National Quality Forum

Moderator: Lauralei Dorian
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Lauralei Dorian: Good afternoon everyone. Thank you very much for calling into this Person and Family-Centered Care Webinar to discuss competing measures. This is Lauralei and Nadine and (Sarah) from NQF. And we also have here our co-chairs, Jim Merlino and Lee Partridge on the line as well.

As the operator mentioned this call is open to the public and we will have a time for public comment at the end of the call.

And before we get started, I just wanted to do a quick roll call. I know we have a number of developers on the call. We might not have many committee members because we did have to schedule this call with not much notice because we weren't ready, if you recall, to discuss competing measures during the in-person meeting.

But as Nadine had mentioned in her e-mail that she circulated to you a couple of weeks ago, this will be transcribed and recorded and posted on the SharePoint site so even if we don't have the entire committee, they will have – other members will have an opportunity to review what was discussed.

So in terms of committee members, I think I saw Sherri Loeb on the line?

Sherri Loeb: That's correct, I'm here.

Lauralei Dorian: Hi Sherri.

Sherri Loeb: Hi.

(Sam Burner): This is (Sam Burner).

Lauralei Dorian: Oh great. Hi (Sam). And (Lisa Marie)?

(Lisa Marie): I'm here.

Lauralei Dorian: Yes, great. And Carin van Zyl? I see Carin on the webinar so – might not be dialing in. And do we have any other committee members?

(Becky Bradley): Hi this is (Becky), (Becky Bradley). I'm on the line. I'm in an airport, so I might keep you on mute most of the time.

Lauralei Dorian: OK great. Thanks (Becky).

(Bryan Lindberg): (Bryan Lindberg) also.

Lauralei Dorian: (Bryan).

Carin van Zyl: Hello.

Lauralei Dorian: Hello?

Carin van Zyl: It'sCarin van Zyl.

Lauralei Dorian: Oh great. Hi Carin.

Deb Saliba: And Deb Saliba.

Lauralei Dorian: Great.

All right. And then let me just check to make sure we have Carol Spence. Is there anyone else from the National Hospice and Palliative Care Organization?

Carol Spence: Yes, Carol's here, and Matt, do you want to introduce yourself?

Matthew Haskins: Hi, this is Matthew Haskins, Director of Data and Analytics here at NHPCO.

Lauralei Dorian: Great, welcome. And I think I saw Mary and (Ian) from PROMISE Center.

Mary Ersek: Yes, and I believe Dr. Scott Shreve on the phone who's the Hospice and Palliative Director at the VA and (Josh Thorpe) who's our Associate Director for Analytics and Research should be joining us.

Lauralei Dorian: Great. And then do we have, I think I saw (Sonia) from Children's Hospital?

(Sonia): Correct, I'm on the line.

Lauralei Dorian: Great. And do we have anybody representing Child HCAHPS? (Sarah) or…

(Sarah Tommie): Yes, this is (Sara Tommie) and (Mark Schuster) and (Allen) (inaudible) will also be joining.

Lauralei Dorian: Wonderful. OK. So just…

Male: Sorry. Just wanted to say it's (inaudible) from Boston Children is also here.

Lauralei Dorian: Oh great. Welcome.

Male: Thank you.

Lauralei Dorian: So we just wanted to give a little bit of a brief background for this call. Then (inaudible) to see them in person.

So as we know, the current quality landscape has a proliferation of measures and some of these are considered duplicative or overlapping and so NQF tries to take a really active role in identifying any potential, what we call competing measures at the onset of a project.

The process is typically that all measures are first, during the in-person meeting, individually evaluated and if recommended, then the committee enters into a conversation about the competing or related measures.

Competing and related measures are slightly different. Competing measures we have defined as measures that are intended to address both the same measure of focus on the same target population. So the target population, you can usually think of as the denominator and the measure of focus is the

numerator. So one staff early on in the process sit down and look at all the measures, we say if these measures are really looking at the same thing and measuring the same thing for the same group of people, then we call them competing.

In that case, we ask the committee to, as I've said, after the measures are individually evaluated, we look into these developers. We reach out early in the process through developers and they give us a rationale for why they think they're competing, why they think one might be superior to the other.

And then, so during the in-person meeting the developer will be given the opportunity to explain his or her point of view. And then the committee can agree or disagree with NQF's initial categorization. So today on the call, asking from the developers. You can say, "Yes, we really do believe these are competing measures and we want to select one of them as best in class," meaning that only one will continue to move forward for endorsement. Or you can say, "No, we believe that there are rationalizations that make sense for both measures to continue forward."

So, for example, we use a decision-logic here at NQF to initially identify the measures that's related or competing. And one question says, whether the measures – if the measures are specified for different care setting, you can categorize them potentially as competing with their rationale for different care setting.

So it's really just, you know, without thinking too strictly about it, it's just a more broad question of whether you think these two measures and both of these groups are warranted as separate measures to move forward as NQF-endorsed measures.

So does any – Did Lee or Jim, did you want to add anything to that sort of background?

Jim Merlino: I don't, no. No.

Lauralei Dorian: OK, great. So just as a reminder, we're going to, maybe on the agenda, we'll bring up the two sets of measures. We have the first group which is hospice

and palliative care. We have the family evaluation of hospice care from the National Hospice and Palliative Care Organization and the Bereaved Family Survey from the PROMISE Center.

And Lee was going to walk us through the discussion about these two measures.

Lee Partridge: Thank you Lauralei and welcome everybody.

Lauralei Dorian: If everyone could keep their phone on mute if they're not speaking please.

Lee Partridge: OK. I think it's not working right.

We have two measures here that both address the care that patient receive at the end of his or her life. The first one, 1623 is, as you remember, developed by the Veterans Administration. And it covers care that's delivered in – and I'm looking for my specs here. Anyone, I believe four different settings could be a –yes. It's under settings on the slide.

Hospice, post acute, long-term care facility, nursing home or skilled care facility, that's the three different groups. And the second measure, 0208, is family evaluation of hospice care and that one is limited as I recall to hospice care. Though the patient could have been as I believe and anyone of a number of different kinds of facilities and still be receiving hospice care.

So with that brief introduction, I think we'll turn it over to the developers. Why don't we start with1623 and VA and just tell us briefly why you believe that this measure is distinct from 0208.

Mary Ersek: Hi, this is Mary Ersek from the VA. Well, I think it's distinct for a number of reasons. One, you know is developed for the veteran population although we think that it could be applied to other settings, if we were to delete about three questions that are very specific to vets and veteran benefits.

But the overall – and that's the survey. Our overall performance measure which is just one item could be applied anywhere. We have applied it in, as you'd say, a number of settings and we have data on differences of care and

care outcomes on those settings, whether it's nursing home or CLC units which are community learning center units, acute care and ICUs. We can divide it out there, as well as our hospice and palliative care unit.

We are also in the process right now of extending it, extending the measurement to our home-based primary care program, because we recognize that the mortality in that program is or the annual mortality is quite high. So it's really a broad-based measure even though, I think it gets sort of zeroed in on this veteran population.

Of course most of our validity data – most not all of the validity data are from the VA. I see there's difference in effect. Certainly, the concepts are similar but the VA contracts out for all of its home hospice care and I'm sure if you all know hospice care in this country is defined very much in some Medicare hospice benefit which it may be changing but still, you know, there's a set of services there that are required by Medicare.

So I do see it almost as apples and oranges. I'm not quite sure having read the materials around NQF. I just – that's not for me to decide whether we're competing or complementary or – But I think we have a very, very strong psychometric properties on this instrument. And more importantly, we have lots of data about the real world application, both as performance measure and as a QI measure.

Lee Partridge: OK, thank you, and developers of 0208.

Carol Spence: Thank you, this is Carol Spence. I'm Vice President for Research and Quality at the National Hospice and Palliative Care Organization. I see these two measures as related but not competing. There are some essential differences as Mary has already pointed out. The population that 0208 is geared for is strictly that hospice population. And we also have an overall rating question on our survey, but our measure that we have submitted for continued maintenance endorsement is a composite. And that composite includes 17 questions that go to very specific aspects of hospice care.

So that a hospice that is using this measure for quality improvement, for example, can look at individual scores on each of those 17 questions in order

to then improve their composite score. So it has utility from a QI standpoint that is different from an overall measure. But in addition to that, it also, you know, from a public reporting standpoint still, because it is a composite and an indication of overall care, has utility for the public who may not be totally familiar with each one of those individual 17 items, so it has that duality.

The other thing is that with an overall measure, you know, you could almost take an overall measure of care. Change the wording very slightly and apply it, not just to end-of-life care but to, you know, almost any setting. I mean, you could ask in a hospital setting overall, you know, how was the care that you received?

And again, ours, you know is more specific than that because it is made up of those 17 components. So I would say these two measures complement each other because there are things set in overall measure that are subjective that may be gotten to, you know, in something like ours which is 17.

But the utility of ours, again, is designed for that hospice provider population because those composites – that composite is based on questions which have elements that are specific to hospice and based on the conditions and certification areas of practice that are mandated in that.

Lee Partridge: Thank you, and committee members, do you have questions or comments of our developers or just comments in general? Our turn.

Sherri Loeb: This is Sherri, is it possible to endorse both of them as complementing each other and not competing?

Lauralei Dorian: Hi, this is Lauralei. Yes, it's perfectly acceptable. It's the initial categorization. It's just the preliminary analysis by NQF. But ultimately, it's up to you as the committee. So it's completely fine for both of these to move forward as recommended.

Lee Partridge: And Sherri, as Jim and I discussed with Lauralei on the same point just before this call, if we had endorsed both – we have recommended both of them for endorsement at our in person meeting, we would have then had a discussion right then and there. And we would have made – and we could have decided

that both of them were indeed distinct but complementary and set forward recommendations to endorse both.

Sherri Loeb: OK, thanks.

Lee Partridge: Other questions?

Carin van Zyl: The fact that this covers, you know, the veteran population which is several million strong, I do think that they have separate needs from the civilian community and I – if I had to vote I'd say, I get these are very similar but I think the populations are more distinct than we've really appreciated and having worked at the VA and then in a civilian place, I can tell you that the populations really are distinct and if anybody wants my vote I think that they're not as competing as we've previously thought.

Lee Partridge: Anybody else?

(Bryan Lindberg): This is (Bryan). Could I just ask, I didn't hear who was saying the last comment.

Carin van Zyl: This is Carin van Zyl.

(Bryan Lindberg): OK, thanks.

Mary Ersek: And I'm sorry, if don't know if I'm allowed to speak up. Again, this is Mary Ersek from the VA. We concur wholeheartedly. We weren't quite certain how to address that issue because we – both organizations are trying and by that I mean the VA-NHPCO are – have central to their mission to enhance palliative care and end-of-life care and we certainly do things collaboratively but then not collaboratively because we're in whole different worlds.

So, I think whereas there is some comparability and that's intentional. We don't want to be so different because one of us is likely to be wrong. I mean there are certain elements of end-of-life care and palliative care that are essential and thus, must be measured and both of them are included in each of these measures but they really are distinct and I think non-exchangeable differences.

Carin van Zyl: Yes, this is Carin again. I mean what's to me the biggest difference is knowing that the VA provides concurrent care where that is not the standard in the community gives you a way to compare satisfaction between the two systems which to me are fundamentally different.

Mary Ersek: And actually we are look – using PROMISE data. We are looking at that exact issue in the VA now among people with lung cancer, one of our investigators up at the Providence VA.

Carin van Zyl: I mean if we could demonstrate that there's a difference in satisfaction using these complementary measures and the VA consistently does better because they do offer concurrent care. That is an enormous help to those of us who are trying to make sure that palliative becomes a concurrent rather than a distinct phase of care. And the VA is the only place that does that. In their mandate you can go for disease-targeted therapy and get palliative care at the same time.

Lee Partridge: Any other comments from or questions from our committee members?

Lauralei, remind me, do you want to do a formal – send out a survey with a vote after the meeting or do you want us to get some sense of whether there's a consensus now?

Lauralei Dorian: I think it's easier at an in-person meeting because we can see everybody and usually, what happens is in this case, it's sort of sounds like, you know, if the committee sounds as though they think the measures are not competing and there is no need to really send out anything to vote on.

Lee Partridge: On the hand as you say we are not in the same room.

Laurelie: Right.

Lee Partridge: We don't have everybody on the call and as I recall, we had 18, virtually all of our members participated in the online voting following our in-person meeting. So, I think I would proceed with the vote.

Anybody disagree with me?

Male: (Inaudible) Clarify what you are saying. We're proceeding with the votes today is that what you said?

Lee Partridge: No, no, no.

Male: No.

Lee Partridge: We follow up with the survey offline. It will be very short. It's just to look – just as we did before, you just fill it out, send it in and I think that would be fair.

Male: OK.

Female: And just to clarify we're talking about voting on that the either picking a measure or voting on that we don't believe that they're competing?

Lauralei, are you going to set it up?

Lauralei Dorian: I think, well, it makes sense to vote first on whatever or not the committee believes them to be competing or not and then it's the answer so I guess we'll have to do this in two pages just to ask…

Female: This is (inaudible). Can I ask a quick question on process? Can you if you vote a completing, if there's a competing vote, do you have to vote then the best in class?

Lauralei Dorian: Yes. Unless you exercise what I said before, there is something called competing with the rationale of different care setting. So you can say it's just the category that NQF uses that we still call them competing but it's OK. You don't need to choose one over the other because there's a rationale having different care setting and that was kind of confusing.

I'm sorry. I confused us, yes.

Male: To follow up on that, the speakers are saying that they believe the lady from the VA believes that they are sufficiently different that they should fall in that latter category not competing because they are different care setting.

Lauralei Dorian: Correct. Yes.

Lee Partridge: I think her point was also the populations are distinct.

Lauralei Dorian: OK, yes, yes.

Lee Partridge… because 1623 is limited to veterans.

Lauralei Dorian: And I mean the very first question maybe Nadine can bring us the decision logic but the very first question that we used for the decision logic is to ask whether the measures address the same population and the same measure focus.

So when we had – when we sat down originally however many months ago, we, I guess, conceptually thought of the same target population as people receiving this kind of care. But if you become a bit more nuanced and say then different, you know, one is the VA population and one is not then, you know, at the onset you can say that they're actually not competing measures.

Well, that's really a decision up to the committee.

Lee Partridge: So. OK. So, what we will be asked first to say, do we – in our judgment – do these measures – are these measures Competing Measures? If yes – Right. So we endorse both or – and if no which, something like that, because we'll do the logic of them…

Lauralei Dorian: Exactly.

Lee Partridge: We'll come up with the wording.

Lauralei Dorian: OK. And then, you know, typically in these circumstances that the committee says no, they're not competing, we would encourage the developers to harmonize the specifications to the extent possible so that the results there are comparable as possible. So for example the age ranges or exception. That sort of becomes then the committee recommendation that we recommend both of these to move forward. There's a reason that they're both in existence but try to work with one another to harmonize the specifications.

(Crosstalk)

Female: Go ahead.

Female: To the extent that, I know, on the readmissions admissions committee there is this controversy about SCS and whether the guidance going forward is to put these measures, some of them, on a one-year look back and there are some other provisions. Do those apply to these measures as well?

Lauralei Dorian: They don't. I'm not involved with that project directly but to my understanding as of January 1st, any measure submission deadline that falls after that date, that criteria will be applied but it's not applicable to this project or the measures in this projects.

Lee Partridge: OK. We took a little longer than I think we had expected on this pair but unless there are more questions I think we should move on to the next pair where Jim is going to lead our discussion.

So, Dr. Merlino.

Jim Merlino: OK, so these are for measure numbers 0725 and 2548. 0725 is a validated family-centered survey questionnaire for patients and patient's experience during inpatient pediatric (hospital) stay developed by Children's Hospital in Boston. And measure number 2548 is Consumer Assessment of Healthcare Providers and Systems hospital survey, child version, otherwise known as Child HCAHPS developed by AHRQ and with also a team at Boston Children's. So, why don't we start with development team for the 0725?

Sonja Ziniel: Hello, I'm Sonja Ziniel. If you know I'm the Senior Survey Methodologist at Boston Children's Hospital and I'm the measure developer of 0725 measure. We believe as I already pointed out in various statements in the encouragement meeting that the measures are related. But they are not competing due to several differences that we believe are very important and have not had not time to really collect data in order to provide more in formation if they are, you know, if these two measures are truly redundant or not.

And one big point is if that we don't exclude any population for our measure. The other point of distinguishment is that we have an additional set of question that has shown to be very, very good in distinguishing sites for our national validation as we submitted just recently and these are called the emotional satisfaction question. And I think the third big point is that they used a response scale that goes beyond 4 points.

And we had had some comparative evidence as well as some other research, internal research that actually might provide more room for improvement in terms of measurement for measures that are already positive due to (27:37) effect, which true for the HCAHPS as well as our measure for some of the questions.

So we believe that there is an opportunity for this measure, the 0725 to be use for example especially in quality improvement or in longitudinal comparisons so that because it gives this opportunity to really measure differences better with the question mark because we haven't really done enough research about this.

Then the HCAHPS, which is limited to two or a 4-point scale due to the harmonization with different HCAHPS measure. So, I think in summer we believe that they're related but they have measurement characteristics that are distinct enough to keep them as twomeasures because depending on the goal of what you're measuring, one might be better than the other, situation dependent.

Jim Merlino: OK, thank you and now the developers for 2548.

(Sarah Tommie): Hi, this is (Sarah Tommie). We agree that these two measures are related. But feel that it's really up to the committee to decide whether or not they're competing.

Once again we developed Child HCAHPS using the CAHP-designed principles to ensure that, been well harmonized. This was mentioned with adult HCAHP and child HCAHP, both standard surveys used throughout the United States.

Child HCAHPS was designed for national comparison of patient experience as well as for quality improvement. Sixty-nine hospitals participated in our field test with over 17,000 completed surveys. And since finishing the field test we have hospitals that have continued to use Child HCAHPS as well as others that weren't involved in the field test who have started to use it. One of the largest vendors is in the process actually of switching over all of its pediatric clients to Child HCAHPS. And another will be ready to make Child HCAHPS available in January. AHRQ has recently posted Child HCAHPS on the website so that all will have access to it.

And what we really wanted to just focus on today was some of the strength of a Child HCAHPS survey. And these include one, hospital level reliability. Child HCAHPS has efficient reliability to distinguish performance among different hospitals which is one of the primary applications a patient experience measures. (PIs) hospital level unit reliability was done with only six hospitals so it cannot provide an accurate measure of the reliability of the composites. And therefore, it's unclear whether it can be used for comparison across hospitals.

Case-mix adjustment. Child HCAHPS survey results are case-mix adjusted and the goal of adjusting for case-mix is to estimate how different hospitals or the same hospital over time would score if they all provided care to comparable groups of patient.

Once again, (PIs) does not adjust for case-mix. So it's unclear that the differences in hospital performances for the measure whether or not they would be influenced by characteristics of the patient population.

Regard to performance measurement itself results from our Child HCAHPS national field demonstrate that hospital have statistically significant and meaningful differences in the performance on the child HCAHPS measures, with the percentage of hospitals whose mean scores fell statistically significantly above or below the average hospital mean to range between 80 and 82 percent. The (PIs) developers did not include statistical significance performance testing so it's unclear in particular since they don't have a case-mix adjustment model if the are meaningful differences in performance.

In any user testing, we thought it was very important to assess the understand ability of reported measure results to ensure that they're useful to patients and their families. After finalizing Child HCAHPS we conducted two rounds of end-user testing and modified item groupings and measure labels to reflect the information learned by testing with parent.

(PIs) composite measures do not undergo the end user testing. In regard to response scales, it is true that we consistently used two response scales throughout to report about care.

And generally speaking, we were focused on the fact that it's easier for respondents to complete Child HCAHPS due to the consistency of these response options. (PIs) uses seven different response option scales throughout the survey. And the (PIs) response scales can become confusing to respondents because there are survey items that have similar but not identical response scales.

For example, (PIs) contain three different variations of a poor to good rating scale. And switching among them, that can – the response scales that are not clearly different from each other is particularly challenging when respondents are with lower educational levels. In addition, testing has been done recently to demonstrate that the 4-point response scale that we have is adequate to demonstrate differences in performances across hospitals. And there's no evidence to date that one or the other produces a higher reliability. And notice there are any evidences to suggest at least in the published literature that one works better for QI than the other.

So, in some we have provided testing that demonstrates that Child HCAHPS can be used for national comparison in addition to being used by hospitals for quality improvement. Child HCAHPS is harmonized with Adult HCAHPS, the national standard for reporting on hospital patient experience for adult. And we are able to provide hospitals with case-mix adjustment scores that could be compared across hospitals and across time.

Thank you, we're happy to answer any questions you might have.

Jim Merlino: I'll open it up now – thank you, (Sarah). I'll open it up now to the committee with any question or comment?

Sonja Ziniel: Could I ask the developer of 0725 and ask a question?

Jim Merlino: Hold on let's get the committee to weigh in first. Anybody?

Chris Stille: This is Chris Stille. Hello, I assume you hear me. I just had a question about the (PIs). One of the things that I thought was interesting was the decrease in ceiling effect. I was wondering if you could maybe provide just a little bit more detail about how that has been used in QI or potentially would be used in QI if you can't name any specific examples?

Jim Merlino: So that was an…

Sonja Ziniel: Yes, so we have. Go ahead.

Jim Merlino: Go ahead.

Sonja Ziniel: So we have basically done some simulation research as well as small testing at Boston Children's Hospital that has shown that if response scales are extended in the area where the ceiling effect occurs, meaning that it's not only important to attend – to extend it to, for example, 5 points but it's also very important that it's extended in exactly the area where the ceiling effect occurs. That it can ameliorate the ceiling effect and by that point, the more normal the distribution of scores gets the more likely it is to detect significant differences for example or over a long period of – over a long time to basically look for quality improvement.

And, so we are actively doing research on that as I described in the in-person meeting.

Chris Stille: Great. Thank you.

Jim Merlino: Any other comments or questions from members of the committee?

(Sarah Tommie): Yes. I just, respond on our end which is just – just so that the committee is aware. Child HCAHP, our development process, we did remove any items for

which there was a ceiling effect and so none of the measures currently stand to have the ceiling effect at this time.

Jim Merlino: Thank you. Any other comments from members of the committee? Any other further comments either from Sonja or (Sarah)?

Sonja Ziniel: Yes, I would actually – it has been a little bit confusing to me because as far as I know our measure has been endorsed by NQF otherwise, we wouldn't be at this state of the process. So, I think it's mute to argue about reliability because we have shown reliability. So, it's a little bit unclear to me if (Sarah) thinks that these measures are competing or not.

Jim Merlino: Well, I think that the issue of whether they're competing is really up for the committee to decide, so Lauralei, do you want to comment on the process?

Lauralei Dorian: Right. That's correct. And just to note that actually none of the measures are endorsed yet if they go through the entire process, so they've been individually recommended and then they go. It's gone through comment and now, a member vote and will then go to CSAC and subcommittee of the board, so. But none of the measures are yet considered endorsed.

Sonja Ziniel: OK. So, they're recommended though.

Lauralei Dorian: Right. They're recommended but with, I mean as Lee was explaining earlier, typically once they're recommended individually then you'd have this conversation about whether one was superior to the other. So, it's with the provision that that discussion has taken place and…

Sonja Ziniel: Got it, thank you for your clarification.

Lauralei Dorian: Sure, no problem.

Jim Merlino: Any other comments from the committee members or the developers? OK. So, the vote then will go out and the committee will determine whether or not these two measures are competing. And I think it's the same methodology right, Lee? So it's competing, yes-no, if yes then which.

Female: OK.

Lee Partridge: That's right. Yes.

Jim Merlino: OK.

Lee Partridge: And, we can…

(Crosstalk)

Lee Partridge: So we'll post the transcript then we'll be sure that in the survey itself we have some of this language to remind everybody, the language about the definition of competing. So there are no more comments or questions about this measure set? All right.

Jim Merlino: All right.

Lauralei Dorian: Well, thank you, Lee and Jim. And, then we did have an agenda item just for a number in public comment, so I'll pause here and have (Cathy) open the line to see if anybody is waiting in the queue to make a comment. (Cathy), if you could open the lines please.

Operator: The lines are open.

Lauralei Dorian: OK. Hearing no comments, that was a very efficient call. And as I'd noted before, member vote is ongoing now through the end of – through November 21st. And, the next step is then to take these recommendations to CSAC at the beginning of December followed by the 4th.

It's going to be a very rush time for staff here, the board meet – the subcommittee of the board meets on December 17th. And, then we will post, essentially if they agree with the recommendations that have been made then at that point the measures are considered endorsed. And there will be a 30-day appeal period through February 3rd at which time the stage of work is considered officially closed.

So I'll be sure to send through a detailed e-mail with a link to SharePoint where the transcript is and a link to the survey. We'll probably give everybody as a (flap) time I think, you now, maybe three days to complete the

survey. It shouldn't take much time at all. It's basically just a yes-no question. And, then acting which if – again if you say it's a yes, if you think they're competing, then we'd ask you to choose one over the other.

So those are next steps. Are there any questions about the process?

Lee Partridge: Lauralei, this is Lee. In order to give people who weren't on the call an opportunity to read the transcript…

Lauralei Dorian: Yes.

Lee Partridge: … I know – I think you may need to – we're talking three business days, I mean I think if it gets to everybody by Friday and sent back by like next Tuesday. I'm just concerned that people have an opportunity to be sure that they're fully informed and read the arguments and material.

Lauralei Dorian: Definitely.

Lee Partridge: OK.

Lauralei Dorian: Yes and it will take us at least two days I think to get the transcript so I'll make sure that it's at the point of – that which I send the e-mail when the transcript is available.

Lee Partridge: Good. Thank you.

I did want to just say looking ahead we have an in-person meeting coming up in January. It will be – we will be guinea pigs for a new process and we're not new to this because we were getting guinea pigs on the person-centered care issues in general. But this time we will be getting a preliminary recommendation from the staff on whether or not a measure needs the specified criteria for endorsement.

So, it should simplify, I think, our discussions and hopefully will give us much more time to focus on some of the issues that probably deserve more discussion in-person than they got because we were all tangled up for at least a number of – we're all tangled up in validity and reliability. And…

(Sam Burner): I have a question. Can you tell us again because I saw that on my calendar, is that an in-person meeting?

Lee Partridge: Yes.

(Sam Burner): … over the phone? OK. And what are the dates of it again? Blank 1st?

Lee Partridge: Lauralei, what's the date?

(Off-Mike)

(Sam Burner): I just need to verify this for my calendar (inaudible).

Nadine: Who is speaking? Sorry. This is Nadine, who am I speaking to? Sorry.

(Sam Burner): This is (Sam Burner).

Nadine: Hi (Sam). I think it's January 21st and 22nd.

(Sam Burner): OK, and it will – I just – and it will be all, pretty much all day, kind of like we did before?

Nadine: Yes, it will be a two-day meeting all day.

(Sam Burner): OK. Thank you.

Nadine: And we're no longer having workgroup calls for phase 2 of this project.

Lauralei Dorian: Right, that's the new issue. We will not be – individual. We will not be working in workgroups prior to that in-person meeting because instead we will be receiving prior to that meeting a staff proposed evaluation.

(Becky Bradley): So, just to clarify, I'm sorry, this is (Becky Bradley). Will it start at 8:00 on the 21st and end at 5 on the 22nd? I'm just trying to figure out how fast we can travel.

Nadine: We're still working out the details for that. We haven't prepared an agenda item for that but we're probably thinking around 8:30, where we're starting the

meeting on the first day and probably end in around 5, 5:30 and then the second day, will roughly be around the same.

We have 29 measures that came through, the measure submission deadline closed on Friday and we have 29 measures to review.

So, I'm thinking that it will be a little bit longer meeting than we had for phase 1.

(Becky Bradley): Thank you.

Nadine: Welcome.

Laurelei: And, in the interim I hope everybody has wonderful holidays.

Male: Thank you.

Female: Yes.

Male: Thank you everybody.

Lauralei Dorian: Thanks to everyone.

Male: Thanks to everybody.

Lauralei Dorian: Thanks Lee and Jim and the developers.

Female: Happy holidays.

END