

**Development of Preventive Cancer Screening and Counseling Patient-
Reported Outcome-Based Performance Measure (PRO-PM):
Summary of Technical Expert Panel Meeting #1**

August 2022

Prepared by:

Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation
(CORE)

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Background

The Centers for Medicare & Medicaid Services (CMS) has contracted with Yale New Haven Health Services Corporation - Center for Outcomes Research and Evaluation (CORE) to develop outpatient outcome measures that can be used to assess the quality of care provided by clinicians who are eligible to participate in the Merit-based Incentive Payment System (MIPS). The contract name is Development, Reevaluation, and Implementation of Outpatient Outcome/Efficiency Measures, Option Period 2. The contract number is HHSM-75FCMC18D0042, Task Order HHSM-75FCMC19F0002.

As part of this project, CORE is developing a Patient-Reported Outcome-based Performance Measure (PRO-PM) to assess the quality of clinician counseling for patients eligible for select preventive cancer screenings (hereafter, the “Preventive Cancer Screening and Counseling PRO-PM”). The PRO-PM focuses on preventive counseling services for four cancer types (breast, 2) cervical, 3) colorectal, and 4) lung cancer). PRO-PMs require using PRO survey instruments to collect outcome data from patients. As part of this PRO-PM’s development, CORE is developing a novel survey tool to collect the outcome data from patients with minimal burden and optimal response rates.

As is standard with all measure development processes aligning with the [Measure Management System Blueprint](#) CORE is obtaining expert and stakeholder input on the PRO-PM under development. CORE has convened three stakeholder groups:

- Technical Expert Panel (TEP): CORE has assembled a national TEP of clinicians (specifically, internal medicine, gerontology, radiology and breast imaging, gastroenterology, obstetrics and gynecology, and thoracic surgery), patient advocates, methods experts (specifically, patient counseling, psychometrics and performance measurement, quality improvement, healthcare disparities, and payer/purchaser perspective), and other stakeholders.
- Clinician Committee: In addition to the TEP, CORE has assembled a Clinician Committee to obtain input to whom the measure will be directly relevant. The Clinician Committee consists of frontline clinicians (such as primary care physicians, physician specialists, and other clinicians) and/or relevant representatives of professional societies. The Clinician Committee members also have experience providing care in rural communities and other underserved settings.
- Person & Family Engagement (PFE) Working Group: CORE has also convened a PFE Working Group comprising patients, advocates, and caregivers from diverse backgrounds, to provide input on the measure under development. CORE has and will seek continued input throughout development from the PFE Workgroup members in preparation for the first pilot.

This report presents the CORE Measure Development Team, the TEP members, and summarizes the feedback and recommendations received from the TEP during the first meeting of the committee held on July 25, 2022.

Measure Development Team

The CORE Measure Development Team includes individuals with a range of expertise in outcome measure development, health services research, clinical medicine, and survey and quality measurement methodologies. See [Appendix A](#) for the full list of members for the CORE Measure Development Team.

Vivian Vigliotti, Ph.D. leads the CORE Measure Development Team developing this PRO-PM. Dr. Vivian Vigliotti is a Health Outcomes Researcher for the Quality Measurement Group at CORE where she leads measure development and reevaluation. The Measure Development Team includes individuals with a range of expertise in outcome measure development, health services research, clinical medicine, and quality measurement methodologies.

Karen D. Sheares, MD, Ph.D., Director of Quality Measurement at CORE and an Associate Research Scientist at Yale University, oversees the work.

Finally, Janis Grady, RHIT, CPHQ (ret.), the project’s Contracting Officer Representative, and additional CMS staff overseeing the MIPS program, including Daniel Green, MD; Lisa Marie Gomez, MPA, MPH; and Sophia Sugumar, MSHM, provide ongoing input.

Technical Expert Panel (TEP)

CORE held a 30-day public call for nominations and convened a TEP for the development of the Preventive Cancer Screening & Counseling PRO-PM. CORE contacted potential TEP members via email to individuals and organizations recommended by the Measure Development Team and stakeholder groups, email blasts to CMS listservs, and through a posting on CMS’s website.

The TEP comprises 18 members, listed in [Table 1](#). The TEP consists of frontline clinicians including clinicians who practice in rural and/or underserved areas, across various specialties as well as methods experts including performance measurements and healthcare disparities. The role of the TEP is to provide feedback and recommendations on key methodological and clinical decisions for the PRO-PM under development. The appointment term for the TEP is through September 2024.

Table 1. TEP Member Name, Affiliation, and Location

Name	Organization (title); clinical specialty, if applicable	Location
Alexis Snyder, BA	Patient & Stakeholder Engagement Specialist	Brookline, MA

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Name	Organization (title); clinical specialty, if applicable	Location
Anna Beavis, MD, MPH	Johns Hopkins University (Assistant Professor); Gynecology & Obstetrics	Baltimore, MD
Anne Marie Murphy, Ph.D., MPH	Equal Hope (Executive Director)	Chicago, IL
Anshul Dixit, MD, MPH, MBA	Blue Shield of California (Medical Director, Medical Care Solutions)	Sacramento, CA
Caitlin Drumheller, BS	American Society of Clinical Oncology (Associate Director, Measure Development)	Alexandria, VA
Gaye Hyre	Patient, Advocate	New Haven, CT
Leisa Lackey, BS	Atrium Health (Business Manager Lung Cancer Screening Program)	Charlotte, NC
Maria de Jesus Diaz-Perez, PhD	Center for Improving Value in Health Care (Director, Research & Performance Measurement)	Denver, CO
Martin Pellinat, MBA	Visiontree Software, Inc. (President and Founder)	San Diego, CA
Nancy Schoenborn, MD, MHS	Johns Hopkins University (Associate Professor/Attending Physician); Geriatrics & Gerontology	Baltimore, MD
Nina Vincoff, MD	Northwell Health (Division Chief); Breast Imaging	Lake Success, NY
Paul Hartlaub, MD, MSPH	Ascension Medical Group Wisconsin (Medical Director, Primary Care Quality)	Shorewood, WI
Rachel Issaka, MD, MAS	University of Washington (Assistant Professor, Physician)	Seattle, WA
Renee Williams, MD, MHPE	NYU Langone Health (Associate Chair for Health Equity)	New York, NY
Theresa Schmidt, MA	Discern Health (Vice President)	Baltimore, MD
Tim Ho, MD, MPH	Kaiser Permanente (Regional Assistant Medical Director, Quality & Complete Care)	Pasadena, CA
Tim Mullett, MD, MBA, FACS	University of Kentucky College of Medicine (Thoracic Surgeon)	Lexington, KY
Wenora Johnson, BS	Patient, Research Advocate	Joliet, IL

Responsibilities of TEP members include:

- Reviewing background materials provided by CORE prior to each meeting;
- Participating in TEP webinar/teleconference meetings;

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- Completion of post-meeting surveys (as needed);
- Providing input and feedback to CORE on key clinical and methodological decisions;
- Providing feedback to CORE on key policy or non-technical issues related to the measure’s development; and
- Reviewing the TEP meeting summaries.

TEP Meetings

TEP meetings follow a structured format consisting of the presentation of updates on measure development, key issues and areas for feedback identified during measure development, and CORE’s proposed approaches to addressing the issues, followed by an open discussion of these issues by the TEP members.

CORE held its first TEP meeting on July 25, 2022 (see [Appendix B](#) for the full TEP meeting schedule).

Overview of First TEP Meeting (July 25, 2022)

The materials provided prior to the meeting included the project overview, measure background and concept, approach measure development, feedback from CORE’s engagement with the projects Person & Family Engagement (PFE) Working Group and the Clinician Committee, and the draft survey tool.

During the meeting, CORE presented background information and a summary of feedback received to date from the PFE Working Group and Clinician Committee. During the TEP discussion, CORE solicited input on the survey domains, survey questions, survey administration, and other topics raised by TEP members.

The following bullets represent a high-level summary of the proceedings of this first Preventive Cancer Screening & Counseling PRO-PM TEP meeting. For a detailed meeting summary, please see the full minutes of the meeting in [Appendix C](#).

Presentation:

- CORE welcomed the TEP and asked TEP members to disclose any individual Conflicts of Interest (COI) to be shared with all members and formally logged.
- CORE reviewed the TEP Charter. No TEP members had any questions or edits to the Charter and unanimously approved the Charter.
- CORE reviewed the goals of the meeting and measure background.
- Meeting goals: introduce the project to the TEP and obtain TEP input on measurement domains and survey administration.
- Project overview and approach: CMS has contracted CORE to develop an outpatient PRO-PM to evaluate the quality of counseling provided by clinicians regarding preventive breast, cervical, colon, and lung cancer screening. Development of the PRO-

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PM is a 3-year process that will run through August 2024. In addition to input from the TEP, PRO-PM development will include input from stakeholders including methods experts (including clinical and quality measurement experts and a psychometrician), a PFE Working Group, a Clinician Committee, pilot testing, and public comment.

- **Measure background:** The goals of the PRO-PM are to incentivize high-quality clinician counseling (from the perspective of the patient) and reduce disparities and promote equity in such counseling. The focus on Clinician counseling for breast, cervical, colorectal, and lung cancers is due to persistent disparities in cancer screening among these four cancer types. To collect outcome data from patients for the PRO-PM, CORE developed a novel survey tool. The survey will be sent to patients following clinician visits to ask about their experience. The data collected from the administration of the survey will be used for PRO-PM calculation.
- **Measure domains:** The survey focuses on four domains: 1) “Your clinician discussed screening with you;” 2) “Your clinician made a recommendation for screening;” 3) “You understood information need to decide on screening;” and 4) “You had what you needed to complete a screening.” The domains were previously discussed with the PFE working group and received the broad support of PFE partners.

TEP Feedback: Measure Domains and PRO Survey Instrument

- Questions from TEP
 - A TEP member asked whether this measure would be used for all eligible patients or targeted to Medicare beneficiaries.
 - CORE clarified that the measure will not be restricted to Medicare beneficiaries and will be sent to all eligible patients, regardless of payer.
 - A TEP member asked about the possibility of including questions that pertained to the genetic screening for several cancer types.
 - CORE clarified that they want the survey to be universally applicable, so there are no specific questions that correspond to genetic screening.
 - A TEP member asked whether the survey would be available in different languages.
 - CORE is exploring options for translation and plans to develop and administer a Spanish version of the survey. CORE will explore creating the survey in additional languages.
 - A TEP member asked about the potential use of the survey. With the survey domains, the survey could have both research and accountability applications.
 - CORE has not determined which questions will be used for scoring. There will be more revisions once pilot results are received, such that certain questions may be used for informational purposes as well as scoring.
 - A TEP member asked whether the survey questions would focus on screening discussions initiated by the clinician.
 - CORE clarified that the conversation could be initiated by anyone, but the survey will focus on the patient’s assessment of the quality of the counseling they received.

- TEP members did not identify any modifications to the domains or any missing domains.
- Several TEP members recommended adding a question about patient trust in their clinician to the survey.
- One TEP member shared their experience of patients receiving conflicting information (current recommendation vs. past recommendation) and how it creates a lack of trust for the patient with their provider. For example, the updated USPSTF guidelines specify cervical cancer screenings to occur every three to five years instead of annually.
- Several TEP members emphasized the importance of health literacy and making the survey more accessible to a broader patient population. They also recommended making the survey available in several languages. Relatedly, they recommended adding a question to ask about the patient’s preferred language for healthcare communication as the absence of translation may be a barrier to quality counseling.
- Several TEP members recommended using “early detection” instead of “cancer screening” to help patients with lower literacy levels.
- One TEP member cautioned against making the survey too simple for individuals with higher levels of literacy.
- Several TEP members recommended adding a question about whether a qualified interpreter was used during counseling and filling out the survey.
- Several TEP members recommended adding more questions that collected qualitative data, such as if the patients felt they had enough time or felt understood or pressured in some way. They expressed that the information being collected in the current draft of the survey was quantitative (checking off pieces of information received) rather than qualitative (the experience for the patient of how it happened). They recommended adding a question, such as “Were you comfortable with your decision?”
- One TEP member highlighted that cancer screening discussions can occur outside of the clinician’s office, such as via follow-up phone calls or EMR prompts.
- For the format of the survey, TEP members recommended adding Likert-style questions adding a submit button at the end of the survey, and defining the words, such as “caregiver” and “excellent health.”
- One TEP member emphasized the idea that patients may be fearful of the results of the cancer screening and suggested adding it as a survey domain for clinicians to address during counseling. This information would be most helpful for patients with fewer resources or individuals apprehensive of the healthcare system.
- One TEP member highlighted the question: “Do you have any concerns about the recommended cancer screening tests?” and recommended adding questions about what concerns patients had.
- One TEP member highlighted the amount of information transmitted between clinician and patient for cancer screenings. They highlighted that patients might not understand all that information and would recommend reframing the question to focus on whether patients felt they received enough information to reach a decision.
- One TEP member highlighted the importance of being mindful to not shame patients who have chosen not to screen. From their work with shared decision-making, every

step of the process required some level of additional resources. They recommended adding more links to the survey for additional information if the patient needs it.

- Several TEP members recommended rephrasing “clinician” because it felt distant and unclear and because many members of the care team can support cancer screening conversations.

TEP Feedback: Survey Administration

- Cohort of Patients
 - One TEP member shared that it is difficult to know when cancer counseling/screening will occur with the different types of cancer screening. For example, for colon screening sometimes primary care physicians refer patients to gastroenterologists who will then counsel the patient about the screening.
 - Several TEP members agreed with CORE’s recommendations for the target cohort of patients.
 - Several TEP members recommended removing individuals over 80 years old from the cohort of patients as the guidelines about the value of screening among these patients have changed.
 - One TEP member noted that care delivery only drives 10-20% of health outcomes.
 - One TEP member asked if CORE was considering shared decision-making as a process or an outcome. They further asked whether the outcome would be if the patient decided to get screening or not and if they are comfortable with the decision or if the measure would focus on the process of shared decision in general. They stated it would be interesting to look at shared decision-making outside of screening guidelines as well.
 - One TEP member wondered how personalized the survey would be and suggested if it is not personalized, then it becomes important to determine how the “average patient” is determined.
 - One TEP member raised the issue of how eligibility would be determined for patients who are eligible for multiple screenings.
 - One TEP member suggested focusing on patients receiving information at a primary care visit at the starting age at which the respective cancer screening is recommended for average-risk patients.
 - One TEP member recommended adding survey questions to assess general eligibility for each survey question to assess general eligibility for each survey to enable stratification.
 - One TEP member stated that because the four cancer types are so different, it would be most helpful to include all possibilities for patients and then parse the data later.
 - One TEP member said CORE could target ICD-10 codes for annual visits with providers understanding the limitations (would exclude those without a primary care physician).

- One TEP member recommended reframing the question concerning barriers as the clinician provides support for various concerns the patient may have.
- One TEP member recommended adding a question to allow patients to expand on why they were not able to follow through with a recommendation from their clinician.
- One TEP member recommended adding stool-based DNA testing to the list of types of colon cancer screening.
- Timing of Survey
 - Several TEP members asked whether a survey is the best approach for gathering patient information because there has been a struggle with declining response rates to surveys. They recommended a case management approach.
 - Several TEP members recommended sending out the survey as soon as possible because most patients do not recall what happened the more time has passed since the visit. They said 14 days (about 2 weeks) after the visit is too long.
 - One TEP member asked whether there will be an adjustment for patients who intended to get screened but were unable to due to logistical issues, such as scheduling and appointment availability. They elaborated that it could influence responses to the survey if dissatisfied with their experience.
 - One TEP member suggested mailing paper copies of the survey or leaving the visit with a printed copy.
 - One TEP member shared that it could take patients several months to initiate following up on their clinician’s recommendation. For this reason, some of the questions about barriers patients encountered could be inaccurately answered.
 - Several TEP members shared that for patients from vulnerable populations paper or call surveys are more effective than digital surveys.
- Dr. Vivian Vigliotti thanked attendees and outlined the next steps for the TEP and the measure development process. CORE will hold the first pilot of the survey tool with 2-4 outpatient offices in Fall 2022 and will provide patient responses in the next TEP meeting to be held via Zoom in Fall or Winter 2022.

Ongoing Measure Development

CORE will continue to encourage further feedback and questions from TEP members via email until the next TEP meeting.

Conclusion

TEP feedback on CORE’s approach to measure development will inform the measure survey. CORE will continue to engage and seek input from the TEP as the measure is developed.

Appendix A. CORE Measure Development Team

The members of the CORE measure development team are listed in [Table 2](#) below.

Table 2. CORE Measure Development Team

Name	Team Role
Karen Dorsey, MD, PhD	Senior Director
Vivian Vigliotti, PhD	Project Lead
Shefali Grant, MPH	Project Manager
Kyle Bagshaw, MPH	Research Associate
Jace O’Neill, BA	Research Associate
Faseeha Altaf, MPH	Outpatient Research and Development Division Lead
Phylcia Porter, MPH, MSL	Contract Manager
Kathleen Balestracci, Ph.D., MSW	Measure Development Expert
Elizabeth Triche, PhD	Measure Development Expert
Kasia Lipska, MD, MHS	Clinical Investigator
Iman Simmonds, MD, MPH	Clinician Investigator
Ilana Richman, MD, MHS	Clinician Investigator
Ricardo Pietrobon, MD, PhD	Consulting Psychometrician
Rachel Johnson-DeRycke, MPH	Stakeholder Engagement
Latrecia Bromell, BS	Stakeholder Engagement
Mariel Thottam, MS	Stakeholder Engagement
Erin Joyce, BA	Stakeholder Engagement
Ariel Williams, BS	Stakeholder Engagement
Alexandra Stupakevich, BS	Stakeholder Engagement

Appendix B. Technical Expert Panel (TEP) Call Schedule

TEP Meeting #1

Monday, July 25, 2022 – 5:00-7:00 PM EST (Zoom Teleconference)

TEP Meeting #2

TBD

TEP Meeting #3

TBD

TEP Meeting #4

TBD

TEP Meeting #5

TBD

Appendix C. Detailed Summary – Technical Expert Panel Meeting #1

Monday, July 25, 2022, 5:00PM – 7:00PM ET

Participants

- **Technical Expert Panel (TEP) Members:** Alexis Snyder, Anshul Dixit, Caitlin Drumheller, Gaye Hyre, Leisa Lackey, Maria de Jesus Diaz-Perez, Martin Pellinat, Nina Vincoff, Rachel Issaka, Renee Williams, Theresa Schmidt, Tim Ho, Tim Mullett
- **Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE):** Karen Dorsey Sheares, Vivian Vigliotti, Kyle Bagshaw, Jace O’Neill, Shefali Grant, Ilana Richman, Iman Simmonds, Kasia Lipska, Katie Balestracci, Beth Triche, Sarah Megiel, Mariel Thottam, Erin Joyce, Ariel Williams, Rachelle Zribi
- **Center for Medicare and Medicaid Services (CMS):** Janis Grady, Lisa Marie Gomez

Detailed Discussion Summary

Welcoming Remarks

- Ms. Mariel Thottam (she/her/hers) welcomed the group on behalf of the Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE) and thanked the Technical Expert Panel (TEP) members for joining the call.
- Ms. Mariel Thottam reviewed the meeting agenda and reminded the group that the content of TEP discussions must remain confidential until made public by the Centers for Medicare and Medicaid Services (CMS) and that all personal opinions and experiences, including any personal health information, shared during the TEP meeting are to remain confidential.
- Ms. Mariel Thottam stated that TEP members represent themselves and not the organizations with which they are affiliated.

Introduction

- Ms. Mariel Thottam summarized CORE’s mission and CORE speakers briefly introduced themselves.
- Ms. Mariel Thottam recognized Janis Grady, the CMS Contracting Officer Representative for this work, along with Daniel Green, Lisa Marie Gomez, and Sophia Sugumar of the CMS Merit-based Incentive Payment System (MIPS) quality team.
 - Ms. Janis Grady introduced herself and thanked the TEP members on behalf of CMS for joining the call.
- TEP members briefly introduced themselves, shared their pronouns, and described their key interests related to the measure. Members also disclosed any potential conflict of interest.
- Ms. Mariel Thottam reviewed the goals for the meeting including completing introductions of CORE and TEP, reviewing of the project and measure background, and obtaining TEP’s feedback for measure development including survey domains, target cohort of patients, and timing to release the survey.

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Approval of the TEP Charter

- Ms. Mariel Thottam reviewed the role of TEP members, highlighting members will provide input and guidance on key development decisions to ensure the measure is valid, reliable, and informed by diverse perspectives, providing input on topics including the cohort of patients, attribution, risk adjustment, validity, and implementation. TEP members will advise CORE as the measure developer; CORE is responsible for the final measure decisions, and the TEP will not advise CMS directly.
- TEP members approved the charter unanimously.

Project Overview and Approach

- Dr. Vivian Vigliotti (she/her/hers) shared that CORE is developing a Patient-Reported Outcome-based Performance Measure (PRO-PM) to ask about the quality of clinician counseling for preventive cancer screening, for use in MIPS. MIPS is a CMS program that ties payment to the quality of care delivered by eligible clinicians. The measure will focus on clinician counseling for preventive screening for breast, cervical, colon, and lung cancers. CORE will use the data from a novel patient survey to evaluate the quality of shared decision-making between patients and clinicians.
 - The measure development strategies are in alignment with CMS priorities including the [Meaningful Measures 2.0](#), [CMS National Quality Strategy](#), and [Digital Quality Measurement Strategic Roadmap](#).
- Dr. Vivian Vigliotti reviewed the measure goals: to incentivize high-quality clinician counseling for preventive breast, cervical, colon, and lung cancer screening for all patients, and to reduce disparities and promote equity in screenings.
- Dr. Ilana Richman (she/her/hers) highlighted that this measure will focus on the quality of counseling for breast, colon, cervical, and lung cancer screenings. CORE chose these cancer types because there is a broad consensus that screening for these cancer types is effective. Screening for these cancer types is recommended for large groups of the US population. Providers screen and counsel patients for these cancers in several primary care settings.
 - Dr. Ilana Richman reviewed the US Preventive Services Task Force (USPSTF)-recommended type of screening test and screening intervals for breast, cervical, colon, and lung cancer.
- Dr. Vivian Vigliotti reviewed key terminology. A Patient-Reported Outcome (PRO) is a patient's personal assessment of something they experienced during a healthcare encounter. PROs are assessed for individual patients using survey instruments called PRO survey instruments. Patient responses from a PRO survey instrument are aggregated as a PRO-PM to summarize the clinician's overall quality of care related to the outcome of interest.
- Dr. Vivian Vigliotti defined the focus of the measure to include: the quality of conversation and shared decision-making between patients and clinicians, the reported experience of patients themselves, and to provide clinicians with overall opportunities for improvement.

- The measure will not focus on whether: a conversation simply occurred, a patient decided to get a particular screening, a patient received a particular screening, or inform clinicians' care for a specific patient.
- As a further note, all responses to the survey will be de-identified.
- Dr. Vivian Vigliotti highlighted the four guiding principles used to develop the measure. The guiding principles include: 1) The measure will be developed using a patient-centered approach, 2) The measure will minimize any additional burden for clinicians and patients, 3) The PRO survey instrument will be as concise as possible while still capturing all relevant items, and 4) The measure will be developed in a diverse and represent patient population.
- Dr. Vivian Vigliotti summarized CORE's stakeholder input to date. Over the past several months CORE iteratively worked with clinical and measure development experts at CORE, a psychometrician expert, a Person and Family Engagement (PFE) Working Group, and a Clinician Committee to codesign the current survey domains and questions. CORE will continue to iterate the survey with feedback from the TEP, plain language consultants, and pilot testing in Fall 2022.
- Dr. Vivian Vigliotti reviewed the measure development process. It is a three-year process and CORE is currently nearing the end of the first year. Currently, CORE is developing the PRO survey instrument and will begin PRO survey pilot testing in Fall 2022.
 - Part of developing the PRO survey instrument includes meeting with various stakeholders including a PFE Working Group (which first met in May 2022), and a Clinician Committee (which first met in June 2022).
 - PRO survey pilot testing will begin in Fall 2022 in two to four outpatient practices. Following PRO survey instrument testing there will be a period of PRO survey instrument refinement, then retesting the PRO survey instrument with changes implemented, followed by validation and finalization.
 - The goal is to complete the measure development in August 2024.

Measure Background

- Mr. Kyle Bagshaw (he/him/his) shared the four measure domains identified from an extensive literature review as well as vetted by the PFE Working Group and the Clinician Committee. The four measure domains include: 1) "Your clinician discussed screening with you;" 2) "Your clinician made a recommendation for screening;" 3) "You understood information need to decide for screening;" and 4) "You had what you needed to complete a screening." Every question asked in the survey draft can be tied back to at least one domain. (The "You" identified in each of the domains refers to a patient that is eligible to receive the survey.)

Person and Family Engagement Working Group (PFE Working Group) Feedback

- Mr. Kyle Bagshaw reviewed the feedback obtained from the twelve-member patient workgroup in the meetings held in May 2022. During the PFE Working Group meeting, patients shared their thoughts, perspectives, and their experiences with each of the four domains.

- For the first domain, CORE learned that patients felt clinician visits are short, particularly if the patient has other priorities to address, patients with specific risk factors may be more likely to bring up cancer at a visit, and that patients in or of underserved communities have lower trust while discussing cancer risk with clinicians.
- For the second domain, CORE learned that patients felt they sometimes are being pushed into a screening or that their current priorities were not reflected, and patients do not always know what information their clinicians need to make the best recommendation possible (the expectations of them as patients could be made clearer) and asking about family history prompted recommendations from clinicians for more frequent screenings.
- For the third domain, PFE Working Group members described specific pieces of information that are helpful when deciding (such as the potential risks and benefits of screening, any alternatives, and why screening is appropriate for them personally). CORE learned that patients' comfort with asking clinicians about the information they need varies widely, and patients appreciated resources with "plain language."
- For the fourth domain, CORE learned that patients valued being able to communicate with their clinician after their visit (such as through a patient portal), patients encountered many logistical barriers to making and getting to the screening appointment, and patients experienced difficulties navigating through the system after the initial visit.
- Dr. Vivian Vigliotti shared that CORE is working with a plain language consultant to ensure the readability of survey questions.
- Mr. Kyle Bagshaw shared CORE iteratively made a series of questions with the domains in mind. He provided an overview of the questions and the domains they correspond to. For pilot testing, CORE will also collect demographic information in addition to these questions. The items that will factor into a performance score are still being determined and will be addressed later in the development process; not every question asked will necessarily be factored into performance scoring.
- Mr. Kyle Bagshaw invited the TEP members to ask any questions they have before the feedback sessions.
 - A TEP member asked whether this measure would be used for all eligible patients or targeted to Medicare beneficiaries.
 - Mr. Kyle Bagshaw stated that the measure will not be restricted to Medicare beneficiaries and will be sent to all eligible patients, regardless of payer.
 - A TEP member asked whether the survey would be available in different languages.
 - Mr. Kyle Bagshaw stated that CORE is exploring options for translation. At a minimum, CORE plans to develop and administer a Spanish version of the survey. CORE will explore creating the survey in additional languages.

- The TEP member elaborated that vulnerable populations often consist of patients with low English proficiency. They confirmed that Spanish was necessary, but other languages should be considered as well.
 - A TEP member highlighted patient literacy as a consideration for the survey.
 - Mr. Kyle Bagshaw confirmed this was one of CORE’s priorities as well and confirmed CORE’s plan to bring on a plain language consultant to ensure that the survey is accessible and readable for as many people as possible and will update the TEP members once plain language changes have been made.
 - Another TEP member agreed with the importance of literacy and highlighted the recommendation to use a 5th-8th grade reading level for patient-facing resources.
 - A TEP member asked about the possibility of including questions that pertained to the genetic screening for several cancer types.
 - Mr. Kyle Bagshaw stated that CORE wanted the survey to be broadly applicable so there are no specific questions that correspond to genetic screening at this time.
 - The TEP member elaborated that certain populations are at a higher risk for cancer and therefore should be screened earlier and more often.
 - Mr. Kyle Bagshaw confirmed that CORE will consider this in measure development. CORE will discuss risk adjustment with the TEP in the future.
 - A TEP member asked about the potential use of the survey. With the survey domains, the survey could have both research and accountability applications. They wondered whether every question in this survey needs to be something to hold clinicians accountable for or if some of the questions will be used for secondary research.
 - Mr. Kyle Bagshaw shared that CORE has not determined which questions will be used for scoring and there will be more revisions once pilot results are received, potentially being used for informational purposes as well as scoring.
 - A TEP member asked whether the survey questions would focus on screening discussions initiated by the clinician.
 - Dr. Vivian Vigliotti shared that the conversation could be initiated by anyone, but the survey will focus on the patient’s experience of the screening.
- In the chat, Dr. Karen Dorsey Sheares (she/her/hers) clarified that the goal of the measure would not focus on screening rates or appropriateness, but instead a measure of the quality of discussion from the patient’s perspective. Optimally, whether the conversation supports shared decision-making.
- Mr. Kyle Bagshaw clarified that the goal for this measure is not to ask about a particular type of screening, whether it is best or appropriate for that patient. It is meant for a primary care or wellness setting where it is not assumed that screening one way or another is appropriate.

TEP Input: Measure Concept & Survey Domains

- Mr. Kyle Bagshaw asked the TEP if they found the concept, domains, and survey questions to be valid constructs of quality.
- A TEP member stated that they found the domains appropriate, however, they highlighted the importance of patient trust in the provider. The questions in the survey ask whether the patient understood the information provided to them, but not whether the patient agreed with or trusted the recommendation; it is possible that a new recommendation may conflict with information a patient received in the past. For example, the recommendations for cervical cancer screening have been updated to every 3-5 years from an annual check, however, patients who do not have insurance believe they are not offered annual checks because of resource limitations which impacts their trust in the system. The TEP member agreed with the importance of plain language for the survey and recommended adding questions in the demographic section about how comfortable people feel in other languages because that might also be a barrier to access and following through with recommendations from the provider.
 - In the chat, another TEP member agreed and suggested instead asking if the recommendations or information aligned with personal values and needs.
- A TEP member confirmed that they thought these were good questions and information that patients can provide but wondered if there was a better way to get a qualitative assessment of their experience, such as if patients felt they had enough time, feel understood, or pressured in some way. They also suggested explaining “cancer screening” as “early detection” to help patients with lower literacy levels. They highlighted vulnerable populations screened for lung cancer may be uneducated, intimidated by medicine, may have some degree of guilt, and are stigmatized in many ways, so careful consideration must be taken not to aggravate those stigmas.
 - The TEP member further elaborated in the chat that “confident” relates to trust as well.
- A TEP member noted that cancer screening discussions occur outside of the clinician's office as well, such as via follow-up phone calls or EMR prompts if patients have those notifications established and highlighted the importance of considering the Medicaid population given they likely have other competing healthcare priorities and may have less access to the healthcare system.
- A TEP member noted the survey questions seemed to focus on whether the information had been transmitted rather than if shared decision-making occurred. They noted the importance of clinicians providing information in a language the patient can understand and highlighted the importance of patients having the opportunity to participate in the conversation, obtaining personalized information for their specific risk, and feeling it was a shared decision rather than simply information being transmitted to them.
 - Mr. Kyle Bagshaw confirmed that CORE intends to ask questions covering the quality of conversation from the patient's perspective and welcomed feedback on specific questions if that information was not coming through in the way it should.

- A TEP member recommended adding page breaks or indications about what each survey section will focus on to guide the person. They noted the difficulty in differentiating between some questions due to phrasing similarities and recommended adding in definitions for ambiguous language, (such as “Excellent health”) because not everyone will describe that in the same manner.
- A TEP member agreed with the previous points raised about trust and qualitative information. They noted the survey felt more quantitative (checking off pieces of information that were received) than qualitative (experience of how the conversation went from the patient perspective) and recommended considering more qualitative questions such as “Did you agree,” or “Were you comfortable with your decision,” or “Did you have a chance to ask all the questions you wanted?” They also suggested adding branching logic to minimize feeling like the questions are redundant, and recommended adding specific questions related to health literacy, what format the patient received the information in, and if someone helped the patient to fill out the survey.
- A TEP member agreed with the recommendation to add qualitative questions to the survey and added that patients care about the concept of respect between the patient and provider, specifically feeling listened to and heard. They recommended adding questions about cultural competence to the survey. They further supported the importance of shared decision-making, including discussions of personalized risks and benefits, alternatives to screening, and steps in the screening process. They highlighted that there were many yes/no questions but recommended considering gradation of response such as a Likert scale. They recommended defining the word “caregiver.” They highlighted the question: “Do you have any concerns about the recommended cancer screening tests?” and recommended adding questions about what concerns patients had.
- A TEP member recommended, via the chat, including a submit button at the end of the survey to allow patients to review their answers before completion.
 - Dr. Vivian Vigliotti thanked the TEP member for their suggestion and confirmed that CORE will add a submit button.
- A TEP member thought the concepts broadly were valid and agreed with many of the points previously raised but urged CORE not to make the information too simplistic either as some people wish to interact on a deeper level and feel frustrated when they are only given simple information.
- A TEP member agreed with the previous points raised and further highlighted the literacy levels of the questions. They recommended asking a question about whether a qualified interpreter was used to explain these concepts to people whose first language is not English. They further emphasized that the questions in the survey now are quantitative, and that qualitative data about the patient experience will be much richer. They thought it was important to send the survey out sooner rather than later for patients to describe their experiences more accurately.
- A TEP member agreed that the concept and survey domains are broadly valid. They highlighted patients may be fearful of the results of the cancer screenings and would

rather not know and thought it might be useful to add the concept of fear of results as a domain for the quality of the conversation a clinician has with a patient. For example, if the screening test does have a result that needs to be followed up on, the clinician could lay out how it would be communicated to the patient and what to expect. They thought this information would be particularly helpful for patients with fewer resources or who are more apprehensive of the healthcare system, so they know they are supported. For question 2.1 in the survey, they interpreted the question as though the patient had already been convinced to receive a screening rather than understand why the screening was applicable to them.

- Mr. Kyle Bagshaw confirmed that CORE is revising question 2.1 to remove the assumption that screening is appropriate.
- A TEP member additionally supported the importance of shared decision-making. They shared concerns regarding the domain focused on whether the patient understood the information the clinician provided given there is so much information that must be shared about each cancer screening type. Many patients may not understand all the information provided by their clinicians and the question should instead assess whether the patient had enough information to decide to undergo screening. They also supported using Likert scale response options, and the question about whether an interpreter was used.
- A TEP member additionally supported accommodating health literacy and using “early detection” as opposed to “screening” and being mindful to not shame patients if they chose not to screen. Every step of the process to get screened required some level of additional resources; there is a lot of opportunity with the web-based version of the survey to make it very personalized with links to other information if the patient chooses to read the additional information. They also recommended providing an open-ended question for the respondents to communicate their concerns about the screening, such as positive diagnosis, cost, or what it means for the patient themselves.
- A TEP member via the chat shared that the term “clinician” felt distant and sterile, and many members of the care team can support these conversations, such as nurses, case managers, and assistants.
 - Dr. Vivian Vigliotti responded that CORE is initiating work with a plain language consultant to be more inclusive and easily understandable for patients.
 - Another TEP member asked whether “clinician” meant the doctor or other clinicians as well.
 - Dr. Vivian Vigliotti confirmed that “clinician” is intended as an inclusive term for doctors and/or other clinicians.
- Mr. Kyle Bagshaw thanked all the members for their feedback and emphasized how helpful their comments were for the measure's development. He shared that CORE is taking notes on all their comments and will be processing them more deeply moving forward. The major themes TEP members shared included the importance of shared decision-making in conversations to help patients understand risks and benefits, improving the reading level of the questions to accommodate a wider range of health literacy, and improving the survey's accessibility, particularly among patient populations that may lack trust in their providers or otherwise feel stigmatized.

TEP Input: Survey Administration

- Dr. Vivian Vigliotti welcomed the group back from the break and reoriented them to the second feedback session which will focus on the administration of the survey. CORE seeks TEP member feedback on two aspects of the process during this TEP meeting: the cohort of patients, and the timing to receive the PRO survey instrument after.
 - Dr. Vivian Vigliotti reviewed CORE's considerations for collecting survey responses which consist of who the target cohort of patients will be (visit types, clinicians), method of survey administration, and timing of assessment.
 - Dr. Vivian Vigliotti outlined the cancer screening PRO-PM quality measurement process. Patients would go to a clinical visit to discuss cancer screening, after which the patient reaches an informed decision. The patient then receives and completes a PRO survey instrument based on their experience. Survey responses are aggregated and analyzed, after which providers will receive a score based on patient responses. Providers can then use their scores to identify opportunities for improving the care they provide in the future.
 - Dr. Vivian Vigliotti shared CORE's considerations for the cohort of patients, including qualifying patients, visits, care settings, and clinicians, thus far. For the demographic of patients: adults in age groups for which screenings are recommended (women 21-85 years of age, men 45-85 years of age), have not already received a cancer diagnosis, and have had a recent visit with a clinician. Qualifying visits include encounters for general exams (with or without abnormal findings) and encounters for general routine gynecologic exams (with or without abnormal findings). Qualifying care settings would include hospital outpatient, institutional outpatient, and private practice care settings. Qualifying clinicians could include general practitioners, family practitioners, internists, obstetrician/gynecologists (OB-GYN), geriatricians, preventive medicine physicians, nurse practitioners, and/or physician assistants.
 - Dr. Vivian Vigliotti stated that in terms of timing to receive the survey the priorities are to maximize the survey uptake and response rate, minimize recall bias, and minimize the burden for providers. For example, Day 0 could be the day the patient and clinician discussed screening, with survey administration beginning on Day 2 and ending on Day 14.
- Dr. Vivian Vigliotti invited TEP members to share their feedback on which patients should be eligible to receive the survey.
 - A TEP member that it is difficult to know when cancer counseling/screening will occur with the different types of cancer screening. For example, for colon screening sometimes primary care physicians refer patients to gastroenterologists who will then counsel the patient about the screening. They supported the proposed list of eligible patients CORE presented.
 - A TEP member asked if CORE would discuss stratification of results because there may be challenges in determining whether a patient within the cohort of patients qualified for a specific cancer screening. For example, there are no

questions in the survey asking for patients' ages to know whether a mammogram would have been appropriate.

- Another TEP member noted that lung cancer screening is not recommended for individuals above 80 years of age.
 - A TEP member asked if, for example, the physician would get credit if an 80-year-old responded that they discussed breast cancer screening.
- Dr. Vivian Vigliotti thanked both TEP members for raising these points and shared that the intent of the measure would be to distribute the survey broadly to patients who may be eligible for a cancer screening.
- Another TEP member agreed in the chat and recommended excluding patients older than 80 years as they have a significant comorbid burden and the time and effort in screening this population is questionable.
- A TEP member recommended including the International Classification of Disease-10th Revision (ICD-10) diagnostic codes for screening encounters, particularly if gastrointestinal providers will be eligible for the measure. Alternatively, the survey could ask a question about whether the visit was a gastroenterology screening visit rather than parsing through ICD-10 codes.
- A TEP member asked what the target population was for the survey and specifically whether the intended population included the general or average risk population across screening types.
 - Dr. Vivian Vigliotti confirmed that this survey would focus on the general population and aims to be as inclusive as possible. CORE may reconsider the target population based on feedback from the TEP and other stakeholders and results from the first pilot.
- A TEP member in the chat asked whether CORE considered shared decision-making in this context a process or an outcome: would the outcome be if the patient decided to get screening and was comfortable with that decision, or would the measure focus on the process of shared decision-making in general? They stated it would be interesting to look at shared decision-making outside of screening guidelines as well. They also noted that care delivery only drives 10-20% of health outcomes.
- Dr. Vivian Vigliotti reoriented the group to ask which patients are fair and appropriate to ask these questions of.
 - A TEP member stated that it depended on how personalized the survey would be. If the goal of the survey was to assess who might benefit from cancer screening, a broad cohort of patients would be appropriate; however, if the survey is focused on an average-risk patient within an existing screening guideline, a narrower cohort of patients would be appropriate. They further noted the importance of determining who would qualify as an “average patient.”
 - Dr. Vivian Vigliotti confirmed that CORE now intends to accommodate patients with a wide range of needs rather than narrowing the eligible population. However, from the literature review and patient feedback, it

- is important to patients that clinicians provide personalized risk information during counseling.
- The TEP member stated that in this case, the cohort of patients would need to be much broader. They also asked how survey eligibility will be determined for patients who are eligible for multiple cancer screenings.
 - A TEP member suggested focusing on primary care visits for the target population of respective cancer screenings to reach average-risk patients. They noted challenges with screening for lung cancer, specifically that these screenings need to be personalized since they do not apply to everyone. They suggested looking at specific ICD-10 codes to help identify populations eligible for cancer screenings.
 - Another TEP member agreed with these points and added that there are different types of cancer, disease mortality, and eligibility guidelines; CORE may have to include multiple populations and then parse out the data later.
 - A TEP member suggested reorganizing the branching logic to first ask questions about eligibility which leads to questions about the types of cancer screenings for which the patient is eligible.
 - A TEP member, via the chat, recommended that if the survey will be administered to a wide group anonymously CORE add survey questions to assess eligibility for each screening.
 - A TEP member noted that determining tobacco exposure may be complicated, but necessary for lung cancer screening.
 - A TEP member asked whether a survey is the best approach for gathering the kind of information CORE hopes to gain given the global declining response rates to surveys and supported an approach based more on case management.
 - Two TEP members echoed this concern.
 - A TEP member stated that if the measure targets the quality of a conversation about cancer screening from a patient perspective (and holds providers accountable for the quality of their conversations), asking patients about the conversation is the best way to do it.
 - Dr. Vivian Vigliotti asked the group to consider the optimal timing for the administration of the survey to patients.
 - A TEP member stated that the survey should be pushed out as soon as possible following the visit because most patients do not recall what happened the longer out from the visit they are. Fourteen days would be too long for many patients to remember the intricacies of the conversation. If surveys are filled out more than two weeks after a conversation and the patient does not recall what was discussed, then those responses should not be used to evaluate a provider's quality.
 - A TEP member highlighted that the survey will not be holding providers accountable for whether the conversation happened, the survey is trying to discern whether the conversation was positive and helpful between patient and provider.

- Dr. Vivian Vigliotti confirmed it would be assessing the quality.
- A TEP member noted there may be certain times when these conversations happen such as yearly health maintenance visits and recommended targeting ICD-10 codes for those visits. They acknowledged limitations in only focusing on these annual visit codes, noting this approach may miss patients without a primary care doctor because they are young and healthy and do not attend yearly checkups. It would be helpful to know when the cancer screening counseling conversations occurred with a primary care physician or with a specialist depending on the cancer type.
 - Dr. Vivian Vigliotti shared that the team includes primary care physicians and some specialists such as OB/GYNs to capture individuals who do not attend wellness checks with primary care physicians.
- A TEP member noted that one of the survey questions asks whether patients intended to get a cancer screening and asked whether there will be an adjustment for patients who intended to get screened but were unable to due to logistical issues, such as scheduling and appointment availability.
 - Dr. Vivian Vigliotti agreed these are barriers for many and clarified the survey will assess the quality of the initial conversation; a clinician will not be negatively affected if the patient did not go through with the screening because of their own choice or a logistical barrier the patient encountered. The measure does not assess the occurrence of a subsequent cancer screening.
 - The TEP member elaborated that it could cause glossing of the response if the patient intended to get a screening because they wanted to be screened but could not.
 - Dr. Vivian Vigliotti thanked the TEP member for this feedback and shared that CORE has incorporated an “Other” box for many questions for patients to input information the team might not have considered yet.
- A TEP member via the chat suggested mailing paper copies of the survey or providing a printed copy when a patient leaves their visit.
- A TEP member stated the survey should be sent as quickly as possible to patients, but it can take a couple of months for patients to follow up on their clinician's recommendations. Although there is a question that addresses barriers in the survey, patients may not have realized that they encountered any barriers until some time has passed. For this reason, patients may not be able to accurately answer certain questions shortly after their visit.
 - Dr. Vivian Vigliotti shared that when first considering the window to send the survey out, CORE considered the average time between when the recommendation was made and the actual screening appointment. The survey could then be distributed during that but acknowledged that the time between the initial appointment and the screening could take weeks or even months.
- A TEP member recommended reframing the questions concerning barriers as an opportunity for providers to support patients. For example, if physicians

discussed how to meet transportation barriers, it could be helpful to learn about that conversation.

- Dr. Vivian Vigliotti shared that Question 7 focused on barriers has been revamped over the last couple of months and heard similar feedback from clinicians as well. CORE wants to ensure that survey questions are actionable items for clinicians to address. CORE welcomes feedback on how to continue to update that question to ensure it is actionable.
- A TEP member via the chat recommended including additional options or open-ended questions for patients to elaborate on barriers and on why they were now able to follow through with a recommendation.
 - Dr. Vivian Vigliotti confirmed that Question 7 has an “Other” box as an opportunity for patients to elaborate on barriers faced.
- A TEP member recommended splitting the question that asks about “planning,” “scheduling,” or “completed” cancer screening into separate questions for more clear interpretation of the response.
- A TEP member asked for an updated written copy of the survey.
 - Dr. Vivian Vigliotti confirmed that CORE will send an updated PDF copy of the full survey.
- A TEP member asked how the patients would receive the survey.
 - Dr. Vivian Vigliotti shared a survey vendor could distribute the survey through email and text to the patients within each clinical office.
 - The TEP member wondered about selection bias that may result from that approach, as vulnerable populations tend to respond to email or electronic outreach at lower rates; phone calls or paper surveys can be more effective among these populations.
- A TEP member noted that individuals living in rural areas and Native American populations also have difficulty accessing healthcare offices as well.
- A TEP member highlighted a discrepancy that the stool DNA test was not included as an option for colon cancer screening question 1.2.
 - Dr. Vivian Vigliotti shared that the recommendations for screening types and ages have been taken from the USPSTF and that any discrepancies will be resolved.
 - Another TEP member recommended using “stool-based testing” because patients may not know the difference between stool DNA and fecal immunochemical test.
- A TEP member asked about the formatting and language of Question 7 because it may be confusing for patients, specifically noting that patients may not know what they “wanted” to receive, and recommended separating it into two questions to ask about what the patient wanted first, but rephrasing the question to “I would have benefited from...”
 - Dr. Vivian Vigliotti shared that Question 7 has been iterated upon many times, including an early version like what the TEP member proposed. The current format of the question was updated after feedback from the PFE Working Group because they felt having two very similar questions was repetitive and confusing.

PFE Working Group members also highlighted that some of the answer choices were education because they did not know they could request such information. Based on the feedback CORE receives from pilot testing, the question may be revamped to include other actionable items or remove it moving forward.

- A TEP member commented that many shared decision-making tools used for other procedures or other patient-reported outcome data have become checkbox activities as opposed to informed consent reflecting a true partnership with a physician.
- Dr. Vivian Vigliotti thanked the TEP members for their thoughtful feedback.

Next Steps

- Ms. Mariel Thottam thanked the TEP members for the rich discussion during the call and provided information on the next steps for measure development. The development team will summarize TEP input and brief CMS, finalize the survey domains and survey questions, begin pilot testing in Fall 2022, send email updates on project progress before the next meeting, and schedule the next Clinician Committee meeting.
 - The next TEP meeting will be held via Zoom, likely in Fall or Winter 2022. At that time CORE will provide patient responses from pilot testing.
 - The team will circulate the summary report of this meeting for review by the TEP members. The names of individuals will not be included in the meeting summary report. The TEP summary report will be publicly posted upon CMS approval; after public posting, it will be okay for TEP members to share information discussed during the meeting. Information not publicly posted will be confidential.
- Ms. Mariel Thottam invited TEP members to submit additional comments on any aspect of measure development to cmsmipsscreeningpropm@yale.edu.
- The development team thanked TEP members on behalf of CORE and expressed appreciation for feedback that will help to clarify the measure.

Additional Feedback Received by Email

- One TEP member provided feedback by email prior to the meeting.
 - The TEP member expressed concern about including patients up to age 85 as some older patients may have already decided to cease screening, so further counseling may not be reasonable.
 - CORE noted that the first pilot will broadly include patients up to age 85 but this may not be the final measure specification.
 - The TEP member asked if the survey would be tied to annual wellness visits (which might increase the yield of screening discussions) or any routine follow-up visits.
 - CORE confirmed the plan to tie the survey to annual wellness visits.
 - The TEP member noted that the benefits of screening do not universally outweigh the harms for all patients, particularly for older adults with shorter life expectancy or competing health priorities. They requested CORE make the wording of some questions more neutral so as not to assume screening is appropriate. They also requested CORE add a question if the clinician discussed both benefits and harms of screening to assess if patients understand the

downstream consequences of screening, which is key to making informed decisions.

- CORE acknowledged this feedback, agreed the survey should not presume what screening decision is appropriate, and confirmed intent to consider these specific components when refining the survey.
- One TEP member reached out by email after the meeting to ask if CORE would consider adding a question to ask if a clinician provided a written patient decision aid addressing relative risks and benefits that may be used during the screening conversation.
 - CORE acknowledged this feedback and confirmed that we are refining the survey to incorporate more specific aspects of shared decision-making into the survey. CORE will also conduct cognitive interviewing of patients surveyed in the first pilot and will ask about aspects of the decision-making process, including the use of written aids.
- One TEP member reached out by email after the meeting to ask if the pilot survey question asking if the survey was completed by the patient or a caregiver could be expanded to ask if someone “other” than a caregiver assisted the patient.
 - CORE acknowledged this feedback and will consider it when refining the survey.