National Quality Forum

Moderator: Person and Family-Centered Care
September 9, 2016
1:30 p.m. ET

Operator: This is conference # 77792555

Susanne Theberge: Good afternoon everyone, welcome to the Person and Family Centered Care phase III post comment call. Thank you so much for joining us this afternoon, this is Susanne Theberge, I'm the senior project manager on the team and I'm just going to make a couple of quick housekeeping announcements, which most of you will be familiar with.

First and most important, if you are – please turn off your speaker on your computer if you are on the phone and the webinar so that we don't get the feedback. Committee members, we need you to be on both the phone and the web using your special individual link, the phone lets you talk and the web special link lets you vote. We'd also like to ask folks to mute if they're not actually talking, so we can reduce interference on the line; we've got a lot of folks on the call today.

And please don't place us on hold because then we get your hold music. We have a couple of folks who were not at the in-person meeting, so we're going to be doing their disclosures during the roll call which will start in just a second. And we also finally, we have the developers on the phone today to answer your questions if you have any, so if you have a specific question about a measure, just let those developers know that you would like them to answer it and they can do so.

Finally, as we mentioned in our e-mails about this call, we have a lot to do in a pretty short amount of time, so we beg you please to keep your comments succinct and not to rehash things that we have already discussed. The staff will help keep the meeting on time but we do have a lot to do, so with that said I will turn it over to (Dezzy) to do the roll call and then we'll dive right in. (Dezzy)?

(Dezzy): Hello everyone, I'll be going through your roll call. First off I'll ask if (Anne Monroe) is on the line? (Bess Everback)?

(Bess Everback): Here.

(Dezzy): Thank you. (Brian Lindberg)? (Karen Denzel)?

(Karen Denzel): Yes…

Susanne Theberge: Hold on a minute (Dezzy)…

Female: … drop off at 11:45.

Susanne Theberge: …will you actually go to the roll call slide and then (Brian) is dialed in so…

(Brian Lindberg): I'm here, can you hear me?

(Dezzy): Yes, we hear you now, thank you (Brian).

(Brian Lindberg): OK I was on mute.

(Dezzy): OK thank, all right and (Karen) you said you have to get off at 2:45?

(Karen Denzel): Yes.

(Dezzy): OK thank you. (Christopher Stilla)?

(Christopher Stilla): I'm here.

(Dezzy): Thank you, (Dawn Doubting)?

(Dawn Doubting): I'm here.

(Dezzy): Hey, (Dawn), (Adrian Boisey)? (Jennifer Bright)?

(Jennifer Bright): I'm here.

(Dezzy): Hi, (Jennifer), (Katharine Bevin)? (Leigh Partridge)?

(Leigh Partridge): I'm here.

(Dezzy): OK, (Leonard Sporezee)?

(Leonard Sporezee): I'm here.

(Dezzy): All right, (Linda Maleela)? (Lisa Maurice)?

(Lisa Maurice): I'm here, thanks.

(Dezzy): Thank you, (Lisa Suitor)?

(Lisa Suitor): I'm here.

(Dezzy): OK, (Nicole Freedman)? (Peter Thomas)?

(Peter Thomas): Here.

(Dezzy): Hi, (Peter), (Rebecca Bradley)?

(Rebecca Bradley): Here.

(Dezzy): (Samuel Burner)?

(Samuel Burner): Here.

(Dezzy): (Sharon Cross)?

(Sharon Cross): I'm here.

(Dezzy): (Sherry Kaplan)?

(Sherry Kaplan): I'm here.

(Dezzy): (Steven Hoi)? OK are there any committee members that may have joined afterwards and I didn't call your name?

Susanne Theberge: I see (Steven) on the webinar, are you on the phone? (Steven) we'll need you to dial into the phone line as well.

(Sarah): OK great, so this is (Sarah) speaking and first of all thank you all for spending your Friday afternoon with us and thank you specifically to those of you who are able to dial in early. It was really our hope we could get started right on time this time and you know, best plans sometimes go a little bit awry. As Susanne indicated, we have a really tight agenda today.

We have changed things a little bit over the past couple of days, so we'll be reacting on the fly a little bit, but we'll keep you posted on that as we move through the agenda. But our overarching goal today is to achieve consensus on those measures that we did not achieve consensus on during the in-person meeting or those -- and then there were a couple of those measures where you did not recommend them at the in-person meeting, however there was a lot of back and forth, so the developers were encouraged to bring more information back to you to see if that would satisfy your request and thus we'll need to revote.

You will notice on your screen, on the left hand side towards the top, you have the mechanism to raise your hand. So if you're trying to say something, and we are not picking you up for whatever reason, all you need to do is raise your hand, and I'll raise mine right now and we'll see if it's working, so you can see that my hand raises.

But with that it we will be – one of those things that we've done for this call is to put some slides together to remind you where we were back in June, when we discussed each of these measures that are still under consideration, what's still open and to help guide you through the process and also address what the developers brought back to you during the public comment period.

We also have in those slides the highlights from what we've heard from public comment, hopefully to get us through the agenda on a quicker basis.

But with that, I'll go ahead and turn it over to (Leigh) and (Chris) who both would like to say welcome.

(Leigh Partridge): Hello everybody, this is (Leigh) and I want to echo (Sarah's) thanks for being available on the Friday after Labor Day weekend. I hope to stay with you all afternoon, but if there's a sudden crash around 3:00 just know that the projected thunderstorms ending our 95 degree heat in New York have arrived, (Chris)?

(Christopher Stilla): Good morning or afternoon, it's (Chris Stilla) and welcome to everyone, I hope you had a good summer. It is really nice here, not 95, I'm glad I'm not there. But anyway, we've got a lot of work to do and hopefully, we'll come to some good positive conclusions to really help wrap a lot of this stuff up. So thanks again for being on.

(Sarah): Great, well thank you both and so let's go ahead and move to the first agenda item which is the related and competing measures. What I – actually let me go ahead stop there on slide number 7 which is measure status. Just for a quick review of where we were after that in-person meeting, the first top set of measures would be those measures that are just recommended.

Those measures are not specifically discussed on this call unless for some reason we had received some public comment on them that we felt would need to be put in front of you for reconsideration of the measures or for any other reason. We did not receive any public comment on any of these measures, with the exception of 0420 the pain assessment and follow up.

And we'll talk about that a little bit more during the public comment section of this agenda. Consensus not reached, so we have three measures that -- where in certain of the must pass area you did not reach consensus. At the in-person meeting we typically call that the grey zone, so those are measures where revoting will have to occur and where the developers had the opportunity to provide additional information.

As Susanne mentioned at the beginning of the call, as we review those measures and go back and talk about them, the developers are available on the phone and we will just ask you to say we really need more information from

the developer and will thus ask the appropriate person to respond to that. Different from the in-person meeting, the developers are not provided an opportunity to make an introduction on their measure, they did that during the in-person meeting so this is more for the committee to talk through and get any outstanding questions answered.

And then finally the two measures that were not recommended, we again – the developers provided more information specifically with measure 2967, there's a significant amount of additional information provided. And so there might be a little bit more back and forth, and we'll go through that as we go through the agenda.

Next slide, so the thing and as I mentioned, next slide, as I mentioned in my original introduction is that related and competing measures, we only had discussed related and competing measures as part of the NQF criteria.

After measures have been recommended for endorsement. And so in this case specifically there were two sets of measures, one set of measures from UDSMR, the functional change measures that were identified for mobility and self care that were recommended for endorsement during phase III, were identified as competing with two measures that were endorsed during phase II and those were measures from (ACA) again on functional status change for mobility and self care.

And one of – the way that NQF looks at related and competing, is again, once the measures are recommended for endorsement or endorsed, we go through a decision logic for related and competing. And we're looking to see if there are things such as the same focus area, in this case both mobility and self care are the same focus area and then the same target population.

And we identify the same target population for these measures to be the skilled nursing facility population. So we did identify them as competing, we did ask both UDSMR and (ACA) during the public comment period to provide us some more information on what are the strengths of their measure, why or why not should they be chosen as best in class?

Are there any opportunities for harmonization, so we can get more information on the measures to help inform the conversation with you? Next slide, what we – some of the considerations once we identify that the measures are competing or even related and specifically if there are opportunities for harmonization are the same as our measure criteria.

Specifically we're looking for are is one set of measures or one measure, are there specifications more consistent with the evidence or with the measure focus. Is one set of specifications clearer than the others, is the testing stronger in one side or another, feasibility of course and usability in use. We'll go to the next slide, but then what happens is then we get on these calls and the committee is ideally able to designate a best in class and that's what NQF would really like.

This has to do with alignment of measures, it has to do with parsimony and really trying to determine is there a more ideal situation for how to measure a specific concept in a specific target population. Now what I want to remind some of you of and some of you who are new to this committee is we had a similar challenge during phase II where we had the mobility and self care measures, some based on the UDSMR measures that are derived from the (sim).

And then others from CMS that are derived from the care tool, during phase II you all were unable to reach consensus on a best in class measure, so all of the measures went forward as endorsed. We continue to talk to both UDSMR and CMS to get updates on their measures, to continuously inform us to determine you know, if something changes is more data helping inform us is there truly a best in class?

However, as you may be aware, CMS's measures are not being collected until October of this year, therefore we won't have true data from CMS until sometime in 2017. So in some ways I didn't want to say we punted the measures but we kind of left them out there as they're all endorsed and still some considerations could potentially be made in the future on is there a best in class.

So while we were preparing for this call we have a similar situation with the measures now identified as competing with UDSMR, it's 2769 and 2775, with (ACA) it's 2612 and 2613 which were endorsed during the last phase of work. Again, the developers provided some information to us to explain why their measures are the way that they are, why they feel they're best in class, et cetera.

And on reflection internally in consideration with (Chris) and (Leigh), what we have decided to do is not have an action item on this for this particular conference call. We feel that tabling the committee action to off cycle will allow us to spend more time in looking into some considerations of how designating a best in class may impact these functional status measures. As you all may be aware, a lot of these functional status measures when they come forward are for an identified need, some of that legislatively from the IMPACT Act.

Others you know, because it's something from industry whether it be skilled nursing, in-patient rehab, long term care where these are really important considerations for the care of these patients. And we don't want to limit any type of new research or new ideas in measurement because of this competing conversation.

So really our proposal to you as staff would be to look at all of the functional status measures in the future, at least all of those that are endorsed. So whether they're in-patient rehab, skilled nursing, any of the post acute care and really probably more globally because we know that functional status is also measured on the acute side for some conditions et cetera.

And look to see what we can learn and how specifically NQF's related and competing criteria might better be improved, or if we can learn from something like this. I think our considerations of tool based measures are impacted by this, but really, that's kind of what we wanted to do and we're not going to vote on this but more of a, does anyone have any strong concerns about us putting this off until sometime in 2017?

It would probably be an off cycle webinar or some other type of meeting of this committee, but it will allow NQF staff more time to do some research on functional status measures to understand how our criteria play out when considering tool based measures and specifically those that are competing and alignment across different sectors of care.

And also I think, allow greater fairness to the developers so that we're not putting some arbitrary rules on them in choosing this best of class. Going to stop there and see if (Leigh) and (Chris) have anything to add to that.

(Christopher Stilla): Yes this is (Chris), I just – thanks a lot (Sarah), I think that was very clear. I think just to add to that, I think we need to have a little bit of a philosophical discussion about what's the impact of saying best in class in general, and I think this will help us do that with some specific examples here. And want to be thoughtful and thanks.

(Sarah): (Leigh) did you have anything additional to add to that?

(Leigh Partridge): No I think we've exchanged e-mails on this topic and I agree absolutely with what (Chris) said. I struggled with the issues from phase II twice versus a member of this committee and then at (CSAC) and I think we do need to discuss not only this set of measures but the broader issue in more detail, and I welcome that.

(Sarah): So any other committee members have questions about that? Otherwise we will just go ahead and move to review of the first set of measures.

(Peter Thomas): I only have one question, this is (Peter Thomas), has there been any other committee that has taken on this issue of best in class and has it gone up through the chain of command so to speak?

(Sarah): (Lisa) can you comment on that?

(Lisa Suitor): Yes (Peter), it has and it's always been an issue in which people are conflicted. Sometimes you have a situation which -- as you have (USMDR), measures that have been in existence for a fairly long time that are used widely and people don't want to give them up. But maybe the next set has an

innovation that is more appealing, it becomes a difficult issue and it's not confined to this committee alone.

But I do think it's probably come here more in the last two years than from any other committee, and (Marcia) you would know better. So we're probably a good committee to start having the broader discussion.

(Peter Thomas): Great, thank you. I have no problem with the recommended approach, thanks.

(Sherry Kaplan): (Sarah) this is (Sherry Kaplan), I'm trying to help NQF in a different level of (trouble) with some of the issues of reliability at different institutional levels. And you used terms just now that I think it would be helpful, I don't know, to the rest of the group, certainly to me, to explain what score versus tool – I don't like tool, instrument level stuff is all about. Because it does confuse people I think a bit when that language, it's a little jargony. Can you explain the difference between score and instrument level?

(Sarah): So that's something I think, (Sherry), that is one of the things that we've really struggled with too that has become very evident in the review of specifically these functional status measures. But then even some of the experience of care measures in that they're all based in the functional status measures; they're functional status assessment tools.

But then if you look through the measure submissions whether it be the functional status measures or even sometimes (caps) measures or experience of care measures, they call the actual tool or instrument or survey also a measure. So a measure of customer of experience of care, and they're referring to the entire survey not just the percentage of patients who have indicated they – the percentage of patients who are satisfied with their care or whatever that specific measure is.

And so I think that's one of the things that comes in the conflict and makes it harder to make a determination of best in class when considering these, what we're calling tool based measures.

And we may not have the jargon or the nomenclature correct yet within NQF but what we're trying to designate is a difference between the survey, the

assessment tool or the instrument and a performance measure, which typically to us would be the percentage of patients who have shown an improvement in function or what the actual metric would be that you would see in public. Does that help?

(Sherry Kaplan): It does, I mean I think that there's no surprise that because health status and quality of life and patient experience are such broad constructs that you're going to get multiple measures that purport to measure that construct. And those measures are going to be multidimensional, for example, in (SF) 36 there's physical function and role function and pain and energy (vital).

And all of those may or may not be relevant or may or may not be the best in class for representing for example, physical function compared to another measure for which that measure is also a sub dimension. So the idea gets a little squirrelly for this committee, I think and forgive me (Leigh) if this is like overstepping, but it gets a little confusing if you're trying to use the whole bundle of things that collectively are supposed to represent functional status as opposed to some sub dimensions.

Or then scores at one level on that sub dimension versus another level of the patients for example, versus nursing homes. And so I, well the long haul is I think more work needs to be done, the decision to table it for a while is a good one. But I think it's going to be an ongoing problem for this committee, especially when you get into these multidimensional complex constructs.

(Sarah): And that's exactly it, so I know just as the rest of the committee is aware, one of my colleagues (Karen Johnson) is engaging a set of statisticians that provides some expert advice to NQF including (Sherry) among others, to help us with some of the things that keep coming up specifically in this committee. And then you know, one of the reasons we do want to table the functional status conversation and choice of best in class if we're able to do that is really to help inform this type of thing more broadly at NQF.

But then specifically when it comes to these tool based measures and where there are sub domains etcetera, because I think that's justice served to anybody developing measures as well.

So if no additional comments about that then that's how we will move forward, you will hear more from us on how we're going to move forward. We very much intend to engage this committee, most likely some other committees and then the developers as well who are being impacted by this so we can get some thoughts from your side as well.

So moving into the review and voting measures…

(Sharon Cross): Hi, sorry to interrupt, this is (Sharon Cross), I have to sign off for about 30 or 40 minutes for another webinar and I'll sign back in as soon as I'm finished.

(Sarah): OK thanks (Sharon).

(Sharon Cross): Thank you.

(Sarah): OK so what we're going to do in this next section is I will do a couple introductory slides and turn it over to, I think (Chris) is doing the first one, go back to that slide you were just on please. Oh actually OK, so this is the first one. OK next slide, so I will introduce each of the sets of measures and turn it over to (Leigh) and (Chris) and I believe (Chris) is doing the first set of measures.

But basically as a reminder, we had three measures from UDSMR, 2776, 77, 78, these are the functional change measures where there's a change in motor score which is a larger, broader measure. The self care which is a subset of motor score and then mobility is also a subset of the motor score, these are all based on the (sim) assessment. And these all, actually two of these were voted consensus not reached, one of them was not recommended, but we really feel that not recommended vote was because a couple people had left the room and had changed the percentages.

So we're introducing them all together again and you did not reach consensus on performance (gap), reliability, validity, use and usability and overall suitability for endorsement, so we'll need to vote on each of those. The in-person meeting concerns from what we picked up were discomfort in assuming, use of the (sim) and long term acute care.

There were comments that it's not a common instrument in that setting, although there certainly was acknowledgement that is has been used and UDSMR was able to provide some data on that. At the time that this was submitted the data was limited on the reliability of the measure across (eltax) and I think that's one of the things that (Sherry) just brought up.

And specifically there was not an interclass correlation analysis provided, and then there's some questions on feasibility and low performance but there were some comments that maybe that was a result of small numbers. Public comments, so as you are all aware, these measures do go out for public comment as part of our draft report. And in our public comment there were some comments in support of the measures more globally about use of measures from the (sim) tool because they have been in use for a number of years and they certainly are used in a number of settings.

Next slide, so in what staff did just so you know in all of the materials that you have we actually have put together a table that went out to you, called supplemental information. Where in one column we put what the measure was and what the votes were, then the middle column were you open issues that I just went over and then the right hand column was what we received back and some links to what we received from each of the developers.

So they're just summarized here where UDSMR did provide updated testing results, I know they hired a statistician to come in and help them look at their data differently as well as they supplemented the data where they originally, I think only had six facilities in the testing provided when you first looked at it. They upped that to about 39 facilities to provide more information on -- between facility variation.

Their performance scores, reliability and validity and then we had also off outside of that asked (Paulette) to provide us some information on use and usability to address your concerns about not being perhaps commonly or typically used in long term care at this time. So if you do have some questions about that I know (Paulette's) available to answer those questions. So with that I'll turn it over to you (Chris), if we could lead the committee discussion

on any residual comments, questions, anything else you need to know before you'd be prepared to vote.

(Christopher Stilla): Great, thanks (Sarah) and I think I don't have to say really much more than that. The two chunks of data that I think we need to consider are the new metrics or psychometrics if you will, good enough with the new data provided and then the second is the question about use and usability given that the data provided are somewhat older. Is there still enough use to give a high grade for this moving forward? So questions for the developers from folks on the committee?

Male: Yes I would like to have them comment on with the new information, how they think this has helped their case?

(Paulette): Yes I am, can you hear me?

(Sarah): We can.

(Paulette): OK so in the initial submission we had the random samples, so I know there were only six facilities but there were – we had certainly many more than that. So with the updated analysis there's 39 long term care facilities and that includes data from over 73,000 patients. When we were sent the (ITC) analyses, compared across the facilities there's a high degree of agreement, the ICC was over 0.9 for all of the measures, the (P) value was less then 0.001 which shows high consistency of rating.

And we also provided the distribution of mean scores by facility, and the range shows that the ICC is not due to a restricted range, there were important differences across facilities that could be reliably picked up by the measures.

So -- the measures are reliable, the measures are valid, the measures are used. I know yes, some of the data was older. But we certainly have even older than 2002 and we do have data that's current, as well. We do have -- the current count is 14 facilities. However, the whole reason that we wanted to bring these measures forth to you for long-term care facilities is because we believe that there is you know, a need for quality measurement and functional

measurement in long-term care facilities. So we really would like to expand the horizons, not go the other way.

(Sherry Kaplan): (Paulette), this is (Sherry Kaplan). The -- I've seen the hospice analysis for the inter-facility ICCs and they're 0.0018 to 0.0 -- I think the highest one is three. I think, I suspect that the ICCs in this case have been done again at the patient level because that would be an enormously high ICC for between facility, interclass correlation coefficients and that's what we were looking for. Can you comment on that? Because I -- that would be really surprising and very unusual to find that level, if it's at the patient level it makes sense. But at the facility level, that's a really unusual finding.

(Paulette): So the way our data is set up that you have admission and discharge scores, right? So we did the ICC at the split half. In terms of what facilities, you know, the difference is by facilities and that's really why we provided those tables with the distribution of mean scores by facility. So you've seen that some were you know, very, very low and some were very, very high.

(Sherry Kaplan): But what you're looking for with a facility level inter-class correlation coefficient is, is there more between than within facility variation, because if you're going to attribute the care to you know, a unit like the facility, you want to see more -- you want to see the facility's thumbprint. Which would be there is more between facility variation and they don't vary much in their care within facility.

(Paulette): Correct and that's what we found.

(Sherry Kaplan): No actually with the -- we need the ICCs for those 14 facilities to tell whether there's…

(Paulette): Thirty-nine facilities, yes, no…

(Sherry Kaplan): So do you have the ICCs at the facility level?

(Paulette): So we -- so we worked with a statistician that is well-versed with UDSMR data, he does not work for UDSMR, he is not affiliated with UDSMR in any way. And this -- this is the way that this should have been run.

(Sherry Kaplan): But we -- we need to see that -- you know, again that some other…

(Paulette): There is the distribution of scores by the facilities.

(Sherry Kaplan): No yes but what you'd need -- you'd have the data then to do that inter-class correlation coefficient at the facility level if you can give it those mean differences. You could also tell us how much variation there is between versus within facilities. And again, the attribution back to the facility, that's a signal of reliability for us.

(Paulette): But that would still be at the patient level.

(Sherry Kaplan): No..

(Paulette): It would be the patients within the facility.

(Sherry Kaplan): No you're averaging…

(Paulette): So let's -- let's say we took one -- facility, right? We -- we just -- we selected only facility A and we ran an ICC because what you're asking me (for) right now would be like 39 ICCs, right?

(Sherry Kaplan): Right.

(Paulette): Which is absolutely feasible. But what's still happening is you're still looking at the patient's score within that facility correct?

(Sherry Kaplan): What you're doing there is averaging across patients within a facility and you want to see if there's more variation at the patient level than -- than at the facility level. And that's a signal of our reliability at the facility level for using this measure.

(Paulette): Correct but that is exactly what we did, we took those -- those patients within those facilities.

(Sherry Kaplan): No it's a different calculation and you give us the inter-class correlation coefficient at the facility level.

(Sarah): So (Paulette) can you hold on a minute? So (Sherry), is this -- I mean it seems to be consistent with kind of the interpretation and I'm -- (Sherry) with some of the other measures where you know, if you remember in June, we were talking about you know, there's the level of what NQF staff were able to suggest to the developers to do. And those measures weren't held at that mercy. And so that's what I'm just trying to get at, that same issue that we don't see this level of testing for any of these types of measures?

(Sherry Kaplan): Well, yes and no because we've gotten them back from -- that's what I was helping (Karen) with. We've gotten them back from the -- from the hospice measure for example, the hospice care measure. And that's what I was reacting to, that -- you know, they've given us what we asked for, Unfortunately, the signal isn't very strong in that case. And so what we're struggling with now is you know, given the reliability doesn't look like there's a heavy thumbprint for some of these measures at the facility level, then what does NQF do?

But I think that just getting the data back that we -- we -- we sort of (feed) it -- at least go further with that kind of exploration at NQF and then what are you going to do with it would be -- would be important.

(Brian Lindberg): This is (Brian). (Sherry) could you just clarify – you're saying that at this point we're not able to compare the facilities in a way that you would like to because they haven't taken the average of the individual data within each facility, come up with a score for that facility that we can compare to others?

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:(Sherry Kaplan): Well, they've come up with a score, a mean score, but what you're looking for is is there a thumbprint within facility across patients and so you want to see not as much variation in the score within facility and a lot of difference between facilities and that score.

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:(Brian Lindberg): Yes.

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:(Sherry Kaplan): And that's – those are the kinds of data we need. Whether we can go forward with some kind of, you know, understanding that we'll need those data to make a long term or – I don't know what the recommendations are, (Sarah),

and I don't know how NQF wants to handle this at this stage, if you know – but that's the kind of, exactly, that's the kind of data we'd need.

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:(Sarah): (So what can)…

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:(Paulette): …(What we) performed was exactly what was instructed of us. We did the ICC using the split half method. We took the data from the 39 (al tax). Each facility had patient data from admission and discharge so we randomly split those into two data sets and the averages at the facility level for each measure were calculated. We compared across the facilities to get the ICC using a two way random effects model to estimate the ICCs (rate of) measure.

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:So then, the split half ICC was based on the average measurements using the agreement definition of the correlation and there is a reference to an article where we based this off of so the total score variance of the denominator of the measure.

:(Sherry Kaplan): (Sarah), this is a – this is one of the things that NQF if it's relying on old directives, you know, the former directives, then maybe this is, you know, this is unfair to the developer because those directives are now being revisited and we're going forward with a different standard. So, how do you – that's kind of, I think that's NQF's going to have to step in.

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:(Sarah): Right, and so, you know, I guess the other thing I would say here is remember this is a set of – so, UDSMR is provided to you the same set of measures for inpatient rehab facilities. Those were all endorsed with some, you know, kind of actually the older data analysis that (Paulette) has updated for this review right now. And then even in June, the measures were recommended for endorsement for the skilled nursing facilities.

:So, again, based on that type of analysis where you're able to, you know, say is this perfect, is this really, really, really what we want to determine between facility reliability? Maybe not but we can't hold the developer hostage while NQF figures out – and we've become more educated on what the appropriate analysis would be done. And then, I think, in this case, (Paulette media somehow) took it another step forward to even try to go further and meet the

needs to exactly – you know, I think what you were just saying, (Sherry), on something that's been transitioning.

:And so, I mean, my guidance is, you know, based on your past review of the other measures, is there something with this set of measures for the long term acute care that make them different that you don't think that they're reliable, valid, usable, feasible, et cetera because, you know, that's what you would need to substantiate in that – in order to not endorse them. And I'm just going to – I know (Alisa) is on the call. (Alisa), I don't know if you had anything additional to say at this point because I know this is something internally we're wrestling with.

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:(Alisa): Yes, I agree with (Sarah). It's something that's going (brooks) and we don't really have an answer right now, but we're working through these issues.

(Sarah): So, you know, I think the direction to the committee is, you know, based on the additional information that UDSMR has provided, you know, do you have any additional questions, you know, we know that there are still some outstanding questions on how do we interpret this between facility reliability but – and you know, and I understand that perhaps we have some developers who have been able to do that but I would also say in looking at consistency and recommendations of this committee, you know, are there any outstanding concerns you have about these functional status measures for the long term acute (queue) care setting that you would need addressed before voting?

:

:(Christopher Stilla): And this is (Chris), again, just to chime in, so there were some concerns about the numbers which we've talked about and then there were some concerns about use and usability and I just wanted to see if anyone had any questions or concerns about that. OK.

:

:Male: I do not.

Female: OK, so (Nam) can you tell us how many committee members we have online?

(Nam): At the moment, it appears as though we have 14.

Female: We have 16 committee members dialed in over the phone.

Female: And we have 14 online able to vote.

(Kirsten): So, this is (Kirsten) and I am willing to vote for both (Leigh) and (Peter) from my end if they're willing to verbally state their vote.

(Peter Thomas): I'm more than willing to do that. (It's Peter).
:

:(Sarah): All right, OK, then (Sean), can you go ahead and do a quick overview on voting and we'll go ahead to the vote?
:

:(Sean): Certainly. If the NQF staff would like to bring up a voting slide for a moment, we'll ask that you not necessarily vote at this moment. Wait until they announce voting is open but when you do see voting criteria options appear on the slide, you'll see those options listed very plainly on one side – one slide and then they'll advance to the next slide and you'll see that you have the ability to vote by clicking a box next to each of the choices.
:

:So, you'll simply click in that box next to the choice and it will record your vote. So, this would be the slide that you would see with your options to vote and then when they advance to the next slide, next to those options, you will see a small box that you'll be able to click in. It's very important that we have only voting committee members vote. Everything is captured and recorded so obviously it does skew the results if we have someone attempt to vote that's not a committee member.
:

:It should be locked down to everyone that is a committee member.

:Male: How are we going to make sure that we're all able to do this, I mean, is there a way you can do a test run beforehand?
:

:(Sean): It's certainly, we can – I'm going to go ahead NQF and pull leadership from you for just a minute and we will go ahead and add a sample question in. Just one moment. And then you'll have the opportunity. There we go. So, right now you should see the ability to vote on a sample slide that reads one or two. You simply click in the box next to your choice.

Male: You don't have to hit enter after you click or anything?

:

:(Sean): No. Just simply click in the small box. And at the moment it looks like we're at 15.

:

:Male: Wow, that's great.

:

:(Peter Thomas): I haven't voted because I'm not voting online. This is (Peter).

:

:Female: OK. There we go.

(Sean): All right, wonderful, so we will go ahead and go back to NQF staff and you can go ahead and reset back to the voting slides that you were getting ready to cover.

:

:Male: All right. So, (Sarah), as we discussed, are we going to vote on the first measure and then just have a consensus on whether the voting will carry through to the other measures in this group?

:(Sarah): Correct.

:

:Male: OK.

:

:(Sarah): All right, (Dezzy), are you calling out the votes?

:

:(Dezzy): Yes. We're now voting on importance to measure and report for performance gap of measure 2776. You may now enter your vote.

Male: The slide doesn't show – OK, there it is.

:

:(Kirsten): So, (Leigh) and (Peter) if you could please tell me how you'd like to vote?

:

:(Peter Thomas): And normally you read out what the four choices are. Are there – is it the same (time)?

:

:(Kirsten): Yes, sorry (Peter). Yes, here we are. Option A is high, option two, moderate, option three, low, and option four, insufficient.

(multiple speakers)

Male: Just a technical thing, we can see everyone else's votes as before we have voted. Is that a problem?

:

:(Sean): No, it's calculating, I believe, as they come in.

:

:Male: Right, I – yes, it's just not exactly. Well, whatever. OK.

:

:(Peter Thomas): Two, please.

:

:(Kirsten): Two, you said, (Peter)?

:

:(Peter Thomas): Two, please. Two.

:

:(Kirsten): And (Leigh), what?

(Leigh Partridge): Same.

(Kirsten): OK.

:Female: That's only 15 votes.

:

:Female: Yes, we're missing one.

:

:Female: We have 15 votes and so we're missing one vote. Could I have you resubmit your votes please? Susanne, are you having issues with (Peter's) vote?

:

:Susanne Theberge: I can't tell if it's taking or not, I'm sorry.

:

:Female: Actually, Susanne, it won't because you aren't logged in. It does look like you have a second session going on there but it doesn't look like it's recording (Peter's) vote because you're tied to your initial session.

:

:Female: OK, so that is a – so it's 15 moderate, one low.

:

:Female: Yes.

:

:Female: All right. You want to move on to reliability?

:Female: Yes.

:

:(Dezzy): All right. We're now voting for the scientific acceptability of measure of properties which is reliability for measure 2776. Option one is high, option two is moderate, option three low, and option four, insufficient. And now, voting is now open and you may place your vote.

:(Peter Thomas): This is (Peter). Two please.

:(Leigh Partridge): And this is (Leigh). Two please.

(Dezzy): Thank you. OK, we have 15 votes. Looking for one more.

:Female: No, (Dezzy), we're fine because we have (Peter's) verbally.
:

:(Dezzy): OK. Got it. So, we have one for high, it looks like (Peter) voted two, correct?

: Female: Yes.
:

:(Dezzy): So it's 13 for moderate, two for low, and zero for insufficient. OK. We'll move forward with validity of this measure, measure 2776. Option one is high, option two, moderate, option three, low, and option four, insufficient. You may place your votes.

:(Peter Thomas): This is (Peter), I'll say number one.

(Dezzy): Thank you (Peter).
:

:(Leigh Partridge): This is (Leigh). I say number two.

(Dezzy): Thank you. OK. Looks like we're still missing one vote. Actually, we're missing two votes. (Sean), are you able to see who has voted and who has not?

:(Sarah): Actually, you know what, we're not even close to not achieving at least grey zone here so let's just move on.

Female: OK.
:

:(Dezzy): And moving on for usability and use of measure 2776. Option one is high, option two, moderate, option three, low, and option four, insufficient

information. You may place your votes. Option one high, option two, moderate, option three, low, and option four, insufficient information and this is for usability and use of measure 2776.

(Peter Thomas): This is (Peter), I'll vote number two.
:
:(Dezzy): OK, thank you.
:
:(Leigh Partridge): This is (Leigh), number two.
:
:(Dezzy): OK, as of now we have two for high, we have 13 for moderate. Zero for low and zero for insufficient. You want to proceed, (Sarah)?
:
:(Sarah): Yes.
:
:(Dezzy): OK. The last vote for this measure, 2776, is for overall suitability for endorsement. Option one is yes and option two is no. Overall suitability for endorsement of measure 2776. Option one, yes, option two, no.

:(Peter Thomas): This is (Peter), I'll say number one.

(Dezzy): OK.

:Male: We need a voting screen.
:
:Male: We're not seeing the screen that shows.
:
:(Dezzy): (There you are). Option one, yes, and option two, no. (Leigh)?

(Leigh Partridge): I'm a yes.
:
:(Dezzy): So we have 15 for yes.
:
:(Sarah): OK, so well, hold on a minute, so you know, I want to go back to how we did the voting in phase II and I believe we even did some of the carry voting in this past phase for some of you new folks but when the measures are this similar and we talked about them in a group, which we did for these, the first question is does anybody have any additional questions or are you

comfortable with carrying the votes that you just voted on the first of the measures of these sets or do you want to vote them all individually?

:

:So, is there anybody opposed to carrying the vote? We'll go with that's a no so what that means is then you have just chosen to use the same vote for measure 2776, for measure 2777, and measure 2778. Therefore, the functional change, change in motor score, mobility and self care for long term acute facilities are recommended for endorsement. Any last concerns about that? OK.

Male: (OK, thank you).

:

:(Sarah): I just wanted to acknowledge that we've heard, you know, and certainly, you know, (Sherry), we do have work to do on this at NQF in guiding our developers but then in turn, you know, translating to what that means for the committees and you have our assurance. You know, I know (Karen Johnson) has taken the first steps of that. There's more to come which will impact this committee but we want to thank everybody and certainly thank UDSMR for being available to answer your questions.

:

:(Sherry Kaplan): Let me just reiterate that it's really not fair to hold the developers to standards that are changing on the fly, so you know, if I've steered you in that direction, I apologize but I do think raising these concerns now so that people are hearing what the issues are going to be going forward is probably not an unwise thing to do.

:

:(Sarah): And we appreciate that, thank you.

Male: Yes, thanks (Sherry).

(Sarah): All right, so we'll move to the next measure so I'll do my brief introduction and I know (Karen Sepouka) is on the line but this is measure 2958, the informed patient centered hip and knee replacement surgery measure. The committee action is to review the additional information provided and revote on criteria where consensus was not reached. You did not reach consensus on reliability, use, usability, and overall suitability for endorsement. The voiced

concerns during the in-person meeting, the way that NQF staff picked them up was there was a little confusion about inclusion versus exclusion criteria.

:

:There were some questions about the two year data collection time frame and then establishing reliability at the practice level. We did not receive any public comments on this measure and then from what (Karen) provided during the public comment period, she – we feel she addressed each of the items above. She provided some updated testing regarding use and usability and she provided some updated information on use and usability and then updated reliability testing. (Chris)?

:

:(Christopher Stilla): Great, so thanks – I think, you know, what (Sarah) said is basically right there. The main reason, I believe, remembering back in the summer is that some people were confused about really what were the exclusions, how important were the exclusions and then, you know, how much could this be used, is this being used, that kind of thing. I think there were some good responses and I have no particular questions but I'd be happy to open it up to the group for questions for the developers.

(Sarah): Do any of the committee members have questions?

(Steven Hoi): Yes, this is (Steven Hoi) and we asked about – we're going back to reliability again and I remember this was a discussion this Summer as well. I have to look to (Sharon) to answer this question but upon my un-experienced eyes, it seemed like they had just barely passed an acceptable mark for reliability at the practice level. Is – am I reading that right, am I understand – am I interpreting that right, is kind of my question.

(Sarah): So, I think that…

(Steven Hoi): …Was it a just barely, you know, make it across the line, is kind of what I'm getting at.

(Sarah): So, (Steven), I'm going make a couple of – first address that and then I'll see if (Sherry) had a chance to look at this or if you want to ask (Karen Sepouka) to provide some comments on that but, you know, the interpretation of kind of reliability statistics et cetera is while there's kind of an acceptable threshold

which we typically see depending on what kind of statistic it is, NQF doesn't have a clear rule of saying, you know, let's say if we're interpreting a 0.7 and the reliability results were a 0.6, we wouldn't necessarily say that fails.

:

:That is up to the committee to discuss, so you know, I think maybe (Sherry), if you have any comments about that but wanted to make it clear that there's really not a pass/fail on a specific number. More of an interpretation of what does that suggest regarding the reliability of the measure.

:

:(Steven Hoi): Right. Thanks, I understand that and I'm just trying to wrap my head around the numbers a little bit. Thank you.

:

:(Sarah): (Sherry), not to put you on the spot, did you have a chance to look at this?

:

:(Steven Hoi): Yes, sorry about that (Sherry).

:

:(Sherry Kaplan): Yes, I have not and so I'll just make a couple general comments. One is reliability and validity are hard to do outside of the purpose they're going to be to – put to. So, for example, there's a reliability coefficient that ranges from 0 to one is 0.7, there's an old rule of thumb that you can find sites for but they're very arcane. They're not only, for example, the 0.7 is about – is adequate for group comparison so that means 50 percent – if you square that coefficient, 50 percent of the variants in that measure's reliable. So, that's OK for group comparisons but you wouldn't want to do that, for example, if you're comparing individual providers one to another. You want that bar to go really high.

(Steven Hoi): Yes.

(Sherry Kaplan): Because you wouldn't want to make mistakes at that level. So, you know, these coefficients give – as was said, coefficients get a little squirrelly to kind of interpret and it also depends on what stage of development certain measures are in. For example, if you add more items to a multi-item question, you can improve the reliability, but if you're early on in the development of reliability of a measure, you wouldn't want to boot it out just because you're still trying to get a sense of how this works, which dimensions you need to

augment with more items and more patients per unit being compared and so on.

(Steven Hoi): Yes.

(Sherry Kaplan): So, they're kind of hard to interpret. I guess I just reiterated what – was it (Sarah) that just said that?

(Sarah): Yes.

Male: Yes. Yes (that explains it). I love your qualitative explanation of this quantitative thing that we're doing. That's great.

(Sarah): So, (Stephen), does that help you or would you like (Karen) to comment on what she found in her testing?

(Stephen Hoi): No, no, it does. I'm looking at it. Thank you.

(Sarah): OK. So, if nobody has any questions, we can go to vote on this.

(Dezzy): OK, are we ready? We'll be voting on the reliability of measure 2958, option one is high, option two, moderate, option three, low, and option four, insufficient. For the reliability of measure 2958, option one high, option two, moderate, option three, low, and option four, insufficient.

(Sherry Kaplan): This is (Sherry). I don't want to screw up the voting process, but this is based on the old criteria, right?

(Sarah): Correct.

(Dezzy): (Leigh, Peter)?

(Leigh Partridge): I'm a two.

(Peter Thomas): Two.

(Dezzy): OK, (we stand at) 15 who voted moderate, zero for one, zero for high, zero voted low, and zero for insufficient. Would you like to proceed, (Sarah)?

(Sarah): Yes.

(Dezzy): OK. We're now voting on the usability and use of measure 2958. Option one, high, option two, moderate, option three, low, and option four, insufficient information. You may now place your votes for the usability and use of measure 2958. Option one, high, option two, moderate, option three, low, and option four, insufficient information.

(Peter Thomas): Number one for me. This is (Peter).

(Leigh Partridge): Two for me. This is (Leigh Partridge).

(Dezzy): OK. As of right now, we have four who voted high, 10 who voted moderate, one who voted low, and zero for insufficient information.

(Sarah): (OK) …

(Dezzy): OK. Overall suitability for endorsement of measure 2958. Option one is yes. Option two is no. For the overall suitability for endorsement of measure 2958, option one is yes and option two is no.

(Peter Thomas): Number one for (Peter), please.

(Leigh Partridge): Number one.

(Dezzy): OK, thank you. We have 15 who voted yes, number one, and zero for no.

(Sarah): OK, so based on your votes, you are recommending measure 2958 for endorsement and that will go forward to member voting in the (CSAC). So, thank you.

Male: OK, thank you.

(Sarah): OK, so the next measure is measure 2967, the home and community based services experience of care measures. To bring everybody back to June and what you talked about then, there was – so, first of all, the developer has provided a significant amount of additional information, some additional testing, and I'll go into that. But they have asked for a request for

reconsideration which is what happens if the committee does not recommend a measure for endorsement.

Your in-person meeting concerns included such things as length of the survey, how long it might take to complete, providing some additional information about those things, some – the impact of the low survey response rates, and understanding feasibility and how that may have played into those response rates, the value of having both the global measures and the recommendation measures, and then some additional data needed on exclusions and impact of measurement.

There were some overall concerns about scientific acceptability and then some evidence from the cognitive testing which helps with the validity. And then what I wanted to make sure that I brought to your light was, you know, we received an overall number of comments during this public comment of 21 comments. Eleven of those 21, so over half of the comments, were regarding the (8CBS) experience of care measures.

One thing I would like to qualify that with is a lot of the comments were more about the importance of the survey for this population, for the (duals) population, just for these types of programs and the need for them in this particular sector of the healthcare industry and not specifically about the measures themselves. And so remember you all are endorsing measures not necessarily the survey.

But we have heard very, you know, loud and clear both through NQF (duals) work group which is part of our measures application partnership but also a special project that was being done on home and community based services to establish a framework and recommend a framework of measures for developers to respond to in the marketplace and this was really an area of high interest to them of kind of coming up with and figuring out experience of care measures.

And so, in some cases, the set of measures was – is kind of in front of that framework coming out but there has been a lot of attention to it and, certainly, a lot of interest in seeing how this committee moves forward. I don't want

that to be translated as we're saying you must endorse these. Again, that's really about the whole process of needing cap survey for home and community based services and then hopefully translating it into measures.

But really, that's the overall public comment we received is the importance of measures in this area, this being a critical group and really being an opportunity to make some program comparisons for eventual quality improvement. And then, on the next slide, you know, the developer follow-up which was lengthy and we really thank (Truven, AIR), and CMS for the extent of work they put into this. But they provided a lot of supplemental information so I think the first update that is important for this group to understand is that when this measure set submission originally came to you all it had just been submitted to the CAPS consortium for approval.

And they have subsequently granted the CAPS trademark so this is now considered the CAPS home and community based services experience of care survey. They re-analyzed data using a larger sample and including those proxy respondents as was discussed during the in-person meeting. This provided some improvement in both performance gap and reliability results. They have also switched to the top box scoring method which I think you all are more used to when seeing CAPS survey results so that has also changed how the results and the scoring is portrayed.

And then, again, they've provided some additional statistical analysis on the measure. So, with that, (Leigh), I know you spent some time with this and I'll turn it back to you.

(Lisa Maurice): Excuse me, (Sarah) and (Leigh), I'm sorry to jump in. This is (Lisa Maurice) and I have to leave the call now for another webinar.

(Sarah): Thanks, (Lisa).

Female: Bye.

(Lisa Maurice): Bye bye.

(Leigh Partridge): Thank you. And thank you, (Sarah), and yes I have spent a fair amount of time not only on these measures but on this issue over the years and I think (Sarah) has outlined very nicely what a tremendous improvement there is in the information that's available to us today as compared to what we had last June and I commend the developer and company for providing it. I would – the one thing I would note is that one of the major purposes here is that this is intended to be a set of measures across all of the HCBS programs, regardless of which particular condition or population that program is serving.

In other words, we – what we call a cross-disability survey. And there are lots of home grown surveys out there that may look at how – HCBS for the developmentally disabled or for the (PBI) or, you know, if you read the list of the, I believe, 39 facilities that – I'm sorry, 27 I guess, facilities that were in the survey, you see the variety. This one is kind of a universal set of measures and that's why I think there's so much enthusiasm for it.

So, we have two issues before us this afternoon. One is do we have any questions based on the additional information that's been sent to us, questions of the developer. Then, after that, we have just a logistical question. Voting on 19 separate measures isn't practical. So, let's first see if we have questions and how much time answering those takes and then we'll move on to the voting process. Is that OK, (Sarah)?

(Sarah): Yes, I think we've lost quorum so we're not going to be able to vote online but I think if we could just have the discussion and it will help us set up the SurveyMonkey, you know, accordingly for the voting so let's just move to discussion.

(Leigh Partridge): OK. Let's start off, if we can, with just sort of general questions about the information and then maybe we can pull out particular measures that somebody wants to discuss in some depth. So, floor's open.

(Peter Thomas): This is (Peter Thomas), can I just ask a question about the CAPS designation? What does that entail? Is there a review of the validity and reliability in that context or is it designated as a CAPS study for some other criteria, they've found some other factor?

(Leigh Partridge): I'm going to let the – who's on the line for us there?

(Sarah): (Susan, Beth)? I'm not sure who's taking the calls for (Truven) and CMS.

Female: Yes, and we also have (Caretta) and (Elizabeth) from (AIR) and (Caretta), I'm thinking this is a good one for you.

(Elizabeth Frensel): (Caretta), are you on mute? While we're waiting for (Caretta), this is (Elizabeth Frensel) from (AIR) and CAPS consortium consists of Yale and Rand as well as, obviously funded by (AARP) and they examine reliability as well as validity in terms of when they look at all of the analyses, they look at the psychometric analyses as well and (case) makes adjustments.

(Sherry Kaplan): This is (Sherry). They don't, however, look at the sort of inter-facility ICCs and when (Ron Hayes) and I last spoke, that was a concern of theirs that those are going to be inherently low. So, just so we're clear on what they look at, it's patient-level reliability we're talking about.

(Peter Thomas): Thank you for those responses. This probably doesn't go to the specifics of the measures, I just want to state for the record how vitally important it is to have validated measures in this area of home and community based services and just the importance of it alone, I think is compelling to me. I'm just very grateful for the additional data so we can make a more informed decision.

(Brian Lindberg): This is (Brian Lindberg) and I agree wholeheartedly, (Peter), with that. I had one – I guess it's a small question. I'm not sure – I think, (Sarah), in your comments you mentioned the framework that's been developed and I'm just wondering since I haven't paid enough attention to that, is this measure consistent with the framework that the other group has put together?

(Sarah): Yes and, you know, what I'd say about – the framework does not go into a real detailed approach of, you know, what exactly, you know, it doesn't go into all of the NQF criteria but what it more does is talks about the types of measures and specific measure categories that are needed in this industry and then talks about some key concepts of measuring experience of care. And this is consistent with what that committee has recommended and we'll be glad to share that report as soon as it's available.

I think it's in the finalization process right now.

(Brian Lindberg): Thank you.

(Leigh Partridge): Are there more – go ahead.

(Jennifer Bradley): It's (Jennifer Bradley) weighing in. I just – I agree that the new data the developer provided was significantly, you know, helpful. It answered a lot of our questions. Maybe not all of them, but I think my one comment would be that I was a little dismayed by some of the public comments implying that somehow the committee was not being thorough or wasn't qualified to weigh in because I actually think this is a good example of the process working.

I think we raised some legitimate questions and I think NQF should think about some messaging about what the purpose of these committees is and to clarify to those developers and to those who are putting in public comment that tabling something or asking for more data does not imply a lack of understanding about the importance of these issues. I don't think that was necessarily on the table.

I think we all understood why these are important things to be doing but I also think just because it's coming from CMS, for example, doesn't mean that NQF should view itself as just a rubber stamp. And I think that these committees, the whole purpose of them is to put another lens or another angle of looking at what developers are coming up with and just asking good questions and so, to me, I just wanted to go on record as saying I think this is a good example of where the process worked. Even if it took a little more time and even if the developer had to come back with a little more data, I think it's a good outcome.

(Leigh Partridge): Thank you and I think that it's pretty clear that the additional time and our questions probably have resulted in a lot better information and it will help us support whatever recommendation we make at the end of this whole discussion.

(Sherry Kaplan): This is (Sherry), I also think that it helped NQF to clarify some of what work has to be done further to kind of understand what we are – actually, these measures are looking for in terms of when it's going to be used to compare certain levels different from what the developer – the original intent of the measure was when it's going to now be used to compare, for example, home health agencies one to another. What's the standard that should be set for that bar?

And the interclass correlation coefficients, for example, on the data that was set for these hospice measures was pretty low and, you know, when you see data like that then you have to go back to the drawing board and say OK, given this now, how are we going to understand reliability at the unit that we're looking at level and are we confident that we've got good measures to compare folks at that level. So, I think it's also helped to clarify the debate here on what – and especially going forward about what the standards are going to be.

(Leigh Partridge): OK. Are there further questions about the additional information submitted in general or are there any particular measures that somebody wants to discuss at any depth? I know last time around we did have some discussion, as I remember, about the last one which was the harm measure and we also had some discussion in general about whether or not we had some measures in which the scores were so high that perhaps the measure wasn't telling us very much. No questions.

Male: What is the developer's point of view on the question, the one about the provider causing harm or – that question seemed like it would be difficult to get honest answers to.

(Leigh Partridge): Do any developers want to respond? I – as I recall, on this particular issue, way back before we deliberated, we had a pre-meeting comment that raised some questions about the survey question itself and then when it came – when we were discussing it in full committee in June, as I recall, the question – our questions had to do with score.

(Susan Rates): Hi, this is (Susan Rates) from (Truven). I'll say a little bit and then I'll ask my colleagues from (AIR) to weigh in. I do recall the pre- in person meeting comment and I believe that their concern was more about what would happen if someone did identify that there was neglect or abuse and how would that be handled. And so, almost kind of separate from how it's recorded in the survey and what it might mean for measurement but more kind of how would you deal with the practical situation.

In terms of the gap, you know, the amount of improvement and the fact that there's – these are high scores, generally, we view this as almost like a never event.

(Leigh Partridge): Right.

(Susan Rates): You know, you would not want there to be even a small amount of harm being identified but you would want to know about that if it were there. I don't know, (Caretta) or (Elizabeth), do you have anything else to add or is that responsive to the question?

Male: Well, clearly you would want it to be a never event but was there any – I'm trying to remember how often you actually got a positive answer. I think, like, almost none.

(Leigh Partridge): Yes, I think it was like 99.9.

Male: The –

Female: (Also) I want to say on the field test it was definitely under 10 so it was something – it was very rare but when it was reported, you know, it was taken very seriously and it shed light on that issue.

Male: OK.

(Leigh Partridge): OK.

Male: I've got a question about process. If we raised issues and concerns in the previous discussion during the in-person meeting and no additional information has been submitted on that point, I'm assuming that in terms of

the record, the record still is there, right? We don't necessarily need to have that conversation again, am I right?

(Sarah): Correct.

Male: Very good, thanks, because I recall mentioning a few things about this and I don't really want to have to go back and re-tread, you know repeat and I don't think that the materials that have been submitted really contradict anything that was said in the last session, as I recall.

(Leigh Partridge): OK, and (Sarah), we're going to have to – you're going to have to switch this over to SurveyMonkey for voting?

(Sarah): We are, we just – we lost quorum and, you know, I think with this specifically we would want to move this to SurveyMonkey but what we would like to get – and you already asked this (Leigh), but we'd be interested to see if there's any additional – we'd like to get an idea, are there any other individual out of the 19 measures that are of any concern to anybody?

(Sharon Cross): Hi, this is (Sharon Cross), just (to let you know I'm on).

Male: No, not to me.

(Sarah): Hi, (Sharon), thank you.

(Sharon Cross): Thank you.

(Leigh Partridge): And (Sarah), I forget, do we have to actually vote on whether we will consider revoting?

(Sarah): You know, no.

(Leigh Partridge): Is there request for reconsideration? No. OK.

(Sarah): Right, and the reason we aren't is because of this – this doesn't technically fall under NQF's clear policy of a reconsideration because of the fact that there was a lot of back and forth during the in-person meeting. The developer had communicated they would be able to bring back more information so, you

know, we feel that a revote should happen. I mean, I guess we could say is there anybody who has concerns with a revote and do it that way.

(Leigh Partridge): OK. Does anybody have any concerns? If so.

(Steven Hoi): This is (Steven). I have no concerns especially considering the amount of public comment.

(Leigh Partridge): OK.

Male: No concerns.

(Sarah): So, and it doesn't sound like anybody wants to vote on any of the individual measures alone so what we will be doing is setting up a SurveyMonkey. You will receive the SurveyMonkey as soon as possible this afternoon and I'm just giving you guys a trigger. We need it back on Monday afternoon at the very latest. So, if everybody could just plan to spend a little bit of time on Monday in order for us to get this revoted and we'll revote consistent with how we have done survey measures in the past which is actually one vote.

So, basically it would – you're voting for this entire set of 19 measures. What we – and that's the only way we can do it unless somebody says right now you feel we should vote in bucket or 19 individual votes.

(Leigh Partridge): Does anybody have an objection to that process?

Male: No.

(Leigh Partridge): Good. Hearing none…

Male: No (they'll all hold together).

(Leigh Partridge): If you're up at four in the morning on Sunday look for your e-mail and vote. OK, I think we are, believe it or not, on schedule. Susanne, you're going to talk to us about comments, et cetera.

Susanne Theberge: Yes, OK. Thanks, everybody. So, we have received a few comments on…

Male: You're hard to hear. Can you get closer to the telephone?

Susanne Theberge: Sorry about that. Is that better?

Male: Yes.

Susanne Theberge: OK. So, just to summarize what was in the memo, the draft report went out for comment from July 14 to August 12 and for our usual 30 day comment period after the close – after the committee's review. During this comment period, we received 21 comments from 11 commenters, and we identified four major themes in those comments. Support for the measures, harmonization and competing measure concerns which we have discussed already on this call, requests for reconsideration of the home and community based services measure which we just discussed, and then measure gaps.

We received a number of suggested gaps that staff has added into the report. So, I think that that pretty much covers all of the comments that we received but we wanted to make sure that there wasn't any other comment that we received that you all wanted to discuss. OK, hearing none, I will move onto our next question which is does anybody have any concerns with the suggested gap areas and with the team adding those to the gaps list that was already developed by the committee?

Male: (No, I liked it).

Susanne Theberge: Great, OK. And then, as you'll see, staff have drafted up some proposed responses although we did leave many of the responses as TBD following this call and so that, you know, if you have any concerns with any of those let us know but they were pretty straightforward. OK. The other piece that we wanted to mention in this timeslot is measure 420. As you may recall, the committee did recommend that measure for maintenance endorsement with an evidence exception.

The developer did provide some additional information. We wanted to just give that as an FYI. I don't think that there's really much action needed on

the part of the committee but you know, we wanted to just put in a moment here and make sure that nobody had any concerns. OK, hearing none…

Male: …Sorry, I'm on the road. Four twenty is what measure again, forgive me?

Susanne Theberge: The 420 is the pain measure. Hang on, let me grab that…

(Sarah): …It's pain assessment and follow up and so right now it is recommended for maintenance endorsement so it continues to be endorsed. The developer just provided a couple of additional notes regarding – and I think in line with the conversation that, specifically, (David Selo) is bringing up during the in-person meeting that, you know, it's kind of brings the measure together, that it's important to do pain assessment and if you're going to do a pain assessment, you should have a follow up plan.

Male: Very good, thank you.

Susanne Theberge: OK, so hearing no other concerns, I'm going to turn this back to (Sarah) to give us a brief update on the CCAT measure deferment.

(Sarah): Sure, thanks, Susanne. So as you recall, (Matt Whitnea) joined us in person in June specifically to discuss the CCAT measures, and the list of measures is on the slide, but basically these slides were due for maintenance review.

And as we were following up with the developers, learned that they had transitioned from American Medical Association to the University of Colorado and were essentially dormant for a period of time as (Matt) got resituated. They actually were looking for hospitals to start using the assessment tools so that they would be able to calculate updated measure data, et cetera.

And we'll go to the next slide as we have been – as NQF staff – in contact with (Matt) and his staff (Heidi) regarding status and having a timeline for when we would be able to reconsider these measures and their plan on if they would similar to what we do with CAPS measures.

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Which this is really a survey – would it be one submission – and pulling together the data. And (Matt) wanted to use the opportunity and speak with you in June to understand what kind of data you had wanted. But what we have learned from (Matt) over the past couple months is that they actually have, I think, over 75 hospitals that have signed up for assessments over the next couple of months.

So they're beefing up their staffing, and they have requested to postpone review of these measures until early 2017. And so, while NQF staff can go ahead and say sure we'll reconsider this for you. We really wanted the committee to consider that and give us a formal yes or no.

Do you have any concerns with going ahead and giving them the more time since…

Male: (Forgive me), sorry about that, sorry.

(Sarah): So they'll be able to pull a significant amount of additional data and submit it to us in 2017. So I guess the question is does anybody have any concerns with that approach and giving them about six more months?

Male: No.

Female: (It) seems to me we can only get a better result, (Sarah).

Male: Yes.

(Sarah): Agreed.

(Beth Averbeck): (Sarah), this is (Beth Averbeck), just a quick question I can't – and apologies for not remembering the actual tool – is it meant only to be applied to a hospital setting and not to be applied to an ambulatory setting?

(Sarah): If I remember correctly, (Beth), it is hospital. But I do remember that question specifically. And it is for the entire hospital setting and I think there were some questions back and forth on can you give results by specific program area.

So, if the ambulatory or E.R. or whatever – and I think (Matt) said that is one of the reasons they wanted more data to be able to support that better. But at this time, they're reporting at the hospital level.

(Beth Averbeck): All right, I'm just thinking ahead as it potentially comes back to this group. Then the intended use is only hospital versus having it be an intended use for other settings. So it would kind of be helpful for us to keep that in mind.

(Sarah): Absolutely. All right, thank you.

OK, since no one has any opposition to that, we will move that forward and go ahead to the next agenda item.

(Leigh Partridge): Which is to open it up for public comment, right?

Female: Correct.

Male: Yes.

(Multiple Speakers)

(Sarah): (Nan), will you hold on? (Jennifer), did you have a question?

(Jennifer): No, that was from about 15 minutes ago, so don't worry about it.

(Sarah): OK, I'm right on top of things. Sorry, (Nan), go ahead.

Operator: Thank you, at this time, if you would like to make a comment, please press star and then the number one on your telephone keypad. We'll pause for just a moment. And there are no public comments at this time.

(Sarah): OK, we don't have any comments in the chat box either, as far as I can see. OK, (Kirsten).

(Kirsten): All right, so next steps. Member vote will be opening next week, so from September 15th through the 30th will be a two week member vote. Full recommendations of the committee will then go to NQF's consensus standard approval committee who will make the final recommendation to the board.

The (CSAC) review will take place on October 11th, and we can send out additional information with the call-in as soon as we get it. Following that, it will go off to the board on October 27th, and then that will be followed by an appeals period from October 28th through November 30th. And that is it for now.

(Sarah): Great, so I would just like to thank everybody, specifically our engineers (Chris and Leigh) for leading us as they always do. But for all of you in one coming onto the call early, two bearing with us through vote – in advance for voting on time by end of day Monday.

On the ACBS measure, we will be providing the clarification on how to vote, the link to the SurveyMonkey, and any additional information you would need on that. And just expect you to be prepared for that. It will – it is our intent to get that out to you today. So, and then, in follow up, you'll hear more from us as we progress through the process.

Through the NQF action – the e-mails that you receive. For the (CSAC) meeting (Leigh and Chris) will be representing the group. If you'd like to join the call, you're welcome to, but it is not a required call for the group. And then, staff will be doing some follow up as mentioned on related and competing and looking at functional status more broadly.

And that'll come sometime in 2017. And we'll keep you posted as person and family center care work at NQF moves forward. But really, really appreciate all of your input, all of your feedback on the measures, and careful consideration. We know it takes a lot of time, and we've kept this group really, really busy over the past couple of years. So thank you so much.

(Peter Thomas): (Sarah), this is (Peter). I'm sorry, go ahead (Leigh).

(Leigh Partridge): I was just going to say we wanted to thank you and your colleagues for all of your really excellent support and tables and charts and patience.

(Inaudible)

(Peter Thomas): I agree from when I started with this committee, at least, the staff work and the preparation of the committee members has really gotten so much better over the years – not to say that it was poor back then by any means. It just was not nearly as directed and organized and streamlined. It just has really gotten quite well done. So thank you.

I have one comment if you don't mind. I know you were just wrapping up and I'm dropping this on you, but would you mind if I made one process point?

(Sarah): Nope.

(Peter Thomas): I think our committee and the NQF process is quite good with respect at gathering public comment on documents and putting it out for reasonable periods of time for comment. I'm not so sure we meet that test on these calls. And perhaps that's one reason why very rarely do we get public comment.

All the votes have been taken. We've talked about all these issues. What's the public got to comment about now? What would it really matter if they had a comment at the very end of the phone call, and we've already basically done our business?

I was just wondering if there's some additional thought that could go into trying to figure out a better way to structure the public comment opportunities as we're making – or prior to making – some of these decisions during our conference call or in person meeting deliberations.

And I don't have a specific proposal, but I just would ask NQF to take a look that. And see if there's a better way to do that. Thanks for your consideration.

(Sarah): No, thank you for that comment. I mean, we do have a few minutes if anybody else has any other suggestions or comments, you're welcome to make them now. We can't fix them in 15 minutes, but we're glad to consider them. OK, then, happy voting this weekend, everybody.

And we're talking about PFCC voting, not to be confused with anything else and please don't confuse it with anything else. And we will get that survey out to you as soon as we can this afternoon. Look forward to hearing back from you and hope everyone has a fabulous weekend.

Male: Thanks, everyone.

Male: Thanks.

Female: Bye:

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

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