE: Right. And, actually, they were the steward and the developer. What she was making and distinction of is then the implementer. So, they may develop the measure and they'll steward the measure but, then, what she's saying is, well, you know, it's up to the states to mandate that their facilities actually use this and collect the data and report it.

So, that's another player in this whole quality measurement space. You know, it's the reporting and use of those measures, whether in a public reporting forum or in a pay per performance program. And that's where

there's --- NQF can endorse measures but the people, CMS, state programs, health plans, they're the ones who actually use the measures in terms of saying, you know, we want data on this. We're going to compile it. We're going to compute these measures and report it.

MEMBER MORRISE: First of all, I want to say that I am so impressed by the people in this room, everybody really. Having been recently to some meetings where people treated patients with disdain, I am so appreciative of people who really are interested in patients and what they think and their feedback, so that that information can be used to improve the quality and safety of healthcare.

And I do think the work group calls ahead of time were helpful. If nothing else, I felt so much better after the call when my colleagues that were on the call said that they, too, were swimming upstream. And I didn't feel like I was just this little

patient who didn't know anything, that maybe, you know, I would be able to make some valid contributions to the discussion.

And I have learned a lot, just being here. So, I think that the orientation for the next round will be easier, just because those of us who have been in the room already understand some of what we're talking about, although I may understand those terms either, Carol.

I thought, oh, my gosh. I think I'm going to go dig out my statistics textbooks and see if I can brush up a little bit. But I really appreciate the opportunity and I appreciate the staff at NQF for trying to make it as smooth as possible for us and help us get through everything and provide the information that we needed to make some good decisions.

DR. PACE: Another thing which you probably noticed, because in the work group calls and some of our discussions we talked

about we were going to define lead and second discussants. And then we switched and assigned some of you to look at some data and items and others to look and reliability and validity.

And I know you didn't have anything to compare it to. Lee has but just any thoughts whether you think that was better or worse? This was a little bit of a test whether that was appropriate. Lee, I'll let you start to see if you thought that was any better.

CO-CHAIR PARTRIDGE: My sense was that, as we went through the two days, the assignment didn't really make much of a difference. Am I right? I mean people spoke up regardless. Some of the people who led off weren't even on the work group. So, what I do think makes a difference is having clusters.

The work group essentially comes in. They have the benefit of the discussion beforehand. They know that they'll be the

leads. And whether you split it as to which art I think matters less.

MEMBER MORRISE: I would feel actually more comfortable continuing to not be in, you know, the strictly statistical scientific realm. And I will go back and have a relationship with my statistical textbook. But I don't feel comfortable that I would be the best representative to evaluate those.

Although, I've very rarely been stopped in my life from commenting on things that are important to me. So, I may still comment but it's definitely not my area of expertise. If you want patient experience, I'm there for you.

MS. DORIAN: We'll go quickly over some next steps. So, it's on the next slide. I won't belabor this because I've mentioned it a bunch of times already. So, we'll be busily working on compiling the draft report over the next two weeks or so. We'll send it to you for your feedback.

But, then, it is published on our website for public and member comment for 30 days. We'll then have another call with you. You do have that date and it should be in your calendars to reflect upon the comments, because we do respond to everyone.

And we might alter or edit the report based on the nature of the comments. So, we'll talk that through with you. And, then, the report is once again posted online for member vote for 15 days.

And, then, as mentioned before, the subsequent steps just follow our process. So, it goes to C staff, the Board review. And, once the Board reviews it, those measures are officially considered endorsed, if they approve your recommendations. And, then, there is an appeals period for anyone who wants to submit appeals.

In Phase 2, the call for measures closes I've been saying November 25th but I was wrong, November 7th. So, your next phase

of work will really start up again in early to mid January.

MEMBER BIERNER: So, the developers that we asked to come back with more information, they'll have until that October 3rd date to provide that?

MS. DORIAN: Exactly. Yes.

MEMBER LEVINE: We have no conference call on August 5th.

DR. PACE: Actually, don't we have a conference call on the books for a week from now?

MS. DORIAN: We do, actually.

DR. PACE: I think we need to leave that, just in case.

MS. DORIAN: It was an actional call, in case there was leftover work.

MEMBER LEVINE: Okay. Because I think I have another NQF action team call at the same time. So, I was confused as to what the purpose of that one was.

DR. PACE: Right. We decided to

schedule something after this meeting, in case we didn't get to something or needed to review something. If you would just leave that on your calendars for just a little while longer, we'll make sure that we don't need it and then we'll send you a cancellation. But that's the reason we do that.

MEMBER BRADLEY: On the appeal process, are we involved in that at all if they appeal?

MS. DORIAN: Oh, if somebody submits an appeal?

DR. PACE: If the appeal is after the Board ratification, the Board and C staff deal with it. So, I'll say that's the general rule. But, if it would be on a real technical issue like clinical evidence, you know, they may ask the Steering Committee to weigh in on something like that. But, generally, it's handled at the C staff and Board level.

That's why we've kind of built that in. If there's something missing or that

we need to do, to do it during that comment period as well, so it's not happening all the time.

MS. DORIAN: Any other last minute questions/comments? We would just like to thank you so much. It's been a wonderful two days. We've really appreciated your candor and I think it's been just a great evaluation of these measures. Thank you to our wonderful co-chairs. You've led the group very well.

And I hope you will all also join me in thanking Karen for her last meeting here. I will miss her. She'd led us so wonderfully these last two days. Thank you. And thank you, everyone. Have a safe trip back. And, Operator, we can end the call now.

(Whereupon, the above-entitled matter went off the record at 3:14 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Person- and Family-Centered Care Standing Committee Meeting

Before: NQF

Date: 07-29-14

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter