Summary of Technical Expert Panel (TEP) Meeting March 28, 2023
Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery, Patient-Reported Outcome-Based Performance Measure (PRO-PM)

March 28, 2023

Prepared by:
Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE)
This material was prepared by CORE under contracts to the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

The materials within this document do not represent final measure specifications for the Information Transfer PRO-PM.

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Background

The Centers for Medicare & Medicaid Services (CMS) is developing a Patient-Reported Outcome Performance Measure (PRO-PM) to assess the quality and content of information provided to patients as part of an outpatient procedure or surgery. Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) is leading the work under contract to CMS. The contract name is Development, Reevaluation, and Implementation of Outpatient Outcome/Efficiency Measures, Option Period three. The contract number is HHSM-75FCMC18D0042, Task Order Number HHSM-75FCMC19F0002.

CORE is obtaining expert and stakeholder input on the proposed measure. The CORE Measure Development Team is composed of experts in the development and implementation of quality outcomes measures. As is standard with all measure development processes, CORE has convened a technical expert panel (TEP) of clinicians, patient advocates, and other stakeholders. Collectively, the TEP members provide expertise in performance measurement, quality improvement, outpatient surgery, clinical care, care coordination and patient experience.

This report summarizes the feedback and recommendations received from the TEP during the fourth and final meeting, which focused on the second pilot study results, final survey instrument, and final measure specifications to be proposed.

Measure Development Team

Iman Simmonds, MD, MPH leads the Measure Development Team. Dr. Iman Simmonds is an Associate Research Scientist for the Quality Measurement Team at CORE and has supported several Measure Development teams. The Measure Development Team is also composed of individuals with a range of expertise in outcome measure development, health services research, clinical medicine, and measurement methodology. See Appendix A for the full list of members for the CORE Measure Development Team.

The TEP

In alignment with the CMS Measures Management System (MMS), CORE held a 30-day public call for nominations and convened a TEP for the development of a Patient Receipt of Key Information Following Outpatient Procedure PRO-PM. CORE solicited potential TEP members via emails to individuals and organizations recommended by the Measure Development Team and stakeholder groups, email blasts sent to CMS physician and hospital email listservs, and through a posting on CMS's website. The TEP is composed of 15 members, listed in Table 1.

The role of the TEP is to provide feedback and recommendations on key methodological and clinical decisions. The appointment term for the TEP is from March 2021 to May 2023.

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Specific Responsibilities of the TEP Members

- Complete and submit all nomination materials, including the TEP Nomination Form, statement of interest, and curriculum vitae.
- Review background materials provided by CORE prior to each TEP meeting.
- Attend and actively participate in TEP conference calls.
- Provide input on key clinical, methodological, and other decisions.
- Provide feedback on key policy or other non-technical issues.
- Review the TEP summary report prior to public release.
- Be available to discuss recommendations and perspectives following TEP meetings and public release of the TEP Summary Report to CMS

Table 1. TEP Member Name, Affiliation, and Location

Name	Organization (title); clinical specialty, if applicable	Location
Nichole Bostic	Patient/Caregiver Representative	AUGUSTA, GA
Jill Dietz, MD, FACS	Formerly, Univ. Hospitals of Cleveland Seidman Cancer Center (Director, Breast Program); Breast surgery	BENTLEYVILLE, OH
Richard Dutton, MD, MBA	US Anesthesia Partners (Chief Quality Officer); Anesthesiology	DALLAS, TX
Patricia Franklin, MD, MBA, MPH	Northwestern Univ. School of Medicine (Professor; Co-Director, Outcomes & Measurement Hub); Research; Preventive medicine	CHICAGO, IL
Caitlin Gillooley, MSPH	American Hospital Association (Sr. Associate Director, Quality Policy)	WASHINGTON, DC
Beth Godsey, MS, MBA	Vizient Inc. (Sr. Vice President, Data Science & Methodology)	DALLAS, TX
Charles Goldfarb, MD	Washington University School of Medicine, Department of Orthopedic Surgery (Executive Vice Chair); Orthopedic surgery	ST. LOUIS, MO
Sherrie Kaplan, PhD, MPH	University of California, Irvine (Psychometrician; Assistant Vice Chancellor, Healthcare Evaluation & Measurement); Psychometry	IRVINE, CA
James Moore, MD	UCLA Health (Physician); Anesthesiology	LOS ANGELES, CA
Ann O'Connor	Patient/Caregiver Representative	LARCHMONT, NY
Carol Raphael, MPA	Manatt Health (Senior Advisor); Nursing	NEW YORK, NY
Kevin Schuster, MD, MPH, FACS, MCCM	Yale School of Medicine/Yale New Haven Hospital (General Surgeon); General Surgery	NEW HAVEN, CT

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Name	Organization (title); clinical specialty, if applicable	Location
John Stoffel, MD	University of Michigan Department of Urology (Physician); Urology	ANN ARBOR, MI
Gina Throneberry, RN, MBA, CASC, CNOR	Ambulatory Surgery Center Association (ASCH) (Director of Education and Clinical Affairs); Nursing	ALEXANDRIA, VA
Jorge Villegas, PhD, MBA	University of Illinois at Springfield (Associate Professor of Marketing, Patient Advocate, Research/Consultant of Health Communication and Access); Research/Advocate	SPRINGFIELD, IL

TEP Meetings

CORE held TEP meetings in April, June, and December 2021, and most recently the final TEP meeting held in March 2023 (see Appendix B for the TEP meeting schedule). This report contains a summary of the March 2023 TEP meeting.

TEP meetings follow a structured format consisting of the presentation of updates on measure development, review of the survey instrument, review of the second pilot study, review of the performance score, voting on measure scoring and face validity, and open discussion of these topics by the TEP members.

Overview of Fourth TEP Meeting (March 28, 2023)

Prior to the fourth TEP meeting, TEP members received detailed meeting materials outlining the results from the second pilot test, the final survey instrument, and suggested measure specifications, including calculations of measure scoring and risk adjustment of the measure. TEP feedback was gathered after the content of each section was presented.

Following the meeting, TEP members unable to join the TEP teleconference were provided with detailed meeting minutes, and all TEP members were invited to provide any additional feedback by email and to vote on face validity of the survey instrument and on risk adjustment of the measure.

The following bullets represent a **high-level summary** of what was presented and discussed relevant to the Patient Understanding of Key Information Related to Recovery Following an Outpatient Procedure PRO-PM during the fourth TEP meeting. For further details, please see Appendix C.

- CORE presented an overview of the project status to the TEP.
- Dr. Kasia Lipska reviewed the final survey instrument, internal consistency of the instrument, burden assessment by patients and providers, and questions eliminated from the final survey instrument that were not used in scoring.
- TEP Feedback:
    - Several TEP members inquired about the readability level of the survey, asking how the team achieved the level of readability.
    - One TEP member inquired about the use of the term 'caregiver' as an option for responding to the survey.
    - One TEP member inquired about what languages were captured during the second pilot study.
- CORE reviewed the methods of survey development that involved patients, caregivers, and the use of a plain language expert to develop the survey and readability level.
    - CORE noted that the term 'caregiver' was decided upon through many discussions and meetings and believes a 'caregiver' should be able to answer questions on behalf of the patient.
- One TEP member commented on the overlap in survey content and question with the OAS CAHPS survey.
    - CORE team noted this to be discussed further in detail later in the meeting.
- One TEP Member asked about 'expected and unexpected symptoms' and if these are always presented together.
    - CORE responded that it is believed that providers will educate patients on both possible scenarios of symptoms after a procedure.
- TEP members voted on face validity of the survey questions with the following results:
    - The survey instructions are clear and unambiguous:
        - Five TEP members strongly agreed, three agreed, three neither agreed nor disagreed.
    - The survey questions are clear and unambiguous:
        - Four TEP members strongly agreed, five agreed, one neither agreed nor disagreed.
    - The survey questions are relevant for measuring clarity and completeness of post-operative instructions:
        - Seven TEP members strongly agreed, two agreed, one neither agreed nor disagreed.
- The survey questions are not intrusive:
    - Four TEP members strongly agreed, four agreed, two neither agreed nor disagreed.
- The scale for each item is understandable:
- Four TEP members strongly agreed, four agreed, two neither agreed nor disagreed.
- All items completely measure the construct and there are no missing components:

- One TEP member strongly agreed, seven agreed, two neither agreed nor disagreed.
- Several TEP members commented on the ambiguity of the survey instructions; one member provided an example that physicians in a certain state cannot advise a patient when they are able to drive, and that decision is left to the patient and their family members.
    - One TEP member asked about the mode of survey transmission, and if there were concerns about patient populations that have limited access to email and text message.
        - CORE responded that web-based (text and email) is the best performing single- method of sending the survey, given the limitations of the study (time and budget) we were unable to use a multimodal approach.
    - TEP members agreed that the questions were un-intrusive.
- CORE presented on the second pilot study.
- Dr. Vivian Vigliotti reviewed the second pilot study, noting participating hospital outpatient departments (HOPDs), case volume, and bed size. The survey was sent via text and email, with a lag time in survey completion of 65 days. The patient cohort, demographic data, nonrespondent data, and common surgeries and procedures were reviewed.
- TEP Feedback
- One TEP member asked about the clarification for use in HOPDs or Ambulatory Surgery Centers (ASCs).
- CORE responded that the scope of measure development only included HOPDs.
- Several TEP members suggested inclusion of ASCs for various reasons, quoting a comment received during the public comment period.
- Two TEP members asked about 'missing' surgical categories and who receives the survey based on procedure/surgery, as well as how it is possible to identify the missing data.
- CORE responded that survey recipients are those who received any outpatient surgery or procedure, based on CPT coding.
- One TEP member noted interest in viewing rural pilot data, as none of these facilities were classified as rural.
- Another TEP member asked about the comparison between respondents and non-respondents, and whether those variables only included significantly different variables.
- CORE responded that the language was significantly different but other information about non-respondents is unknown because data is not received for that cohort. CORE team also noted the differences in age, more likely to be greater than 60 years old, and respondents were older than nonrespondents, and more likely to be female.
- One TEP member commented that in their experience with a survey / vendor, the response rate is closely tied to the lag time, noting a 5-day lag time between procedure and survey with a 35% response rate.

- CORE agreed, answering another TEP member's question that the CORE team wanted the survey sent 2-7 days post-procedure, but several issues interfered:
- Lack of hospital's CPT codes
- Overlapping timeframe with OAS CAHPS
- Implementation issues with the survey vendor
- CORE presented on calculation of the measure score.
- Dr. Simmonds presented the top box approach chosen for calculating the measure score.
- TEP Feedback
- One TEP member commented that this method of scoring seemed harsh, suggesting loss of variance by using a top-box approach.
- Another TEP member asked if the results were shared with the hospital.
- CORE responded that they were shared, and facilities felt that the survey was a quantitative assessment of what they already know about their performance and discharge instructions.
- CORE presented on risk adjustment considerations:
- Dr. Simmonds introduced the topic of risk adjustment for the measure; she reviewed the statistically significantly associations with different variables and shared that measure scores calculated with a risk adjustment model and measures scores calculated without risk adjustment showed little difference. A vote from the TEP will be collected to assess face validity for both the adjusted and unadjusted measure; COREs team strongly recommended not risk adjusting as the accountable entity should be able to effectively communicate discharge instructions to all patients regardless of their age, prior surgical experience, or education.
- TEP Feedback
- Several TEP members expressed concern over risk adjusting for HOPDs that have sicker patient populations and therefore poorer scores, as well as the assumption that large urban hospitals can apply resources to improve transfer of information.
- CORE responded that the measure is measuring a hospital's ability to clearly communicate discharge instructions. Hospitals should be able to control barriers to effective communication by adapting their approach based on the patient's need. By adjusting for factors that are under the locus of control of a provider, differences in the quality of care may be adjusted and could reinforce a double standard of care.
- Another TEP member commented that it would be ideal to reassess the topic of risk adjusting after one year of implementation with national data to revisit the models between risk adjusting and not.
- CORE facilitated face validity votes:
- Ms. Mariel Thottam shared the results on the face validity vote of the un-adjusted measure score:

    - Six TEP members were able to participate in this vote during the meeting.
    - Question one was "the unadjusted information transfer PRO-PM as specified, will provide a valid assessment of the transfer of key information to patients at discharge from the facility." The results were as follows:
        - One vote for Somewhat Disagree
        - Three votes for Somewhat Agree
        - One vote for Moderately Agree
        - One vote for Strongly Agree
    - Question two was "the unadjusted information transfer PRO-PM as specified, can be used to distinguish between better and worse quality care at measured facilities." The results were as follows:
        - One vote for Somewhat Disagree
        - Two votes for Somewhat Agree
        - Three votes for Moderately Agree
- Ms. Thottam discussed and shared the results of the face validity vote on the adjusted score:
    - Five TEP members were able to participate in this vote during the meeting.
    - Question one was "the adjusted information transfer PRO-PM as specified, will provide a valid assessment of the transfer of key information to patients at discharge from the facility." The results were as follows:
        - One vote for Moderately Disagree
        - Four votes for Somewhat Agree
    - Question two was "the adjusted information transfer PRO-PM as specified, can be used to distinguish between better and worse quality care at measured facilities." The results were as follows:
        - One vote for Moderately Disagree
        - One vote for Somewhat Disagree
        - Three votes for Somewhat Agree
- CORE presented on potential survey item reduction.
- Dr. Simmonds introduced the discussion of reducing the items of the survey instrument, to reduce overlap with OAS CAHPS' survey and reduce the time to complete the survey. She presented the following three options to consider:
    - Option 1: To create a new survey where there is a single question in each of the domains. This would create a five-item survey, but it would not eliminate the overlap with OAS CAHPS.
    - Option 2: Eliminate the questions where there is overlap with OAS CAHPS. This would remove the global clarity domain and questions as well as the warning signs and symptoms domain and questions. This would eliminate five questions resulting in a total of ten questions.
    - Option 3: Eliminate the overlap with OAS CAHPS as suggested in option two and further reduce the items using an empiric approach.

- TEP Feedback
    - Several TEP members agreed with eliminating overlapping questions and/or domains with OAS CAHPS, however they also expressed concern as to how that would impact the survey and if the overlapping questions are truly measuring the same thing.
        - CORE responded by explaining the similarities between this survey and OAS CAHPS, including sampling populations, time frame, and purpose. The two primary differences are that OAS CAHPS identifies exclusion of institutionalized patients from their population and only includes specific outpatient procedures.
    - Another TEP member asked if the team would reduce the number of questions in each domain as well as eliminating overlap.
    - Dr. Simmonds asked TEP members their preferred approach to reduce the survey:
        - Three TEP members preferred an empirical approach, one preferred qualitative, and another had no preference.
        - TEP members further inquired about factor analysis or measuring correlation between the two surveys.
- CORE responded that the factor analysis confirmed there were a distinct number of factors, but the model did not suggest a good fit; further, the team did not look at correlation of total score between the surveys.
- Ms. Thottam thanked attendees and outlined the next steps for the TEP and the measure development process.

Next Steps

Ongoing Measure Development

CORE will continue to encourage further feedback and questions from TEP members via email until the next TEP charter ends. Additionally, CORE will continue to finalize the survey instrument with guidance from CMS, considering the feedback from all stakeholders including TEP and Patient Working Group members.

Conclusion

TEP feedback on CORE's second pilot study results will inform the final survey instrument and measure specifications.

Appendix A. CORE Measure Development Team

Center for Outcomes Research and Evaluation (CORE) Team Members

Name	Team Role
Iman Simmonds, MD, MPH	Project Lead
Clarissa Myers, DPT, MPH	Project Coordinator
Alexandra Stupakevich, BS	Project Associate
Phylicia Porter, MPH, MSL	Contract Manager
Elizabeth Triche, PhD	Associate Director
Kasia Lipska, MD, MHS	Subject Matter Expert
Katie Balestracci, PhD, MSW	Associate Director
Shefali Grant, MPH	Project Manager
Karen Dorsey Sheares, MD, PhD	Project Director
Zhenqiu Lin, PhD	Analytic Director
Si Zhou, MS	Project Analyst
Prince Omotosho, BS	Project Associate

Appendix B. TEP Call Schedule

TEP Meeting #1

Friday, April 23, 2021 – 3:00-5:00PM EST (Zoom Teleconference)

TEP Meeting #2

Wednesday, June 30, 2021 – 3:30-5:30PM EST (Zoom Teleconference)

TEP Meeting #3

Thursday, December 16, 2021 – 12:00-2:00PM EST (Zoom Teleconference)

TEP Meeting #4

Tuesday, March 28, 2023 – 4:30-7:00PM EST (Zoom Teleconference)

Appendix C. Detailed Summary of TEP Meeting #4

Tuesday March 28, 2023, 4:30 PM – 7:00 PM EST

Participants

- **Technical Expert Panel (TEP) Members:** Nicole Bostic, Jill Dietz, Richard Dutton, Patricia Franklin, Caitlin Gillooley, Beth Godsey, Charles Goldfarb, James Moore, Carol Raphael, Kevin Shuster, John Stoffel, Gina Throneberry, Jorge Villegas
- **Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE):** Karen Dorsey, Shefali Grant, Zhenqiu Lin, Kasia Lipska, Clarissa Myers, Prince Omotosho, Phylicia Porter, Iman Simmonds, Allie Stupakevich, Mariel Thottam, Beth Triche, Vivian Vigliotti

Executive Summary

- CORE welcomed attendees to the meeting and reviewed the current status of the project, including the following topics.
    - CORE reviewed results from the second pilot test at 19 Hospital Outpatient Departments (HOPDs).
    - CORE reviewed feedback from the fourth Patient Working Group meeting, held in January 2023.
    - CORE discussed the survey results, calculation of measure score, and the final survey instrument.

TEP Action Items:

- TEP members were invited to email cmsoutpatientpropm@yale.edu with any additional comments and suggestions or questions.

CORE Action Items

- CORE will consider TEP feedback on risk adjusting, the measure score, and the final survey instrument.

Detailed Discussion Summary

Welcoming Remarks

- Ms. Thottam welcomed the group on behalf of CORE.
- Ms. Thottam reminded attendees that the content of the Technical Expert Panel (TEP) discussion must remain confidential until made public by CMS and that all personal opinions and experiences, including any personal health information, shared during the TEP meeting are to remain confidential. She stated that the project can be discussed in general as some information, including the first two TEP summaries, have been made public, but the information shared today is still confidential.

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- Ms. Thottam reminded the group that the work is funded by a contract with CMS for which Ms. Janis Grady is the Contracting Officer Representative.
- Ms. Thottam reviewed the goals for the meeting to obtain TEP input on the survey instrument; discuss patient feedback, psychometric assessment of the survey, and the final survey instrument; and obtain TEP feedback on performance measure calculation, unadjusted versus risk adjusted approaches to the measure, reliability of the measure score, and meaningfulness of the score.

Introduction

- Ms. Thottam welcomed the TEP forgoing formal introductions since the group has met several times in the past. Ms. Thottam introduced the CORE staff, highlighting the main speakers, Dr. Simmonds, measure team lead; Dr. Lipska, subject matter expert; and Dr. Vivian Vigliotti, subject matter expert. Ms. Thottam thanked CMS attendees for joining the call and offered Ms. Janis Grady the opportunity to introduce herself to the TEP members. Ms. Grady introduced herself and welcomed the TEP members.
- Ms. Thottam offered TEP members the opportunity to ask any questions or discuss any concerns about the roles and responsibilities outlined in the TEP. No disapprovals or questions were made from the TEP members, thus confirming approval of the TEP Charter. Ms. Thottam moved forward with the TEP meeting.

Project Status

- Dr. Lipska reviewed the project status. The first version of the survey was developed in Spring 2021. In the Summer of 2021 (July to August 2021) CORE launched pilot #1 including 302 patients and two hospitals. These results were previously reviewed by the TEP. April 2022 to October 2022 the survey was refined with additional free text added to the survey. This led to the launch of the second pilot in September 2022. Pilot 2 included 15-30 hospitals with 100 patients per hospital and based on the results from the second pilot CORE finalized the survey, validated the survey, and finalized survey scoring.
- Dr. Lipska reviewed the background of the Information Transfer PRO PM measure. The measure is based on the concept that patients who undergo outpatient procedures and surgeries need information to care for themselves when they are home for proper recovery. The concept is that when patients have a good understanding of the information they need during the surgery and after surgery, this will improve the experience and the recovery after they have arrived home. The PRO PM assesses patient understanding from their point of view about the information they received after the surgery.
- Dr. Lipska reviewed the overview of the survey instrument. The survey measures hospital performance on the clarity and completeness of the information given to patients having an outpatient procedure at their facility. The survey includes 21 items or questions, sent via text and email ideally two to seven days following an outpatient

surgery or procedure. Fifteen items from the survey are used for scoring and the cohort for the measure includes all adults aged over 18 years of age who had a surgery or procedure in a hospital outpatient surgery department. Cases may be elective, emergent, or urgent. Patients can also be discharged on the same day but no greater than two midnights post-surgery.

- Dr. Lipska reviewed the measure construct. The measure construct was developed with input from patients, the TEP and other stakeholders to include the information that is important for patients to receive post-surgery. The information was divided into 4 categories: Activities, which includes patients understanding of wound care and the restrictions to their physical activities and diet; Medication, which includes changes to medication or any new medication patients should be aware of; Warning signs, which include symptoms of infection, bleeding, and other complications that patients should be aware of in order to know when to call for help; and Follow Up, which pertains to post-surgery care. Dr. Lipska concluded that the survey was designed to include the first three domains since the survey is sent to patients two to seven days after discharge and this timeline could not adequately capture the fourth domain.
- Dr. Lipska reviewed the survey question development. The survey was designed to include information about the global clarity of information that the patients receive, how the information is applicable to the specific patient (their needs, preferences, personal situation, and home community/environment), and whether it includes discharge instructions on the three previously mentioned categories: activities, medications, and warning signs.

Review Survey Instrument

- Dr. Lipska stated the survey was developed to reflect patient understanding and patient-centeredness; the survey was designed with psychometric soundness through consult with a psychometrician; and the survey is meaningful for assessing discharge instructions related to self-care and recovery accomplished through engagement of patients and stakeholders. She noted that the survey needs to be easily implementable, in a way patients can automatically receive the survey and the data can be seamlessly transferred from hospitals to quality departments. She explained that it is designed to be minimally burdensome, accomplished through a median completion time of five to eight minutes, and via the preferred mode of completion (text or email).
- Dr. Lipska noted engagement with patients at every step of development. This is crucial to a patient-reported outcome measure; four patient working group meetings were held over three years of measure development that informed definition of the construct, refining survey questions, cohort, timing of survey, the outcome, and scoring the measure.
- Dr. Lipska reviewed psychometric assessment, describing reliability testing using Cronbach's Alpha, a measure of the internal consistency of the instrument. The Cronbach's Alpha of the 15-item instrument was 0.89 (range of zero to one; one

indicates redundancy), a high alpha score (>.7) indicates good internal consistency but is not so high (>.9) as to indicate questions are redundant. The overall alpha score is very good as is the alpha score for each of the 5 domains.

- Dr. Lipska reviewed the burden assessment, accomplished by interviewing patients and providers after the survey was completed to understand both the time it required to complete the survey and staff workload for administering the survey, as well as the meaningfulness of the survey. In general, when patients find value in the questions, they tend to be more willing to complete a survey that is longer.
- Dr. Lipska read patient quotes: "The survey was easy to understand. It was not a long-drawn out process;" "If a survey is going to be 10 minutes or longer and it does not tell me in advance, I will quit".
- Dr. Lipska read provider quotes: "The burden was minimal. My coworker had to, once a week, download [CAHPS vendor] file and upload it to Qualtrics. This took less than 15 minutes"; "There is no burden on the frontline staff".
- Dr. Lipska offered the TEP members time to review the final survey instrument and offered to answer questions.
- Dr. Lipska reviewed the final survey instrument; there were ancillary questions not used in scoring.
- One TEP member asked about the survey instrument, if the readability level was addressed mainly through the patient engagement, or was it addressed in another way?
- Dr. Lipska responded that the questions were designed to be readable at an eighth-grade level, which did include patient review and review by a plain language expert.
- One TEP member noted the patient or caregiver options for filling out the survey and asked if there is an option for a friend or family member to help a patient complete the survey.
- Dr. Lipska stated that it should be the patient or a caregiver caring for the patient should be able to answer those questions.
- Dr. Simmonds stated that Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers & Systems (OAS CAHPS) does try to identify who is completing the survey; our survey does not try to identify if a caregiver is a family member, aide, or friend. However, based on free text respondents did indicate the caregiver responding to the survey.
- One TEP member asked about the language questions (Spanish, English or other) and asked if other options were captured.
- Dr. Simmonds stated that Korean and Chinese were captured in free-text responses but 99% of the survey was filled out in English.
- Another TEP member commented that in their experience, google translate does a good job and patients they survey are offered a link to translate the survey themselves.

- Dr. Lipska stated she is unsure if that is scientifically sound, as we do not use google translate for this purpose, but she explained the survey is offered in English and Spanish.
- One TEP member commented on the concern of overlap between this survey and OAS CAHPS, noting questions 13-22 in OAS CAHPS that ask about recovery. This is a point to consider, recognizing this is a different instrument tool, but the overlap is noteworthy. With regards to plain language, comparing OAS CAHPS and this survey: OAS CAHPS offers binary responses, whereas this tool asks about level of clarity. The TEP member asked what the differences in phrasing (yes/no versus level of clarity) mean.
- Dr. Lipska stated this overlap is a good point and will be discussed at the end of the meeting; the point is well received that this survey is meant to capture the patients' understanding of the discharge instructions. These decisions will be made clear in terms of measure scoring.
- One TEP member asked about 'expected and unexpected symptoms' and asked if both options are always presented together?
- Dr. Lipska stated that yes, certain expectations are normal and others not normal during the recovery period, and it is up to the patient to respond whether that information was clearly shared.
- Dr. Simmonds stated that the free-text responses from patients commented on the differences in expected versus unexpected symptoms, and both should be covered by provider.
- The TEP member asked about the logo on the survey, noting it read "Yale Qualtrics" and asked what logo will be on the survey, as patients may interpret it differently depending on what is listed.
- Dr. Lipska stated the final survey will not have "Yale Qualtrics" on it.
- Dr. Simmonds stated the survey is administered through the vendor, so the vendor and hospital will choose how it is set up. The language at the beginning of the survey reads as if it is from the hospital.
- Ms. Thottam continued to guide TEP members to the poll pertaining to the face validity of the survey instrument. She explained that link will be posted in the chat, to obtain votes on the clarity, correctness, completeness, and patient-centeredness of information / discharge instructions given to the patient following a procedure. She asked TEP members to complete a survey on face validity of the survey instrument.
- Ms. Thottam reviewed the responses to the vote on face validity of the survey instrument, with the results following:
- The survey instructions are clear and unambiguous:
- Five TEP members strongly agree, three agree, three neither agree nor disagree.
- The survey questions are clear and unambiguous:
- Four TEP members strongly agree, five agree, one neither agrees nor disagrees.

- The survey questions are relevant for measuring clarity and completeness of post-operative instructions:
- Seven TEP members strongly agree, two agree, one neither agree nor disagree.
- The survey questions are un-intrusive.
- Four TEP members strongly agree, four agree, two neither agree nor disagree.
- The scale for each item is understandable:
- Four TEP members strongly agree, four agree, two neither agree nor disagree.
- All items completely measure the construct and there are no missing components:
- One TEP member strongly agreed, seven agreed, two neither agreed nor disagreed.
- One TEP member asked what individuals thought were ambiguous about the instructions.
- One TEP member noted that they did not think the instructions were ambiguous, but asked whether the questions are set in stone; in Missouri, a physician does not decide when a patient can drive – that is a decision left to the patient and family. Intentionally, instructions surrounding return to driving are left ambiguous, which is relevant to a questionnaire like this.
- CORE accepted the feedback, and asked if that ambiguity is explicitly explained to a patient, does a patient still interpret that as 'clear'?
- The TEP member responded that that it is not clear enough for patients and families, at times; they want clear direction (i.e., "you can drive on day 3), and if that is not shared, they are not happy.
- One TEP member asked about readability, and use of Microsoft word tool, which they tested while reviewing and noted that it returned a 'difficult to read' level.
- Dr. Simmonds responded that patients interviewed who completed the survey found that the survey was understandable and were able to articulate how each question was interpreted.
- The TEP member understood and presumed that patients were representative, in terms of health literacy level.
- Another TEP member asked about interpretation and noted that the survey is sent via email and text, and asked if there are concerns about patient populations that do not have access to such methods of communication.
- Dr. Simmonds stated that the team explored access to broadband broadly in the United States, and that pre-pandemic 15-40% of patients over 65 were completely offline; under 65 years old, 90% were online. Since the pandemic, that has shifted, however there is a small subsection of the population that would not be reached via web and mobile-based surveys. Limitations of this study include time and budget, so to have a one-mode survey, the best performing mode chosen was web-based.
- Dr. Simmonds asked TEP members about the question of the intrusive nature of questions, as patient work group members noted this.

- One TEP member responded that asking any questions or observing someone is by nature intrusive. Beyond that, they do not find the questions 'more intrusive.

Review Second Pilot Study

- Dr. Vivian Vigliotti introduced the discussion of the second pilot; the survey was sent out to patients at 26 different hospital outpatient departments (HOPDs) across the country, noted in yellow. Results were analyzed for individual facilities. Based on reliability testing 6 facilities that shared a single CCN were collapsed into single facility. Characteristics of the HOPDs include the following: 26 sites, predominately teaching facilities; no rural facilities; median case-volume of 758 and bed size of 266.
- Dr. Vivian Vigliotti continued, stating the survey was distributed via email and text (82% email versus 18% text). Patients received the survey if they had a surgery or procedure between May 2022 and February 2023; surveys were sent on a rolling basis from August 2022 to March 2023, noting there was a lag time from the surgery or procedure date to when they received the survey. The average lag time for the survey was 65 days.
- Dr. Vivian Vigliotti discussed the cohort. 3,139 survey responses were received. Patients were excluded if they had a procedure at a facility outside the study (n=5), the were under 19 years old (n=56) or had a length of stay indicating it was not an outpatient surgery or procedure (n=9). The final cohort for the second pilot was 3,069 responses or 97.8% of the original total.
- Dr. Vivian Vigliotti discussed the demographic data comparing respondents to non-respondents. For both groups, the average age was approximately 60 years old with respondents being slightly older than non-respondents on average. Both populations were more likely to be female than male, with the respondents slightly more likely to be female than non-respondents. While a third of the data was missing a type of surgery code at the time of the meeting, respondents were more likely to have had a major surgery than non-respondents.
- Among respondents were mostly white, mostly spoke English, mostly older adults, and most female. Most respondents had at least some college education, had had major surgeries and had had 1-3 surgeries.
- Dr. Vivian Vigliotti discussed the most common surgeries and procedures for patients from this pilot.
- The top ten surgeries from most to least were arthroplasty knee; lens and cataract procedures; hip replacement (total and partial); other therapeutic procedures on muscles and tendons; inguinal and femoral hernia repair; arthroplasty other than hip or knee; cholecystectomy and common duct exploration; hysterectomy, abdominal and vaginal; lumpectomy, quadrantectomy of breast; and other OR therapeutic procedures on joints.
- The top ten procedures from most to least were colonoscopy and biopsy; other diagnostic ultrasound; other non-OR or closed therapeutic nervous system procedures;

upper gastrointestinal endoscopy, biopsy; insertion of catheter or spinal stimulator and injection into spinal canal; other OR therapeutic procedures on skin and breast; other therapeutic procedures, hemic and lymphatic system; extracorporeal lithotripsy, urinary; other diagnostic procedures, female organs; other non-OR therapeutic cardiovascular procedures.

- Dr. Vivian Vigliotti paused for a break and questions from TEP members.
- One TEP member asked for clarification about the intention of the measure to be used in HOPDs and/or ASCs. During public comment for the measure, possible implementation in both was noted, however this pilot was exclusively tested in HOPDs.
- Dr. Simmonds stated that CORE was contracted to pilot this measure in HOPDs because of their readiness and ability to participate. HOPDs were and are actively preparing to participate in OAS CAHPS as a mandatory program and because of this they have the resources, vendors, and infrastructure to participate in this pilot. After the development of the measure, it will be investigated whether ASCs are prepared to implement this measure successfully, but it is noted that they may not yet be as ready for participation as HOPDs.
- The same member stated that without the inclusion of ASCs, the number of facilities, patients, and clinicians available for surveying may be limited. One TEP member recalled that during the public comment period the American Medical Association (AMA) recommended that the measure be applied to both HOPDs and ASCs. They recommended the team consider how to include ASCs in the future.
- Dr. Simmonds agreed and stated that at this point it is believed that most procedures still occur within HOPDs (and hospital affiliated ASCs that would have similar infrastructure) and not privately owned ASC facilities that would be limited from participation.
- The member agreed and understood.
- One TEP member asked for clarification on the “missing” surgical category, and asked if those patients were having procedures since the survey was sent to patients that had undergone something to receive it.
- Dr. Simmonds noted this as a challenge in the outpatient setting. During provider and administrator interviews with facilities, CORE was informed that they spend more resources on updating inpatient codes than outpatient codes because that is the majority of where their funding comes from. Because of this, the outpatient codes are more likely to be missing from the data or delayed beyond two weeks. Dr. Simmonds stated that this is an obstacle with the way data is collected right now, however hopefully in the future with FHIR technology there will not be a need to wait on Current Procedural Terminology (CPT) codes for procedure information.
- The same TEP member asked if it was possible to identify surgeries or procedure types based on the survey information or other data.

- Dr. Simmonds stated anyone who has had any outpatient surgery or procedure receives the survey. Because of that variety it relies more on the hospitals to supply the CPT codes to identify the type of procedure the patient had. CORE has been working with these facilities over several months to try and get the information once it becomes available.
- Dr. Beth Triche emphasized that the cause is low coding on the part of the facilities, but all patients should have had a surgery or procedure.
- Dr. Simmonds also clarified that she examined a few of the free text responses and they generally referenced a surgery or procedure.
- A TEP member asked about survey distribution. Typically, patients are given a preference option for communication of email or text message. They asked if patients were contacted based on only their preference or was another method used.
- Dr. Simmonds stated that the survey vendor was first limited by what was legally available (in some states facilities are not allowed to text patients, for example). The hospital then supplied the survey vendor with the contact information that the patient consented for. They could have consented to only email, only text message, both or neither. The survey vendor then sent the survey to the patients in all forms that they had consented to and were legally allowed to. If a patient had both text messaging and email available, they were sent both.
- Another TEP member stated that they would be interested in seeing rural pilot data.
- CORE responded that none of the facilities in this pilot were classified as rural and that population could have a variety of issues (such as service issues) that would not have been represented in this population. The member stated that they understood the limitations of the pilot but wanted to add the comment for future discussion and implementation efforts.
- A TEP member asked if the table comparing respondents and non-respondents only showed significantly different variables. Specifically, were there any differences in terms of race, language etc.
- Dr. Simmonds stated that there was a difference in language, but a potential difference in race is unknown. Because non-respondents do not provide data, the team needs to work with the facilities to obtain the information for the non-respondents. One of the variables that needed from hospitals is race/ethnicity data and the team is still working to get that data from a few hospitals.
- One TEP member commented on the text response rate. The text response rate was significantly lower than the email response rate, and they did not find this unusual given all the spam and phishing text messages that are now being sent around. There is a mistrust in links in text messages even more so than emails. This may be an on-going challenge with this mode going forward. They suggested including physicians or a notification process to inform patients that they would receive a text message with a survey after their surgery and legitimize the link.

- Dr Kasia Lipska commented that patients made similar comments about text messages being more suspicious to them than emails.
- A TEP member mentioned that they work for a vendor that sends out over two million patient satisfaction surveys a year using a similar survey vendor as the one used for this pilot and a similar mode. They stated that they have found that the response rate is very tightly tied to the lag time (or how quickly the survey is sent out). In the survey he is referencing, there is about a 5-day lag time between procedure and survey. They consistently have an average response rate about above 35%.
- They went on to discuss that they have not heard about states legally restricting text messages before. For their survey they get a CPT code, phone number, and email for most patients rather quickly. In their process they first send a text message and if there is no response to the survey 24 hours later the patient receives an email with the same thing.
- They have found with this process that they receive approximately two thirds of the overall responses via text message.
- In terms of the missing CPT codes, the member suggested that it is likely a logistical/interoperability issue because the CPT codes are required for billing for those procedures. The issue is getting this data out of the hospital system and to the survey vendor and/or the CORE team.
- Dr. Simmonds responded that the team agrees that the response rate is directly linked to the lag time. In this pilot alone the lag time for implementation varied by hospital and so did the response rate.
- One member asked what the anticipated implementation timeframe was for sending out the survey.
- Dr. Simmonds stated that the team is hoping to specify the survey is sent out 2-7 days post procedure, but this is likely to change due to implementation challenges.
- The member asked to clarify that the lag time challenge is a function of the hospital's ability to submit the necessary information.
- Dr. Simmonds confirmed that it is a function of the hospital's ability to supply CPT codes. There is also a secondary issue of overlapping the timeframe with OAS CAHPS, and because of the conflict with OAS CAHPS the specified timeframe is likely to change to potentially 30 days which will also be more feasible for hospitals.

Review Calculated Performance Score

- Ms. Thottam opened the next section on the agenda which was reviewing the calculated performance score.
- Dr. Simmonds introduced what will be discussed in this section. This section includes how the measure will be calculated, the interpretation, potential risk adjustment, a review of empiric validity and reliability testing, face validity of score and meaningfulness of score.

- Dr. Simmonds stated that a top box approach was used for calculating the measure score. In this approach, question responses of "yes" and "very clear" were assigned a single point and "somewhat clear" and "no" were both assigned as zero points.
    - The numerator is calculated by summing all the points for "yes" and "very clear" for each of the fifteen items used in scoring.
    - The denominator starts at fifteen for total number of items included in scoring and is then calculated by taking that fifteen and subtracting the quantity of responses selected as "does not apply."
    - The numerator is then divided by denominator and multiped by 100; this creates a score that ranges from 0-100 and that does not score or penalize hospitals for answers of "does not apply."
- Dr. Simmonds stated that to calculate the hospital's overall score, the arithmetic mean takes all the individual patient scores. The overall hospital score can range from 0-100. A patient score is only calculated if they have less than four responses missing from the total fifteen.
- Dr. Simmonds discussed the score range across the different hospitals that participated in the pilot. When discussing the box plot, she stated that the total is 26 hospitals, however six are collapsed under one for reliability testing since they function under one CCN, so we refer to 19 facilities based on the CCNs.
    - Dr. Simmonds explained the details of the box plot, and that there are 19 facilities with scores ranging from 0 -100. The box plots show the mean, median, range, and outliers for each of the 19 facilities.
- Dr. Simmonds showed a table that identified the unadjusted score for each of the 19 facilities. The table showed the number of responses, the mean score, and the standard deviation.
    - Dr. Simmonds stated that for reliability testing only the hospitals that had more than 100 responses were included. In this pilot there was a twenty-point range between all facilities but when excluding facilities under 100 responses the range minimizes to a twelve-point difference.
- Dr. Simmonds stated that a top-box approach was chosen because patients often score facilities very high and are reluctant to give negative feedback in a survey. Because the goal of this measure is to assess 100% clear communication, the team determined it was fair to only give hospitals credit for what a patient felt was 100% clear information and not give partial credit for a "somewhat clear" question response.
- Dr. Simmonds asked if any of the TEP members had any questions regarding the previously presented information.
- One TEP member stated that they understood the approach for scoring but felt it was a bit harsh. They stated that there is variance lost by using a top box that could be mitigated by replacing 0 with 0.5 or another half step option.

    - Dr. Simmonds stated that the team also looked at using a mean score as well as a top-box approach. The team found that the variance improved with a top-box approach because patients are skewed positively when answering surveys about their providers.
    - The TEP member replied that it is almost as if the answer is binomial because of this which makes sense with how patients often think. They agreed with the scoring for the top-box.
- Another TEP member asked if the results were shared with the hospitals that participated in the pilot.
    - Dr. Simmonds stated that the results were shared with the hospitals. The opinion of the hospitals was that the score reflected what was expected. The facilities felt that the survey was a quantitative assessment of what they already know about their performance and discharge instructions. Dr. Simmonds stated that many of the facilities send free text surveys on this topic and receive similar qualitative information through that.
    - The TEP member clarified that the facilities were not surprised by this information and that it aligns with what they have seen in the past.
    - Dr. Simmonds confirmed that the facilities were not surprised by the results and had heard these experiences before from patients.
- Dr. Simmonds reviewed the topic of risk adjustment for the measure. The potential patient factors for risk adjustment are age, gender, race, language, health status, education, and number of prior surgeries. The logic model illustrates that more effective communication of discharge information produces better patient outcomes. These potential patient factors were assessed for whether they would affect communication. Education level and number of prior surgeries were used as proxies for health literacy and previous experience.
    - Dr. Simmonds stated that the team discussed risk adjusting for these factors but felt that providers can consider these factors when communicating with patients and that patient understanding is not outside of the provider's control. High quality care and facilities can take these factors into account to create more patient-centered and effective discharge instructions.
    - Dr. Simmonds reviewed the pilot data showing a statistically significant difference in outcomes between age, health status, education, and number of surgeries with health status being the most significant.
    - Dr. Simmonds stated that the team compared a risk adjusted scores to a non-risk adjusted scores and found that there was little to no difference. Dr. Simmonds reviewed the scatter plot correlation of the risk adjusted versus non-risk adjusted scores. This reinforces the concept that providers and facilities can overcome the differences in these patient factors (sicker, older, less surgery experience, etc.).

        - Dr. Simmonds stated that the team brought both options to the TEP for their evaluation.
    - Dr. Simmonds described the considerations for risk adjustment. Risk adjustment would account for differences in case mix, and it would promote fairness for providers. It would also allow for a more accurate direct comparison of scores. Alternatively, the measure should not be adjusted for items that are indicators for quality and within the locus of control for the provider.
        - Dr. Simmonds stated that the patient working group felt strongly about not risk adjusting the measure.
        - Dr. Simmonds stated that the measure development team also recommends not risk adjusting the measure.
    - Dr. Simmonds discussed the reliability testing for both the adjusted and unadjusted models. Dr. Simmonds stated that the difference between the models is minimal and conceptually the team feels that these factors are under the locus of control for the provider.
- Dr. Simmonds stated that the measure development team would be asking the TEP to assess face validity by voting on both the adjusted and unadjusted measure, but strongly recommended not risk adjusting the measure.
    - Dr. Simmonds introduced the formal face validity voting and asked for any questions prior to voting.
    - One TEP member stated that as a surgeon, they are concerned for HOPDs that have sicker patient populations having poorer scores. They asked for further explanation on how the risk adjustment did not show any significant changes, but based on the information presented they strongly recommend risk adjusting the scores.
        - Dr. Simmonds stated that while patient level factors can affect an outcome for complications, the outcome for this measure whether the patient understood the information. The more understanding the patient has the better outcomes you are likely to have. When assessing the risk variables in a univariate analysis there was a statistical difference in outcomes, however there was not a difference in risk-adjusted versus non-risk-adjusted outcomes.
        - Dr. Simmonds stated that providers and facilities should be able to communicate with patients effectively regardless of their level of education or level of health literacy. Providers and facilities should be able to meet patients where they are and address their individual needs (such as requiring more time, having more visually instructive discharge instructions, getting information translated for the patient, having the support of a family member in instructions, etc.) All these actions are within the locus of control for the facility and for the provider.

        - Dr. Simmonds stated that the measure is measuring the quality of information; it is not measuring the quality of resources or access to care a patient would have outside of the facility preventing complications.
    - The TEP member stated that they appreciated the further explanation, however, do not feel that that is true. They stated that they are still concerned with the measure not being risk-adjusted but understands that not everyone will agree with that.
        - Dr. Simmonds thanked them for their opinion and understands that some may feel the same way. The team was reassured by the near perfect correlation between the unadjusted and adjusted scores. She understands that providers are not going to be 100% clear with every patient, but that should not impact the quality of the provider's communication to meet patients where they are.
    - Another TEP member stated that they understood that the team evaluated for risk variables but asked if they had analyzed the data to evaluate if certain operations or procedures showed variance in patient's ability to understand their instructions. They stated for example if orthopedic surgeons are more likely to have poorer scores because of the surgeries they perform rather than the actual clarity of their discharge communication.
        - Dr. Simmonds stated that because of the amount of missing procedure data, the team could not analyze whether procedure type affected outcomes. For the purposes of quality reporting the entity is the entire hospital, so although this information may be helpful within the hospital to help improve outcomes the measure is reporting the general quality of an entire hospital's discharge instructions.
        - Dr. Simmonds stated that often the structure of the discharge process is that providers are often not directly giving discharge instructions to patients and nursing providers or other staff for the facility are giving the information. This makes it the facilities' responsibility to provide quality information. Dr. Simmonds stated that for example one of the participating facilities had a joint specialist that communicated instructions to specifically these types of patients due to the increased specialization of this care. This is just one type of way the facility can facilitate better communication to patients and facilities should be able to overcome some of the barriers to communicating with harder to reach patients.
        - Dr. Simmonds emphasized that the purpose of risk adjustment is to eliminate factors that are outside of the control of the hospital. If the measure is risk adjusted for factors that could be measuring quality, then

the measure would enable facilities to give different levels of quality to different patient populations because they are harder to reach.

- Another TEP member commented on the correlation of the risk adjusted and non-risk adjusted scatter plot. They stated that based on how well the scores are correlated, they feel that this indicates that even if patients may be older and sicker that does not impede the hospitals' ability to communicate effectively with them. Some facilities still reach this population better than others. They stated that they agree with the team's concern that using a risk adjustment model will impact factors of quality within the control of the hospital. If the measure is risk adjusted, less of a difference may be apparent between hospitals and there may be less incentive to fix the issues. They stated that if this becomes involved with payment, it may be unfair to penalize hospitals for having higher populations that are older and sicker patients that are harder to communicate with.
    - Dr. Karen Dorsey Sheares stated that at this current point in development, the measure is far from being implemented in a payment program. The measure still needs to be implemented on a national scale and collect a national data set. Then the measure would need to be implemented into voluntary reporting and then public reporting. Only at that point are payment programs considered.
    - Dr. Karen Dorsey Sheares stated that the vote today on risk adjustment is not about implementation because there is not enough data at this point for that, but the question to the TEP today is about the quality of the metric as it stands alone. Does this metric give valuable and important quality information as it is.
- Another TEP member commented that they understand conceptually why the team is recommending against risk adjusting. They stated that they understand based on the pilot data that there is no difference, but they wanted to emphasize that the data is limited at this time. They would like to see a comparison after the first year of implementation with national data to be able to confirm differences such as rural vs. urban and using larger numbers. This would confirm that both approaches (risk adjusted and not) are the same.
    - They just wanted to emphasize that this is only one pilot of data that is informing this decision and that data could change once more data is gathered, but they understand conceptually.
    - Dr. Simmonds stated that the team understands the limitations of the pilot. When the measure goes into implementation there is an option to reevaluate the need for risk adjustment.
    - Dr. Simmonds stated that the goal is to improve communication to all patients regardless of patient factors which the team feels is within the

control of the hospital. The team acknowledges that there is a difference between patients receiving information they understand and their ability to use that information and the measure is only holding hospitals accountable to providing patients with the information they understand.

- A TEP member stated that the measure development team's assumption is that larger urban hospitals could apply resources to this issue is flawed. They stated that that goal is admirable, but facilities are not always able to overcome the challenges to communication and it is not fair to assume that is possible within the model.
    - Dr. Triche stated, first, that the measure is not assessing knowledge, but assessing whether the patient got the information they needed to safely recover from a surgery or procedure, most of which are elective. Secondly, sometimes risk factors do not work the way that is expected. In this case, she believes that scores are higher for lower income and less educated populations.
        - Dr. Simmonds clarified that health status and number of surgeries are associated with the measure score as expected, but that higher patient education resulted in lower scores. The team suspects that that is because more educated patients are less satisfied because they have more questions.
    - Dr. Simmonds stated that in her personal experience, she has clinically treated very different patient populations with a distinct difference in the ability to communicate with those populations. She found that patients did not understand their conditions not because they were not given the information (and often they were carrying the documentation of it) but because they did not understand what that information meant. This is a measure of communication, and communication is within the control of the providers and the facilities.
        - Dr. Simmonds also commented on the differences in resources, and she personally experienced the lack of resources, as well, as a provider. Hospitals should be forced to improve what they are doing to address the communication need.

- Ms. Thottam asked for final thoughts on the topic and explained the face validity survey logistics.
    - Ms. Thottam discussed and shared the results of the face validity vote on the ***un-adjusted*** score. (Six TEP members were able to participate in this vote during the meeting.)
    - Question one was "the unadjusted information transfer PRO-PM as specified, will provide a valid assessment of the transfer of key information to patients at discharge from the facility" The results were as follows:

        - One vote for Somewhat Disagree
        - Three votes for Somewhat Agree
        - One vote for Moderately Agree
        - One vote for Strongly Agree
    - Question two was "the unadjusted information transfer PRO-PM as specified, can be used to distinguish between better and worse quality care at measured facilities." The results were as follows:
        - One vote for Somewhat Disagree
        - Two votes for Somewhat Agree
        - Three votes for Moderately Agree
    - Ms. Thottam asked for questions or reactions to this vote.
        - There were no questions or comments.
    - Ms. Thottam discussed and shared the results of the face validity vote on the *adjusted* score. (Five TEP members were able to participate in this vote during the meeting.)
    - Question one was "the adjusted information transfer PRO-PM as specified, will provide a valid assessment of the transfer of key information to patients at discharge from the facility" The results were as follows:
        - One vote for Moderately Disagree
        - Four votes for Somewhat Agree
    - Question two was "the adjusted information transfer PRO-PM as specified, can be used to distinguish between better and worse quality care at measured facilities." The results were as follows:
        - One vote for Moderately Disagree
        - One vote for Somewhat Disagree
        - Three votes for Somewhat Agree
    - Ms. Thottam asked for questions or reactions to this vote.
        - There were no questions or comments.

Review Next Steps and Closing Remarks

- Dr. Simmonds stated that at this time the team would like to discuss with the TEP the concept of reducing the items of the survey instrument.
    - Dr. Simmonds described the current survey. There are 15 items that cover five domains. A factor analysis was done on the items and confirmed that there are five separate domains. Each domain varies from two to four questions.
    - Dr. Simmonds stated that the goals are to reduce the overlap with the OAS CAHPS survey and to reduce the overall time it takes to complete the survey. As previously discussed during the meeting, there is some overlap with the OAS CAHPS survey. Dr. Simmonds stated that there are three options the team has considered.

        - Option 1: To create a new survey where there is a single question in each of the domains. This would create a five-item survey, but it would not eliminate the overlap with OAS CAHPS.
        - Option 2: To eliminate the questions where there is overlap with OAS CAHPS. This would remove the global clarity domain and the warning signs domain and questions. This would eliminate five questions to a total of ten questions.
        - Option 3: To eliminate the overlap with OAS CAHPS as suggested in option two and further reduce the items using an empiric approach.
    - Dr. Simmonds asked for feedback on what members felt would be the best option. She also asked if the TEP members felt the survey should include all five domains since the patients selected them or if reducing the items that overlap with OAS CAHPS, thus eliminating those domains, would be appropriate.
        - TEP members suggested that eliminating the overlapping questions/domains with OAS CAHPS would be best.
        - A TEP member asked if the team would consider doing both (reducing the survey to four questions, one in each of the domains that does not overlap).
            - Dr. Simmonds responded that the team could do both, but asked the members to clarify which they think would be most important.
            - They responded that the priority should be shortening the survey, however they do not have a stronger recommendation for removing the overlap or maintaining the domains to a single question.
        - A TEP member stated that the unique questions may have more relevance within the survey with the overlapping questions. They wonder if this will impact the quality of information gathered.
            - Dr. Simmonds stated that the survey is patient-centered, has good reliability, five distinct domains for measurement, and good internal consistency as a 15-item survey. The reality is that the 15-item survey does take five minutes to complete so to alleviate some patient-burden the team is evaluating the best options for shortening the measure.
            - Dr. Simmonds stated that the team is looking for what the TEP feels the goals should be for shortening the survey (eliminate overlap or maintain the domains) in order to best inform the strategy.
        - Another TEP member agreed with the previous member that reducing the items to eliminate overlap may cause an impact on the answers given

to the unique questions. This member is not as familiar with OAS CAHPS and asked if removing the overlap would truly be measuring the same thing in two different databases. The member clarified by asking if OAS CAHPS samples the same type of person, at the same time, using similar questions. They stated that if the answer to these questions is yes and the approach is similar enough, then the best option would be to cut the overlapping questions/domains.

- Dr. Simmonds responded that the information transfer survey is not identical to OAS CAHPS, but the sample populations, the time frame, and purpose are very similar. The two primary differences are that OAS CAHPS identifies excluding institutionalized patients (prison, skilled nursing facilities, etc.) from their population and OAS CAHPS also only includes specific outpatient procedures.
- Dr. Simmonds stated that the team still believes in the 15-item survey. The survey was developed out of information provided by patients that they wanted more coverage of these domains than what OAS CAHPS previously covered, but the team also wants to explore the option of item reduction.

- Dr. Simmonds stated that based on this conversation with the experts on this call the team will likely move forward with focusing on eliminating the overlap of with OAS CAHPS. Dr. Simmonds asked about options for further reducing the items after removing the overlap with OAS CAHPS. The options are:
  - Option one: Qualitatively- asking the members of the TEP and internal experts to vote on which questions they felt were most important.
  - Option two: Empirically- looking at correlation. The correlation between the survey and the total score, the correlation between questions within a domain, and/or the correlation between questions within the entire survey could be analyzed. The team could also evaluate the internal consistency of the survey such as analyzing the Cronbach Alpha to measure how consistently the set of questions is measuring the construct.
- Dr. Simmonds asked the members to vote and/or state their opinion on the two further reduction options presented.
  - Three members preferred an empirical approach, one member preferred a qualitative approach (if the statistics were relatively close), and one member had no preference.
  - A TEP member asked if the team was able to use a factor analysis for further reduction.

        - Dr. Simmonds stated that factor analysis confirmed that there were a distinct number of factors, however the model did not suggest a good fit.
- A TEP member asked if there was a way to measure correlation between the OAS CAHPS survey and this survey.
    - Dr. Simmonds stated the team did look at the correlation of total score between the surveys when the facility data was publicly available (it was not for all the facilities in the pilot). Due to the limited number of facilities and other reasons, the correlations were not able to be direct comparisons. The data was also a year older than the pilot data. For scoring, the information transfer uses top-box arithmetic mean and OAS CAHPS uses linear score mean.
        - Dr. Simmonds stated that with these limitations the correlation was a moderate correlation.
    - Dr. Simmonds stated that in terms of using OAS CAHPS as a criterion validity assessment for the survey instrument of communication by providers, the moderate correlation supports that the information transfer survey is different, and it has unique questions that are assessing aspects of communication that are not assessed within OAS CAHPS.
    - The TEP member clarified to see if the same population could be sampled to see if there was a way to quantify the relationship between the two surveys to help make a clear decision.
        - They noted that for patients, being asked similar questions can be frustrating, but they understand that patients may also give different information based on the nature of the question and the context of the survey.
    - Dr. Simmonds stated that the team agrees that they are concerned about implementing this measure now that OAS CAHPS is becoming mandatory. During the pilot this created challenges of double sampling patients in some facilities. In those facilities, the survey was submitted to the population remaining following administration of OAS CAHPS. At the most recent pilot site the populations were not separated, and patients may have received an OAS CAHPS survey and then several weeks later received this survey, and in these sites the response rate ranged between 30-40%.
        - Dr. Simmonds stated since this site just concluded survey testing that interviews with these providers and patients

are upcoming, but the team plans to investigate the response rate in these interviews.

    - Dr. Simmonds asked if any of the TEP members or the information transfer team members had any other questions or points for this discussion.
- Ms. Thottam reviewed the next steps for the survey. The TEP minutes and summary report will be shared in the coming weeks prior to public posting. There is potential for the measure to be put through consensus-based endorsement in the Fall 2023 cycle, and the timing for measure implementation is still unknown at this time.
    - Ms. Thottam stated that the TEP members that missed the meeting and/or the votes will be receiving updates via email after the meeting.
    - Ms. Thottam encouraged the members to share further thoughts or questions through the measure inbox: cmsoutpatientpropm@yale.edu
- Ms. Thottam thanked the TEP members for their participation, feedback and concluded the meeting.