NATIONAL QUALITY FORUM

Moderator: Person and Family Centered Cate
October 20, 2014
2:00 p.m. ET

Lauralei Dorian: Good afternoon everyone. This is Lauralei Dorian and the rest of our team members here at NQF. Thank you for dialing in for the Person and Family-Centered Care Post Report Comment Call. Just a reminder before we get started to please keep your lines on mute if you're not speaking. We will have public comments for the end of the call.

We are – this is also a webinar and we're screen sharing but if for some reasons, you can't access the webinar or it's not working for you. For the committee members, we have all of the materials available on SharePoint and for members of the public materials are also available online.

So, we have two purposes for this call today. Usually, it's just reserve to discuss any public and member comments that have come in during this 30-day public comment here.

But, if you are called during our two-day in-person meeting, there were a number of unresolved issues. You as a committee had voted a number of measures (down) that the developers indicated that they actually had testing data – (data supply), so we agreed to allow them to do that during that comment period. And then you would be able to rereview that and vote on that information.

So, the second part of our call today is reserve for discussing all of that additional data. And we're not going to be voting live on the call today, but we do have a link on the left hand side and we'll e-mail it to you as well, and give you probably three days. We recommend that you vote as quickly as

possible based to the information, refreshing your mind. So you'll be voting at following the call.

We also have Lee Partridge on the call, your co-chair. Unfortunately, Jim Merlino can't be here today. And Lee will lead us to some of the comments. I'm going to talk about some general comment we got in. And then we'll discuss that additional data.

So, before we get started, does anybody have any questions about the purpose of the call today? Great.

So I just did want to note that we didn't – I don't think there weren't any overly controversial comments. Usually, we've seen the comments and you will have seen in that memo the things that being noted.

The other comments, there are number of comments on individual measure that sort of recommend, does it changes the measure specification or asked question. So, for those comments, we send them to the developer for clarification. And then that Excel spreadsheet, we have the developer responses. Some of the comments require in their committee responses as well especially the (seen) ones.

So, we have proposed responses for you. And we just ask that you either say yes. We agree with your proposed wording or if you'd like to discuss and change to the wordings, please feel free do that as well. But this is just to note that we do not need to go through every single individual comment that I hope you have reviewed the excel table and raise any issues with us, any individual comments that you would like to discuss.

So, the first theme was support for committee recommendation 6 of the 17 comments expressed agreements with the committees with your recommendation for endorsement. Put it here. We're still (trying this) on the screen now. And the numbers of comments often said we agree with the recommendation not to recommend the measure. And so for those, we just said the committee agreed with you. And we'll review any additional data during its comment call.

The next theme related to related and competing measure. So, there were three comments regarding two groups that potentially competing measures. The first group is the family survey of end of life care measures, so the bereaved family survey and family evaluation of hospice care.

And we've just said that at the time with the in-person meeting, the developer family evaluation of hospice care did not provide sufficient evidence to evaluate reliability at the facility level.

And the developer did submit additional testing data during the comment period and the committee, we'll review it today. And so, usually the process for competing measures is that they measures individually has to be recommended for endorsement and then competing issue are discussed.

So, we actually won't get to the discussions on the call today because we need you to vote on those measures to see if both do move forward. And at that time, we can start whether to have another half hour call or whether we can deal some of these issues via e-mail. And it's a similar issues for that second measure group which is the family survey for pediatric care.

Does anybody have any questions or just Lee want to have anything?

Lee Partridge: No, I just wanted to be sure that people understand what Lauralei just said.

Lauralei Dorian: Yes.

Lee Partridge: And in other words we're going to have to comeback again in this one instance. One, two – one instance, I think. And say make a decision on the competing measures issue.

Peter Thomas: And are we doing that on this call?

Lee Partridge: No, that's what I wanted to make sure everybody understood. As a technical matter because we have been voted to recommend, assuming that – when we do vote, we vote to recommend, then we would have both measures in font of us to make a decision on whether or not they're competing. And we should

therefore select one as best in class or a go forward with both because we think they are complementary rather than actually competing.

Peter Thomas: And again, that happened (inaudible) meeting.

Lee Partridge: Yes, right. Or by e-mail as it is pretty straightforward, we might be able to solve that.

Peter Thomas: OK, thank you.

Lauralei Dorian: Great, thanks, Lee. You explained it very clear.

So, we do have just holder responses in place for those public comments for the moment. And we will update them based upon your ultimate recommendation. So now we can move into a discussion of specific comments or comments that's been submitted about specific measures. And Lee will lead us through that. And we're just bringing it up on the screen now.

Lee Partridge: OK, as the first – which one are you bringing up first Lauralei? On my Mac Air, the screen – the print is so tiny, so I can barely …

(Crosstalk)

Lauralei Dorian: Well, (inaudible) of the spreadsheet, so that first one is about 0228. So, it's the comment about this three item care transition measure?

Lee Partridge: Right. Which was simply as I saw that one our developer is said – repeated what he said in the meeting itself which is that in the instance in which it would be – there was a comment that would be desirable to have children a pediatric content. Is that – and Eric Coleman said he was working with, I think the (cheaper) funded center in Boston to adapt his CTM measure for pediatric, right?

Lauralei Dorian: Exactly, right.

(Off-mike)

Lauralei Dorian: I'm sorry. You broke up so we couldn't understand it.

(Chris): I'm sorry. This is (Chris). I spoke with Eric afterwards, interested in collaborating if you didn't already have a …

(Off-mike)

Lauralei Dorian: OK.

Peter Thomas: I'm wondering if that speaker was on WebEx alone and not on speaker phone where on conference call whether they could get on conference call because it seems to be breaking out the quality of the audio.

(Chris): I'm on speakerphone only, I have no microphone on my computer.

Peter Thomas: Really? OK. Sorry about that.

Lee Partridge: OK, but as I – I don't think there is – unless anybody has any concerns. I don't think that comment changes our decision. Agree?

Peter Thomas: Agree.

Lee Partridge: OK.

Lauralei Dorian: OK.

Lee Partridge: All right. Next one, Lauralei.

Lauralei Dorian: So, the next comment is comment number 4532 on 0166 HCAHPS. And this is a comment that came in from the American Medical Association.

Lee Partridge: Right.

Peter Thomas: I'm so sorry if I keep speaking. This is Peter Thomas. Just to clarify. So we're not going to through each comment, right? You already said that in the beginning. So you're jumping on the spreadsheet. You're moving from one to another that you just find particularly salient that we need to discuss, correct?

Lee Partridge: Right. So these are comments that are on individual measures. We need don't need to discuss them as we just – so in that last instance sort of just agree that,

that everything is fine. But if you want to raise anything in detail and call it out and have a conversation, you can feel free to do that as well.

Peter Thomas: OK, thank you.

Lee Partridge: This is one the ones that we need want feedback from the committee on though.

Lauralei Dorian: All right. So open for comments. The issue is the AMA is concerned about the (pain) question measures. And they are in particular concerned about the possibility – I'm paraphrasing here. The possibilities that – there are two countervailing influences here, as the national issue we are attempting to reduce the dependence of our population opioids. At the individual level a facility or provider might be given a poor score by patient because the provider or was very reluctant to prescribe the opioid.

So, comments.

Lisa Morrise: This is Lisa Morrise. I read that and I've been involved locally with some efforts to be more responsive to pain issues in both adult and pediatric population and having been involved also on this kind of side lines with a project with our state Medicaid office to provide appropriate pain intervention.

I still think that the percentage of the population that is direct-seeking and in attempt to alleviate pain is relatively small. And that most of the (detained) with experience inpatient in the hospital is acute related to the patients condition in the hospital often surgery.

And I don't see anything specific in the measure that says that you're going to say that somebody didn't relieve your pain if they didn't give you opioids. It doesn't suggest in the questioning or anything that there was a specific methodology for pain relief, just the pain was relieved. And regardless of whether an individual has an opioid addiction or not when they are inpatient and they are suffering from pain. I think its incumbent from the providers, the hospital to provide pain relief in some fashion.

So I don't know why the AMA chose to focus in specifically on opioids because, I think at some sets and not necessarily relevant to the specific questions that being asked the patients.

Sherri Loeb: This is – Lisa, are you done? I don't want to …

Lisa Morrise: Yes, I'm done. Thank you.

Sherri Loeb: This is Sherri Loeb. I agree. You know, if there is addiction in a patient or drug-seeking, when someone is admitted acutely, that's not the kind to address it, you know? The time to address is afterwards not where they're admitted for procedure or for – a new acute issue. And I saw that as a nurse, you know, a patient who had been on a narcotics for a long time for a real issue and maybe was addicted to it now. And then went for surgery and then they said, "Well, it's done. Way too much narcotics so we need to cut those in a way back." That's not the time or the place.

So, I agree with you wholeheartedly that this measure just addresses whether their pain is under control in the hospital, whether it be through narcotics, whether it be through, you know, non-opioids, whatever method is necessary. Their pain needs to be controlled while they're in the hospital.

Lauralei Dorian: OK. Any further comments?

Carol Levine: And this is Carol. I agree with that. I think the AMA wanted to be on record as supposed something rather hear but I was thinking it's appropriate for this particular instance.

Lee Partridge: All right. Does anybody disagree? If not, then I think we can be comfortable with our original recommendation and go forward to the next one.

Lauralei Dorian: Great. So the next one is comment number 4531 or on 0517, the CAHPS Home Health Care survey. The comments have had asked for a clear explanation of the methodology and other of this have never some time usually always combined with the yes/no response. And we did received response from the developer as with all these questions which we've provided.

It's not necessarily something that requires committee discussion, but if you'd like to discuss it, you of course can.

Lee Partridge: Does anybody wanted view comments anybody want to discuss that issue?

OK, I'm going to take the silence as a no. And move on.

Lauralei Dorian: Moving on to comment 4529 on 0208 Family Evaluation of Hospice Care and comments – had comments suggesting that consideration be given to individual questions rather than the composite score. And the developer responded that the composite score is designed to assess the overall quality of care, so you have an overall understanding.

And again, unless the committee wants to specifically discuss this comment? I think we can move on.

Lee Partridge: Does anyone wish to comment? OK.

Lauralei Dorian: OK, great. Then comment number 4005 on 0726, The Patient Experience at Psychiatric Care as measured by the ICS. There were number of comments about just corrections in the measures submission and questions about the specification which the developer thoroughly responded to and we have the response in the Excel spreadsheet.

Lee Partridge: Yes, and I – this is the one as I recall in which – the respondent was working an older submission version in part.

Lauralei Dorian: Yes.

Lee Partridge: Yes, which complicated the respondents understanding of the specifications – yes. Any issues here? OK. Next.

Lauralei Dorian: OK. So I think that's the only we have. So we have two general comments about – so the first one was 4542 and that said that a number of the measures considered by the Committee include or recommend some degree of case mix adjustment and suggest that that some of these measures be included with the upcoming pilot within NQF for adjusting sociodemographic factors.

And we as NQF provided a response just saying that when a child period begins in early 2015 describing the policy which restricts the use of SDS factors and statistical risk models will be suspended and we will implement the risk adjustment expert panel's recommendations on the appropriate use of SDS risk factors.

The current measures of course don't fall into that time period for the child measures but it could potentially when they come back is part of those criteria.

Lee Partridge: All right. Comments on this comment? Well …

Lauralei Dorian: Great. And then the very last comment …

Lee Partridge: Wait, wait, wait, wait.

Lauralei Dorian: OK. Sorry.

Lee Partridge: That comment actually was filed by my colleagues. And I don't have a problem with the NQF response but I did want to make sure that we all realized that the SDS issue is going to be very important as for the child period begins. And we'll almost certainly surface in our discussions quite possibly as early as January, I don't know what we've got coming at us.

But, I went to the recommendations – excuse me – I went to the specifications of the measures before us. And most instances what we have is specifications that recommend that the end user make certain adjustments. The actual risk adjustment is not embedded in the measure before us. I think I'm right inversely all instance. Lauralei, if I'm not, correct me.

Lauralei Dorian: No, you're right.

Lee Partridge: OK. But it is something that we should all be thinking about and we'll certainly surface as we worked together over the next few years. OK. Any other comments from my colleagues?

Peter Thomas: That issue or any other issue in the list?

Lee Partridge: On that issue.

Peter Thomas: So other than to say that risk adjustment is obviously extraordinarily important and I need to understand how implies better than I do.

Lee Partridge: Yes. Well, I think we'll probably end up going to SDS school.

Peter Thomas: Right.

Lee Partridge: Any other comments before we move on to – are we almost ready for the next section, Lauralei?

Lauralei Dorian: We are. The very last comment was just general on that being supported of measuring patient experience and encouraging representation to include other consumer organizations. And we just noted that we can continue to outreach to add new members of the committee as appropriate.

Lee Partridge: Right. All right. So it's amazing efficiency.

Lauralei Dorian: Yes.

Lee Partridge: We are moving to the next segment of our discussion which is the specific recommendations which we either didn't reach consensus or we held back and said we would give the developer time to submit additional information.

Sarah Sampsel: Yes, so this is Sarah. And I know it's been brought up on the screen right now but we wanted to refresh everyone's mind regarding what happened during the meeting where there were a number of measures that were submitted where the level of testing that was required would not either provided for all of the measures or there were some questions from the Committee. So we saw that – but that committee differ the vote or, you know, voted the measure down at one of the critical stages and must-pass stages criterion so that we didn't move forward.

However, what we did is post that in-person meeting. We've had a number of discussions with the measure developers to – one, ensure as they understood what the vote meant and then provided some additional supporting information were needed to explain well the committee was looking for.

So yes, as a reminder there were four measures that fell into one of these categories. The first one was 000 – 0006 which is the CAHPS Health Plan Survey and the – there was the adult – the eight adult measures made it all the way through the process and we're recommended for endorsement. However, they were the eight child measures that fell during one of the must-pass criterion.

With the 0258 which is the CAHPS In-Center Hemodialysis Survey, similar issue except this – the measures submitted for this one, half were multi-item measures and then half were global measures. Where the multi-item measures had a gray zone. Remember that gray zone puts the committee between 40 percent and 60 percent which means there was no consensus. And then there were three global measures that were not recommended in additional testing was requested.

And then finally, 0725 which was the validated family-centered survey questionnaire for parents' and patients' experiences during inpatient pediatric hospital stay, that was measure at about in children's hospital because that was a split vote but did not pass one of the must-pass criteria. They were asked to provide more information during the public comment period, but we've fallen to under the none recommended category until reconsidered, and then similar issue with 1623, the Bereaved Family Survey.

So let's go a little further down. So what we did after having the conversations and receiving the information submitted by the developers. We went through the information submitted, really for a content review to make sure that if we add – which we adapt for validity testing at the measure level that's what – that was provided or reliability data or whatever the open issue.

And so, what this table does is walk you through what the measure is the unresolved items, so for CAPHS health plan, it was worthy testing at their individual measure level for the child measures, and then the – there's a link to the document that was submitted that you should all have access to SharePoint – can you go back. I'm sorry.

Lauralei Dorian: Sorry, going back now.

Lee Partridge: Sorry.

Sarah Sampsel: And then, you know, and then just kind of a brief summary of what's that sound when we look through and, you know, just confirming that the information submitted with what you were looking for.

And then the last column in the table would be the committee action of, you know, what needs to have been post this call. What we want to do for the rest of this call or until the last 10 to 15 minutes of the call is give you an opportunity to discuss each of the additional items submitted.

So for CAHPS Health Plan, they did – the developer did provide the individual measure level, validity testing, sort of child measures. In the information provided, they provided composite correlations, composite correlations and individual level composite and single item correlations with the overall rating.

You know, we found the information provided to be consistent with the material that you requested and that what you reviewed for the adult measure components. What we did not do is make any kind of judgment on, you know, is this good enough for the committee. We're asking you to do that and just want to know prior to voting, do you have any questions of the developer or additional questions based on the information that provided.

Lee Partridge: OK. So, the floor is open for comments on the information supply by the additional information supply by the developer.

Sarah Sampsel: Yes, and …

Lee Partridge: And I believe our developer are also in the line. Is that right?

Lauralei Dorian: Correct.

Sarah Sampsel: Yes.

Lauralei Dorian: OK.

Lee Partridge: So why don't we go do this and kind of format of starting with the CAPHS health plan survey. You know, it self-reviewed the attachment. Are there any additional questions?

Lauralei Dorian: I wonder first if it might be helpful if the developer just provided a couple of those results quickly for us.

Lee Partridge: Sure.

Lauralei Dorian: In part, so we don't have to toggle back and forth.

(Joan Campion): My name is (Dr. Joan Campion) from (Westat) and can everyone hear me?

Lee Partridge: Yes, we can.

(Joan Campion): OK. So we had data from the most recent submission to the database. And so for the child Medicaid CAPHS is the Medicaid data that we collect on child. Is we have a hundred health plans which was up from the floor, from what he had before and which is why we just supply some demographics of the data because it was a newer dataset.

And so, the demographics were similar to the first time we submitted. A little bit difference in the number of plans per state but the gender, ethnicity, age categories were about the same. We did plan level correlations again, even though we had submitted those before just to show them and they actually improve especially with the global rating of the specialist.

And then we supply the validity scores for at the individual level, and those all had good values.

Lee Partridge: OK. Thank you, Dr. (Campion). Members, questions, comments?

Peter Thomas: When you say that the information was consistent with the material, the committee reviews the adult measure. And the adult measure was ultimately endorsed. Is that saying that it's – would it be – wouldn't it be inconsistent for us to vote this down with – when that data was consistent with the adult data?

(Joan Campion): I actually meant in consistent with the level of detail and the level of data that was provided.

Peter Thomas: OK, OK.

Female: Yes, we only rerun on child.

Female: OK.

Peter Thomas: Thank you for the clarification.

Lee Partridge: Any other questions?

Peter Thomas: And again, you're not going to vote right now? Press for vote or?

Lee Partridge: Correct. You will receive – staff on requesting your vote on this, the remaining criteria for each of these measures.

Peter Thomas: OK, great.

Lee Partridge: All right. If there are no further questions, should we move – we should move on.

Lauralei Dorian: Correct.

Lee Partridge: And take them in order 0258 hemodialysis.

Lauralei Dorian: Yes. So with this one, you know, just as a reminder as I just mentioned – and I'll go ahead and wait until we're scrolled down a little bit.

Lee Partridge: Again, do we have the developer on the line?

Lauralei Dorian: Liz Goldstein, are you on?

Female: She may have thought she could come in a little later.

Lauralei Dorian: Can you hear us?

(Crosstalk)

Female: Oh yes.

Female: Now we can.

Female: Hello. Yes. I'm the developers for, ICH CAPHS Survey are here.

Lee Partridge: OK. Do you want to go ahead and just make some comments about what was provided?

Female: Sure.

(Barbara): We provided. Additional information from the pilot testing period. The show at central level reliability estimates for the ICH CAPHS measures as well as – patient level, reliability and validity measure correlations.

Looking at the measures against the global ratings and looking at the correlations between the ICH CAPHS rating.

We've found that all of the results were statistically significant. It was very strongly statistically significantly at the point, 0.001 level.

We also presented one of the frequency distributions that was missing and we presented back in July which show the frequency distribution for the item in the last three months. How often did the dialysis center staff show respect for what you have to say, with 59 percent at the responded saying always.

Lee Partridge: Thank you. And was that Barbara?

(Barbara): Yes, this is (Barbara).

Lee Partridge: OK. This would then we go back to the committee to see if there are any questions by, you know, as (Barbara) indicated, you know, and the staff review. We did find that material, the additional material provider – provided was what the committee requested. And, you know, they did a good job of providing some summaries of what the found in the data for committee to considerations.

Lauralei Dorian: Open for comments and questions.

Peter Thomas: This is Peter Thomas. I was just wondering, I know that – again, I guess I think I noted this in the meeting in July, but that this is just for in-center hemodialysis. Is there any comparable measure or is there something in development for home dialysis patients?

(Barbara): At this point, CMS is only work on in-center hemodialysis.

Peter Thomas: OK. That is a growing population for what I understand from what I understand.

Lee Partridge: Yes, but the summary was developed for in-center hemodialysis patients because we are, in sort of an addendum to the dialysis facility compare website, the clinical information that's presented there.

Peter Thomas: I see. OK. All right. There is also a star – five star rating system going to affect in January and I was wondering whether you could explain the difference between these measures and that rating system if it's relevant.

(Barbara): So, the rating, the five surveying system is for the measures that are already being collected and reported and display it on dialysis to fully compare. So that does that not include the survey at this point.

Eventually, when we have, you know, data that reported to CMS and enough of it, you know, this eventually would be incorporated into scoring system but not yet.

Peter Thomas: OK. So in terms of redundancy or anything like that that's not an issue at this point.

(Barbara): No, because that's scoring system for next year would just be the clinical information that's already collected if we're not include patient experience information at this point.

Peter Thomas: Got it, thank you very much.

(Barbara): No problem.

Lee Partridge: (Barbara) and (Lisa). This is Lee. Could you talk a little bit about the one – I just lost it, higher on the page I think. There is one instance in which the – yes. The rating – no, it was – I think home care and discharge instruction. All right. Maybe I'm mixing something else. No, I am. I'm sorry. I withdraw that question.

(Barbara): No problem.

Lee Partridge: We have in this instance, we have – I should note that we will have to vote on the all for questions on the global measures. Am I right?

(Barbara): That's correct.

Lee Partridge: OK. All right. And further questions or discussion from anybody on the committee.

Lauralei Dorian: And Lee, this is Lauralei. I just wanted to note that the globe – they will be voting on the global measures. You also be revoting on this multi-item measures because they were in the gray zone.

And usually, we use the public comment period to fill up the comment, they don't receive any on – about these issues. So, we want to have the committee revote, and then at that point those folks will stand and it will go to member voting and CSAC, and if it's still in the gray zone, then it will be up to the purview of the staff to point review group. So both the member voting, CSAC and then the board.

Lee Partridge: All right. So, for the data set of everyone on the call, could we – could – even Sharon or Lauralei, just summarize for us what the issues where on the multi-item measure that resulted in the split.

Lauralei Dorian: So, the three multi-item measures. I'm just looking at the report now. The reliability of the multi-item measures is tested at both scale level using a Chrome Box Alpha with strong result.

The reliability of the multi-item measures at the performance score level was also demonstrated to be high or moderate. The validity was determined to be

insufficient. And the voting results leave the multi-item measures and the gray zone as they fell between 40 percent to 60 percent which – in our guidance means that consensus was not reached.

Lee Partridge: Right. And the vote – but the specific issues around validity?

Lauralei Dorian: Yes, exactly. So maybe if we wanted the developer to comment on whether any additional information.

Lee Partridge: At the time of the meeting in July, we did not have it all to present at the time. It wasn't in our pocket. So we were asked to provide that information which we did in a memo that was attached in this pocket for today. I did it in august, right.

So again, in both instances, what we had – we had gray zone result on the multi-items and we have a diff – and not recommended on the global but in both instances, the issue was inadequate information. Am I correct?

Lauralei Dorian: Exactly.

Lee Partridge: OK. Comments? OK. All right. If there are no further questions from members of the committee, I think we can move on to 0725.

Lauralei Dorian: Yes. And so, this is the validated family-centered survey questionnaire for parents' and patients' experiences during inpatient pediatric hospital stay. Committee member voting staff get reliability because the computed hospital score were not provided.

And, therefore, the committee will need to look at the evaluation of the global measure which only submitted data, and the developers did submit in the provided document entitled computed hospital scores reliability and validity.

You know, the developer did a great job of summarizing the results available, and I believe it's also suggesting a name change to the measure. So, what the developers comment on what was provided and summarize what was provided.

Lee Partridge: And do we have – the developer on the line?

Lauralei Dorian: Hello.

Lee Partridge: Hello

Lauralei Dorian: (Maria) or (Sonia) can you hear me?

Female: Oh yes, I can hear you.

Female: Oh OK. So we just have to turn the volume up. I apologize for that. So be provided in the document, the site performance scores with regard to reliability and validity. The reliability scores were all above .7 except for one domain for discharge and home care preparation which was .63.

Validity was assessed using Pearson correlation coefficient and since he only had six sites was more than 100 responses that confidence interval for this correlation coefficient are fairly large as expected, but nevertheless with regard to the direction of the correlations, basically the correlation coefficients are in the directions that they were hypothesize.

With regard to the name change in the – I believe it was the in person meeting or the phone meeting after that, the committee raise the comment that we basically did not indicated that it was a parent reported experience measure. So, the basically proposed to change the measure title to reflect that comment.

Lee Partridge: All right. Open for comments. No questions or comments from our committee?

Peter Thomas: So again, the number .7 being very important number to be above that in terms of reliability testing, correct?

Female: That's correct.

Female: Yes.

Peter Thomas: When you say that the – it was consistent with the hypothesize results, that just basically meaning that you hope to would come in, in a certain place and that's where it came out, correct?

Female: Yes, so basically the question, like there are certain correlations that they both assumed to be positive so as – you know, a parent or parents are more satisfied the nurse partnership, we would assume that there are also more likely to recommend the hospital and we had one question in the survey, the ever upset questions will be would expect negative correlations for that, and for most off the domain. That was exactly what we saw.

Peter Thomas: Great, OK. Thank you.

Lee Partridge: OK. Any further questions? Remember, this is the measure which we will address again the issue of competing or complementary after we vote, assuming that the measures approved.

And I just wanted tell the developer how much I appreciated their additional submission that was very nice and clear to follow.

Female: Thanks so much.

Lee Partridge: And next.

Lauralei Dorian: So the last one for the considerations, the committee for revoting is 1623 or the Bereaved Family Survey. Originally, this has been methodology use for reliability testing was appropriate from multi-item scale but not for the single item instruments.

The committee will evaluate the measures based on the nearly submitted data. Therefore, the document provided is the single item facility level of validity and reliability. And the development provider expenses information on both reliability and validity testing.

And, you know, from our staff review, appear to the information, establishes the reliability and validity of the measure but would be helpful to have the developers comment and just provide a brief overview of what they submitted.

Lee Partridge: OK. The developers on the line?

(Mary): And (Joshua Thorpe).

(Joshua Thorpe): Yes, I'm here.

(Mary): OK. So everybody can hear us. So I'm going to walkthrough this and basically just summarize. So the first section which is, is simply the clarification that yes indeed we're not talking about the bereaved family survey, you know, 19 items but rather the single item overall score which is dichotomize into excellent in every other response, very good, good, very poor.

And that the scores then are reported on a 0 percent to 100 percent reflecting the facilities, the percentage of respondents of that facility where they answered the overall question excellent.

Figure one, simply sets the kind of outlines or relationships of the kinds of things that we look at the (VA). We have data on all this. And I wanted to include this because it helps people make sense of some of our validity analysis in which we run associations between all the process measures than the outcome, of course, with the hypothesis that higher receipt of best practices which are a process measures would be associated with higher bereaved family performance measure.

The additional validity analysis, so the primary center. So what we did is all these are focused at the facility level, the VA actually looks at the bereaved family survey at both the facility level and at a regional level. The VISN is what we call our 21 integrated networks, but where the rubber meets the road if you will is really at the facility level where our teams, we see the results quarterly and so that's what we emphasize here.

On table one. Basically we redo the analysis to reflect facility level scores as opposed to individual level score. So, here you see the variability from year to year. We've had a study increased in the performance measure. We've also – this is been associated with the steady increase in a higher percentage of best practices.

So the number of palliative care consultative has increased in the (Inaudible) context have increased, et cetera.

And so, this is just basic information but it's all in the facility level. Figure two, shows that we do have variability if there was no variation in scores than it wouldn't be – they're useful as a quality improvement measures, performance measure because everyone would look the same, and this demonstrate for those facility that had at least 30 served completed surveys, the variation across facilities.

Let me just stop there for a second, are there any question and what I've presented thus far?

Lee Partridge: Committee members? Question?

Peter Thomas: No, not for me.

Lee Partridge: OK.

(Mary): OK. So, table two. And this, you know, it has all the detail hopefully that you'd want. But basically, this is further evaluation of validity, you know, as I indicated before in association of these best practices with higher scores as, you know, a measure of further measure of validity.

And so, what you see here also is in 2013 we transitioned the Bereaved Family Survey from a telephone survey to a mailed survey. And we – we've, you know, done similar analysis on both versions. And just for completeness sake, we wanted to show you both the results from the telephone survey and the mailed survey.

And as you can see here, there is a consistent association. So, for example, on the first line, the palliative care consult prior to death, if the veteran had a consult for veterans – and this all at the facility level. If a veteran had a consult prior to death, the average facility score was 60 percent as opposed to 57 percent. And there you can see the beta coefficients and the conference intervals, et cetera. So, all these were – I believe all of them were, yes, statistically significant in the direction that we would expect. Any questions on that table?

Lee Partridge: Not for me.

(Mary): OK. And then we just included a couple additional publications that also document the association between our best practices and our outcomes. I'm going to turn, for the next two analyses, the reliability analyses. I'm going to ask Dr. (Thorpe) to explain these two analyses because we did them under his direction.

(Joshua Thorpe): Thank you. And so, we were asked to provide some additional facility level reliability information for the DFS overall rating event of life, the single item which we've done here. We actually did it in two different flavors. We had asked – we have been asked to provide kind of a general measure of signal-to-noise. We're looking at kind of within facility variation versus across facility variation.

So we first provided this sort of a standard measure of that signal-to-noise, the interclass correlation coefficient. In this case, ICC1, which decomposes within and between facility variants for the overall score using a mixed effect, with just a correction model. And I'll sort of cut to the chase on that because what we're looking for here is that there is indeed significance between facility variations.

So we did find that the signal-to-noise is measured by the ICC1 of the between facility variability relative to the total variability was significant at the 0.04 with a point (assessment) of 0.04. And this sort of demonstrates that there is the indeed what we'd hope to see of a facility level variability in our latent facility level BFS scores. So that was sort of a first path through.

The second we had asked to be thinking about something like the Spearman-Brown split-half for reliability at the facility level, which we did conduct. And the estimated reliability of the aggregated facility mean scores of BFS was 0.89, which did exceed the recommended reliability threshold of 0.7. And additionally, if you cut – incorporate our estimated ICC1 or Intraclass Correlation Coefficient from the first path through, there's a Spearman-Brown formula – prophecy formula indicates the minimum facility level sample size of 56 respondents is required to achieve that recommended reliability

threshold of 0.7. And going back to the numbers that we have at the facility level, any given sort of year period, over 97 percent of our facilities have sufficient sample sizes to achieve that 70 percent reliability. Any questions?

Lee Partridge: No.

Lee Partridge: I'm sorry. I have a question. Are you sampling that 100 percent of the population or is this – what type of sampling are you doing?

(Mary): We essentially do a population sampling with – there are few ineligibility criteria. Basically, any veterans who dies in inpatient facility – and I might add that we are expanding this to our home base primary care program. So any veteran who dies, we look, we access the LA – the legally next of kin or legally authorized representative from the chart. The people – the denominator excludes people who have been in – at the inpatient setting less than 24 hours, thinking that we're asking them to assess care.

And if they've been in less than 24 hours, they may not have adequate time on anyone. Let's see – but basically, there are very few criteria. So we essentially send introductory letters out to any identified next of kin. And we, you know, there is a certain percentage we don't have a valid address or phone number. And we attempt to get a completed survey from all those family members.

Lee Partridge: Thank you and (inaudible). Thank you, (Bradley), thank you.

(Mary): Yes. And what's also nice about that is we collect chart data on all the veterans who die. And so, we've been able to do some pretty good non-responses bias analysis as well because we do have a fair number of characteristics on people who – on all veterans regardless of whether they're family respondent or not. I'll go on to the last point, if it that's OK. Any other questions?

Lee Partridge: Any other questions from the committee? OK, so I think you can go on.

(Mary): OK. And then there was an issue about public reporting. All facilities in the inpatient facilities, and perhaps by next year all the home base primary care

programs in the country, will have BFS data collected on them. So currently, its inpatient. And people – facilities don't get a choice whether or not we send surveys out. And these are all reported within the VA but you need – but not publically reported yet.

Anyone who has a VA log on can go into a system called BFSC. And they're all – it's in there with a series of performance measures. We're one of many. And you can look from quarter to quarter, facility to facility, VISN to VISN. We – Dr. Joe Francis who is the director for clinical analytics and reporting for the entire Veterans Health Administration is very committed to public reporting. The VA does publicly report some of its performance measures.

We will be honest with you right now. We are focused on some other issues, but I am confident that – and so is Dr. Francis – that within the next few years, the Bereaved Family Survey will be publically reported.

Lee Partridge: So, let me make sure I understand. Right now, this survey is used to assess the family's experience with inpatient facility. But …

(Mary): Correct.

Lee Partridge: … you are adding and you're going to start sending the surveys or you already are beginning to send the surveys out …

(Mary): Yes.

Lee Partridge: … to patients who are being cared for at home?

(Mary): You know, yes, we have several programs that fall under Geriatrics and Extended Care, hospice and palliative care being one of them. Another one is our medical foster home, another one is home based primary care.

And when we recognized that about 25 percent of veterans on that program die annually, the leadership said we want the Bereaved Family Survey extended to that program. I believe that we will also extend to other programs. But, you know, it's an issue of manpower, et cetera.

So we have conducted – we have sent out, using very similar procedures for inpatient survey, we have send it out to all next of kin in home base primary care for one of our VISNs, VISN 16, which is Arkansas, Louisiana, et cetera. So they've been our pilot. In the next quarter, we're going to expand. There are 21 VISNs. We're going to expand to – how many more, three? Three more VISNs. And, you know, hopefully, be able to approve more and more VISNs. This is what we did when we rolled it out for the inpatient death.

Lee Partridge: And would you expect that then you'd come back with a separate measure for the in home programs?

(Mary): Well, the performance measure is exactly the same. Remember, we're only talking about the single item. So, for QI purposes – and this is kind of I think where we were challenged initially in our submission is we always reporting, incorporate all the items, and we look at, you know, item to overall score correlations, et cetera, et cetera. But no, it would be a performance measure of the single item.

Lee Partridge: OK. Thank you. Other questions?

Carol Levine: I have – this is Carol. I just have one question. (Mix) of 10 has kind of a quaint sound to it, given the complexity of family relationships and who actually has been involved, who would be able to answer these questions is somewhere generic term. I mean, next of kin, I don't know. It just doesn't …

(Mary): Well …

(Crosstalk)

Carol Levine: Everybody is kin. I guess what every way you want it.

(Mary): Well, all – that's not how they self identify and it's simply what it is in our electronic medical records. We asked people. And when we get them on the phone or when they respond, we ask them, "Were you involved in the care? And if you weren't, can you tell us who – if anyone was in your family, who would know about the care if it's determinacy?"

Carol Levine: Right, OK. Well, it sounds that sounds exactly right and it just sounds the label might be family – involved family member, family caregiver or something that has that more direct involvement sounding than next of kin. But I know how hard it is to change all these labels.

Lee Partridge: OK, further questions or comments?

Peter Thomas: This only applies to the VA facilities, correct?

(Mary): Correct, at – yes.

Peter Thomas: But is it generic enough to use in other health care provider settings?

(Mary): Well, the 19-item Bereaved Family Survey asks – I mean uses the term veteran, although you could change that. It does ask about – we have three VA-specific questions about, you know, would you have liked to have known more about VA burial benefits. Because as some of you might be aware, you know, the VA, you know, provides certain benefits, and we want to make sure that families feel as though they're receiving those benefits.

And we also have one question on PTSD which, you know, veterans are the only ones who suffer from PTSD, but we do have that question. The overall question though is very generic. And in fact, we purposely – when the VA decided, "OK, what piece of the Bereaved Family Survey are we going to use as our performance measure," there was a question about, you know, we considered, "Well, let's do a mean score of all the items," or, "Lets do a composite score."

And it was felt that by leadership, you know, because we also report to the broader clinical – Dr. Francis' group. And they wanted the overall score because we include, as I said, data on all the items. But for the performance measure, they wanted the overall score because we felt like that would be the most interpretable outside the VA. It's actually a very similar item to the fact and to some other similar measures. So we thought, "Well, you know, we need to make our measures as equivalent as we can to the broader health care systems."

Peter Thomas: Thank you.

Lee Partridge: So, Peter, are you suggesting that in the final report we might have something that urges that other providers are – would take a look at this survey? I think we might add that …

(Crosstalk)

Peter Thomas: You know, I mean, if it's gone through this kind of testing, it's got, you know, it could certainly help other settings that aren't necessarily veteran settings. But I don't know, it just strikes me that it would be much more generally applicable and could be very useful in other settings. Of course you'd have to delete or modify those questions in some way.

Lee Partridge: Right. How about the rest of the committee, do you think Peter's point is worth including?

Carol Levine: Yes, I do. This is Carol. Yes.

Lee Partridge: OK. Thank you. All right, further questions, comments, 1623? If not, I wonder if that wraps up our discussion of these measures.

But I did want to know that in the general comments, I believe – or maybe because I have specific comments on 0725, there is a comment relating to the complementary or competing measures position. So you may want to just hang on to that for our future reference, assuming that 0725 does get approved in the final voting. All right, Lauralei, anything next?

Lauralei Dorian: Great. So, I'll pause one last time to see – before we open it for public comments, to see if there are any more questions or comments on either the comments we discussed at the beginning or the additionally submitted information.

Lee Partridge: Lauralei and Sarah, I just think we should mention real quick that, you know, in that table that summarizes the additional information, there were two additional measures, 0166, Hospital CAHPS, and 0228, 3-Item Care Transition Measure. Both measures, you know, made it all the way through

voting and were recommended for endorsement. But the committee in their deliberation to that for some additional information, you know, I just think it was supplementary more than anything. So those were also attached but, you know, you won't be asked to revote or anything else on those measures.

Lauralei Dorian: Right.

Sarah Sampsel: Right.

Lee Partridge: All right, so should we open for (some) for public comment?

Lauralei Dorian: Yes, please. (Cathy), can you please open the line for public and member comment?

Operator: Yes, ma'am. At this time, if you would like to make a comment, please press star then the number one on your telephone keypad.

And you have a comment from (Karin Rubin).

Lee Partridge: Great, go ahead.

(Karin Rubin): Hi, this is (Karin Rubin) from the AMA. The AMA appreciates the measure developer acknowledging our comments and our concerns, and we'd happy to work with CMS to draft additional guidance about any use of the HCAHPS survey to evaluate individual physicians contravening CMS' guidance. The AMA supports the use of patient experience surveys as part of the process for evaluating care.

The AMA does understand that the HCAHPS survey is designed to capture and report patient experience at the hospital level. However, physicians are concerned that the pain questions contribute to part of the problem with the over prescribing of opioids. And there has been need to evaluate and further test the wording and content of the HCAHPS pain survey questions.

Lee Partridge: OK. Any questions with our commentator from the committee? If not, thank you.

Lauralei Dorian: Thanks. And do we have any other public comments?

Operator: At this time, there are no more comments.

Lee Partridge: OK.

Female: Yes.

Female: Excuse me, this is CMS. The HCAHPS developer is here and wanted to know should we respond to the comment from (Karin Rubin)? I hope I said her first name correctly.

Lee Partridge: What's the committee's (pleasure)? I think we – well …

Peter Thomas: Yes?

Lee Partridge: Yes, go ahead.

Lauralei Dorian: Go ahead.

Male: OK. Thank you. This is (Inaudible) at CMS. I work in HCAHPS survey. Yes, we have had members' comments about pain items on the survey. We are going to look at the wording of it to make sure it accurately captures what we hope it captures. If the AMA or anybody else has suggested wording they'd like to provide to use, we'll look at that and possibly test that. We thank you for your comment.

Lee Partridge: And again, going back to processes, this is a new committee. I think that if the wording were significantly changed, you'd probably bring that back to us in an annual update. Am I right, Lauralei and Sarah?

Lauralei Dorian: That's correct. And actually, now that we have standing committees, the developer could opt to bring that back at anytime and we would just have an ad hoc, sort of impromptu call with committee.

Lee Partridge: OK. So, AMA and CMS, the door is open.

Female: Thank you. Well, we'll be in touch with them.

Lauralei Dorian: Great. Well, thank you everyone. Before I hand it over to Nadine for next step, I did just want to know that unfortunately we've had a lot of new projects here at NQF. And so, just as a matter of balancing projects, I am going to have to step off of this, which is unfortunate because I've really – it's been a pleasure working with you and meeting all of you. I'll still remain involved and I'm certain at I'll come across you in other projects in the future of our work.

But I would like to – and Sarah will remain as the acting senior director and Nadine will remain as the project analyst, so you'll have that consistency. And then I'm pleased to introduce Mitra Ghazinour as the new project manager and Suzanne Theberge will actually – will also be joining as the senior project managers. So Mitra is here, if you want to introduce yourself so that they could hear your voice.

Mitra Ghazinour: OK. Thank you, Lauralei. Yes, so I have been working on other NQF projects as well, mostly the Measure Applications Partnership projects. And currently, I'm supporting the work of MAP Post-Acute Care or Long Term Care workgroup, as well as a new project at NQF for identifying quality measurement issues for rural health. And I'm looking forward to supporting the work of this committee and working with you all. Thank you.

Lee Partridge: And on behalf of the committee, Mitra, we say welcome. I know your experience working with the measurement application group will be of benefit to us as we go forward. And I have had the pleasure of working with Suzanne Theberge on previous standing committees. And I'm delighted that she's joining us. You will all enjoy her very much.

Peter Thomas: And, Lauralei, thank you very much for our service in the committee.

Lauralei Dorian: Thank you.

Lee Partridge: And now, I'll turn it over to Nadine to go through some next steps for you.

Nadine Allen: Thank you everyone for joining the call today. As a next step, we ask that you would take this time to engage in a voting survey. If you look on your left tab, underneath the links tab, there is a voting survey link. We ask that you

consult the memo, think about the discussions that you had today on the additional materials that we received before continuing to vote on each of the measures that were discussed today. If you have any questions, feel free to send me an e-mail at nallen@qualityform.org. Thank you very much.

Lauralei Dorian: And we'll ask that you return the survey results by close of business this Wednesday. I know that's soon, but we think it's, you know, once you get in their and do it, it shouldn't take too long and as best to really do it, of course, if you can to the call so that it's also fresh in your mind. And then following that, we're going to open for member vote on November 7th to the 21st. And then the CSAC is expected to review your recommendations on December 9th.

And the Board actually is December 17th. So, hopefully, we'll be able to stick with that timeline right around the holidays, but it might end up getting pushed back a week or two. So, lets us know. We'll send an e-mail out with the link and let us know if you have any questions or concerns. Any questions of process for voting?

Lee Partridge: And if your organization is an NQF measure – member, please urge them to vote. We have – one of the problems we have had at the CSAC level is that sometimes the number of members voting is very small and it's hard to judge whether we really do have a broad-based consensus.

Peter Thomas: Just a point of – well, in terms of voting, that my Adobe flash plug-in has crashed, it informs me. So, I guess I'm off with that. But if I just go back to where we were today, tomorrow say, and plug-in, I'll be able to see that link that you speak off.

Nadine Allen: We're going to send you also a follow e-mail sometime today. We'll send an e-mail with the link in that e-mail

Peter Thomas: OK great. Thank you.

Lee Partridge: We put it to SharePoint as well.

Female: Can I have some point of clarification if our organization is a member?

Lee Partridge: Right.

Female: And they vote – Sarah is there a limit to how many people within the organization can vote on the measure?

Sarah Sampsel: Yes. Each organization has one vote.

Female: OK.

Sarah Sampsel: So one of you has to agree to push the button.

Female: So if we're member of the committee then one other person can also vote from the organization? Or do I constitute the organizations member?

Sarah Sampsel: It all depends on who in your organization has the responsibility for casting the vote. If they give it to you, then it's your vote. But you can't – you can't – there's no bar on being a member of the standing committee and your organization also voting. You just don't get two votes that way in the member of votes.

Female: OK.

Sarah Sampsel: OK. I think I confused you with that one. But basically, I can't vote as much – if the partnership doesn't get two votes because I'm on the standing committee.

Female: OK, thank you.

Lee Partridge: All right. Any further questions? If not …

Female: OK.

Lee Partridge: … its 20 after 3 in a Monday afternoon. I thank you all for working so carefully and so efficiently. And, Lauralei, we will miss you. I guess I have one final question, do we have – are we going to have – do we have a call from measures out for the next round?

Lauralei Dorian: We do. That's a good point. So the call for measures for the second phase ends on November 7th. So, Mitra and her team are busy working with developers. And as we get closer to that date, you should have the meeting fold in your calendars already because that second phase of work. But Mitra will send an e-mail with – reminding you of all of the dates.

Peter Thomas: So those are mainly the functional and quality of life measures, correct?

Female: That's correct.

Peter Thomas: And when you say that they haven't told the 7th of November, you're – the developers have additional time to submit their request for us to review the materials, their measures?

Lauralei Dorian: Yes. So we put a call – what we call a call for measures out on our public website which essentially just says we're having a second phase of this project. These are the dates. This is the general topic, please submit by the state. So we'll have new measures that are submitted and then also measures that are called maintenance measures which have been endorsed for about three years. And its time for them to undergo a new review, and they also have to submit new information by November 7th.

Lee Partridge: And, Lauralei, do we have – Mitra, do we have any sense of the numbers?

Lauralei Dorian: We have a lot. We're just actually thinking. We want to make sure it's manageable, so we're in conversations right now regarding whether we might have to have (subsequent) and additional phase as well. But I think at least with the functional status, you know, the …

Mitra Ghazinour: I think it's – approximately, we have 30 measures so far.

Lee Partridge: 3-0?

Mitra Ghazinour: Yes.

Lee Partridge: We are having conversations and if we – 30 is not possible. So I mean, obviously, it's possible, but we're not going to do that.

(Crosstalk)

Lee Partridge: … how to stage everything, so don't panic.

Female: Don't panic.

Lauralei Dorian: We'll make sure it's all OK.

Peter Thomas: Well what's very encouraging is that there is a real dearth of measures in this area that are well accepted and approved. So, great news that we'll have a lot of good – hopefully, good and reliable and valid data to look at, although it will be a lot of work.

Lee Partridge: OK.

Lauralei Dorian: OK, all right. Well, thank you everyone for joining us all today.

Female: Thank you.

Lauralei Dorian: Thanks, Lee, and thanks to the developers and everyone else.

Lee Partridge: Right.

Peter Thomas: Thanks very much.

Lauralei Dorian: See you on Monday.

Female: Bye.

Female: Bye-bye.

Female: Bye-bye.

END