SUPPORTING STATEMENT

Part A

AHRQ's National Nursing Home COVID-19 Coordinating Center

Version: February 10, 2022

Agency for Healthcare Research and Quality (AHRQ)

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A. Justification

1. Circumstances that make the collection of information necessary

The mission of the Agency for Healthcare Research and Quality (AHRQ) set out in its authorizing legislation, The Healthcare Research and Quality Act of 1999, is to enhance the quality, appropriateness, and effectiveness of health services, and access to such services, through the establishment of a broad base of scientific research and through the promotion of improvements in clinical and health systems practices, including the prevention of diseases and other health conditions.[1] AHRQ shall promote health care quality improvement by conducting and supporting:

1. Research that develops and presents scientific evidence regarding all aspects of health care;
2. The synthesis and dissemination of available scientific evidence for use by patients, consumers, practitioners, providers, purchasers, policy makers, and educators; and
3. Initiatives to advance private and public efforts to improve health care quality.

Background for this Collection

As of February 3, 2022, nursing homes have reported 902,964 confirmed cases of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and coronavirus disease since 2019 (COVID-19), resulting in over 147,000 COVID-19-related deaths.[2] The U.S. Department of Health and Human Services (HHS) has distributed funds to nursing homes and launched several initiatives to improve nursing home safety and infection control.[3] AHRQ's National Nursing Home COVID-19 Action Network (the Network) is a cornerstone of HHS's response, intended to provide training and assistance to nursing homes on best practices to minimize transmission of SARS-CoV-2.[4] The Network expands AHRQ's programmatic efforts to address quality and safety in long-term care,[5] and aligns with other agency efforts to provide COVID-19 guidance to nursing homes.[6] As the pandemic continues, nursing homes require easy access and implementation support for up-to-date best practices on SARS-CoV-2 infection control, COVID-19 care and management, and safety measures to protect residents and staff.

AHRQ's National Nursing Home COVID-19 Coordinating Center plays a critical, complementary role to the Network as a bridge between AHRQ's initiatives and the nursing home quality improvement (QI) community that: 1) engages scientific and policy stakeholders to identify safety needs and best practices, 2) ensures coordinated development and dissemination of QI tools and other resources, and 3) assesses the impact of the Network to inform the nation's COVID-19 response.

In March 2021, as part of the Coordinating Center activities, AHRQ sought to solicit the opinions and information from respondents (nursing home staff) who have experience with the Network's program and have already indicated that they have made a change (minor or major) in their facility as a result of participating in Network activities. This

customer satisfaction survey was designed to collect information related to how certain AHRQ ECHO National Nursing Home COVID-19 Action Network (the Network) participants experienced the trainings and what specific types of changes they made as a result of their participation.

The goals of this customer satisfaction survey were to understand the participant experience with the Network and the types of changes they have made as a result. The information collected was used for internal program management purposes in order to identify those topics which resonated with participants who reported making changes, the resources they found the most helpful, and the types of changes they reported as a result of their participation. The survey was emailed to 2,145 individuals from 1,683 nursing homes. Approximately 20% (429) of respondents completed the survey. The information gathered was not used as part of the program assessment (described below) and the questions proposed to be fielded as part of the primary data collection activities below are substantially different than those fielded as part of the customer satisfaction survey.

As part of the Coordinating Center activities, AHRQ seeks to conduct an assessment of whether and how the Network activities covered by the Provider Relief Funds (PRF) aided the nursing homes' efforts to mitigate the challenges posed by the COVID-19 pandemic. The goals of the performance assessment are to:

1. assess the reach, retention, and engagement of the Network;
2. study the implementation approach, gaps and barriers;
3. determine the long-term impact, sustainability, and replicability of the training program and Network activities.

Nursing homes participating in the Network are submitting data that will be used to assess the Network's reach and retention, extent and duration of participation in the Network, participants' perceptions on whether the disseminated knowledge is actionable, and the nursing homes' knowledge and resource gaps. This required secondary data is listed in Attachment B. Secondary data will include:

- Data on the Network's training centers, cohorts, and sessions, and topics covered
- Nursing home eligibility, level of participation, and duration of participation
- Session attendees and their feedback on the sessions

To further achieve the goals of this performance assessment, AHRQ is requesting OMB approval for new data collection. More specifically, the new data collection activities intend to collect systematic information from nursing homes on the following:

- Motivations for participation and non-participation in the Network
- Context of participation (including state and local context, and participation in other COVID-19 related-initiatives)
- Perceptions on recruitment, engagement, and retention, including facilitators and barriers of engagement and retention
- Perceptions on the Network training and mentorship resources, including access to and utility of the Network training and resources
- Gaps in knowledge, skills, and resources required for identifying residents and staff infected with COVID-19

- Impacts on the prevention and spread of SARS-COV2, implementation of best practice safety measures; improvement of quality of care for residents with mild and asymptomatic cases; and reduction of social isolation for residents, families, and staff

The primary data collection includes the following activities:

1) **Survey** of all participating nursing homes (approximately 8,308) and a 50% representative sample of nonparticipating nursing homes (approximately 2,782) eligible for the Provider Relief Fund. Separate survey instruments will be used for network participants ("Participant Survey" and non-participants ("Non-Participant Survey"). The Participant Survey will be conducted primarily via a secure web-based platform. The Non-Participant Survey will be conducted via web and telephone. (See Supporting Statement B for an explanation of nursing home stratification and selection to ensure a representative survey response). The survey instruments can be found in Attachment B.

2) **Key informant interviews** with up to 96 individuals from 32 nursing homes participating in the Network across all assessment domains, conducted virtually on a secure platform (see Supporting Statement B for explanation of nursing home stratification and selection). The participants will be interviewed using the attached protocol (see Attachment E)

This performance assessment is being conducted by AHRQ through its Coordinating Center contractor, NORC at the University of Chicago (NORC), pursuant to AHRQ's statutory authority to conduct and support training and technical assistance on healthcare and on systems for the delivery of such care, including activities with respect to the quality, effectiveness, efficiency, appropriateness and value of healthcare services and with respect to quality measurement and improvement. 42 U.S.C. 299a (a) (7).

2. Purpose and Use of Information

This assessment seeks to answer the following questions about the Network through primary data collection:

1) How effective was the Network's recruitment and retention efforts in achieving the participation goals? Was the Network effective at recruiting nursing homes that serve vulnerable populations?
2) What efforts, if any, were made to tailor the recruitment efforts to nursing homes located in or serving vulnerable populations [(1) located in areas with high COVID prevalence; (2) located in rural areas; (3) with a disproportionate share of racial/ethnic minorities; (4) with a disproportionate share of residents with high needs; (5) that were small or independently operated; and (6) located in economically disadvantaged areas?
3) What were the barriers to participation for non-participating nursing homes?
4) To what extent did the nursing homes connect with other nursing homes in their community?

5) What were the results of any efforts the Network took to support nursing homes with the following: reducing social isolation for residents, families, and staff; implementing best practice safety measures; and improving quality of care for residents with mild and asymptomatic cases?
6) Did the training and mentorship help nursing homes have impacts on the following: preventing and reducing transmission of infections; implementing best practice safety measures (use of protective equipment; robust testing and screening practices); and improving the quality of care for residents with mild and asymptomatic cases? How? Did this vary by context (community prevalence of COVID; population density; and socio-demographic factors of the community); structure (nursing characteristics, such as size, ownership, quality and patient safety history; and case mix); and extent of participation in the Network?
7) How well and what value did the Network bring to reducing isolation of nursing homes and nursing home staff?
8) Were there any unintended/spillover effects on staffing and resources, as well as prevalence of influenza or other acute respiratory illnesses for nursing homes because of participating in the Network?
9) How applicable is the learning collaborative model for addressing other patient safety priorities?

Information collected will inform whether and how the activities funded by the PRF aided the nursing homes' efforts to mitigate the challenges posed by the COVID-19 pandemic. This data collection effort will also provide information on why nursing homes may not have been able to participate in the Network and why (Non-Participant Survey). Findings from the assessment will allow AHRQ to:

- Assess the Network's reach and the effectiveness of the retention and engagement strategies;
- Study implementation of the Network's training sessions, mentorship and technical assistance activities, and dissemination of the safety and quality improvement tools;
- Assess the Network's impact on ensuring availability of protective equipment, rapid identification of nursing home residents and staff infected with COV-2, entry and transmission of COVID-19, and improving health outcomes; and
- Determine the long-term impact, sustainability, and replicability of the training program and Network activities to address other patient safety and quality improvement priorities.

The data collection described below and analyses of secondary data will support these assessment goals. The assessment team will use a survey of all PRF-eligible nursing homes and key informant interviews to gather information about the Network from key stakeholders.

Survey. AHRQ will conduct a nationwide survey of all PRF-eligible nursing homes based in the 50 U.S. states, the District of Columbia, and one U.S. territory (Puerto Rico). The nursing homes include both Network and non-Network participants, with customized questionnaires for facilities that participated in the Network and those that did not. The survey will assess the following:

- Motivations for participation
- Perceptions on recruitment, engagement, and retention
- Perceptions on the implementation of the Network's training and mentorship resources
- Perceptions of the training and mentorship resources to address the prevention and spread of SARS-COV2, implementation of best practice safety measures; improvement of quality of care for residents with mild and asymptomatic cases; and reduction of social isolation for residents, families, and staff

The primary topics covered in the survey is shown in Exhibit 1.

Assessment Survey Topics
▪ Motivations for participation
▪ Perceptions on recruitment
▪ Facilitators and barriers to engagement and retention
▪ Perceptions and utility of training session topics
▪ Perceptions on the implementation of the Network
▪ Access to and utility of the Network's training and mentorship resources
▪ Participation in other COVID-19 related-initiatives and quality improvement efforts
▪ Investments and changes made as a result of participation
▪ Likelihood of making permanent changes to patient safety procedures, infection control protocols, and quality improvement activities

The survey instruments can be found in Attachment B.

Collection of this information addresses all three goals of the performance assessment by providing insight into the reach, retention, and engagement of the Network; the implementation approach, gaps and barriers; and both short and long-term impacts of Network participation.

Data will be collected from a senior nursing home leadership team member on behalf of their facility. We will target the following job titles within each nursing home to serve as survey respondents on behalf of their facility:

- Executive Director/Administrator
- Medical Director
- Director of Nursing/Nursing Supervisor
- Department Head
- Unit Manager/Charge Nurse
- Assistant Director/Assistant Manager
- Minimum Data Set (MDS) Coordinator/ Resident Nurse Assessment Coordinator (RNAC)

Key Informant Interviews. The assessment team will conduct semi-structured interviews with up to three Network participants per nursing home. The interviews will assess the following:

- Motivations for participation in the Network
- Context of participation (including state and local context, and participation in other COVID-19 related-initiatives)

- Perceptions on recruitment, engagement, and retention, including facilitators and barriers of engagement and retention
- Facility's experience of participation in the Network training and activities, including access to and utility of the Network training and resources
- Gaps in knowledge, skills, and resources required for identifying residents and staff infected with COVID-19
- Impacts on patient safety procedures, infection control protocols, quality improvement activities, vaccine rollout, capacity to obtain protective equipment, and capacity to obtain testing resources

Collection of this information addresses all three goals of the performance assessment by providing insight into the reach, retention, and engagement of the Network; the implementation approach, gaps and barriers; and both short and long-term impacts of Network participation.

The interviews will be conducted with respondents on a virtual web platform. Key informants represent the following general groups:

- Leadership: Includes Administrators, Executive Directors, Directors of Health Services, Directors of Nursing, Assistant Directors of Nursing, Directors of Staff Development, Medical Directors, and Quality Assurance and Performance Improvement (QAPI) Specialists
- Staff: Includes Registered Nurses (RNs), Licensed Practical Nurses or Licensed Vocational Nurses (LPNs/LVNs), Certified Nursing Assistants (CNAs), Infection Preventionists, Social Workers, Activities Directors, Human Resources, Dietary Managers, and Housekeeping Supervisors

AHRQ and NORC will create a list of eligible key informants that reflect the appropriate mix of roles and depth of experience to ensure a comprehensive assessment.

The primary topics covered in the interviews are shown in Exhibit 2.

Exhibit 2. Assessment topics

Assessment Topics
▪ Facility's experience with managing the COVID-19 pandemic, including state and local context ▪ Participation in other COVID-19 related-initiatives ▪ Recruitment into the Network ▪ Motivation for participation ▪ Facility's experience of participation in the Network training and activities ▪ Interactions with affiliated Training Center ▪ Access to and utility of Network's training and mentorship resources ▪ Interactions with other nursing homes within the same cohort ▪ Changes made as a result of participation ▪ Facilitators and barriers to engagement ▪ Impacts on patient safety procedures, infection control protocols, and quality improvement activities, vaccine rollout, capacity to obtain protective equipment, and capacity to obtain testing resources ▪ Gaps in knowledge, skills, and resources required for identifying residents and staff infected with COVID-19

The key informant interview guides for Nursing Homes are contained in Attachment E.

3. Use of Improved Information Technology

Survey. In order to minimize respondent burden and to permit the electronic submission of survey responses, the Participant Survey will be deployed using a low burden and respondent-friendly web-based self-administered questionnaire (sometimes called computer-assisted web interview or CAWI). CAWI technology minimizes respondent burden by 1) automatically providing text fills within questions and handling skip patterns based on responses to each question; 2) allowing respondents to complete the survey at a convenient time; 3) allowing respondents to stop and re-enter the survey if needed; and 4) capturing data in real-time, thereby eliminating the need for manual data entry.

Given the low anticipated burden of the Non-Participant Survey (about 5 minutes in duration), this survey will also be deployed as a telephone survey using computer-assisted telephone interviewing (CATI) technology. The survey will be administered by trained telephone interviewers employed by NORC. Similar to CAWI technology, CATI technology helps minimize respondent burden with built-in functionality that moves through skip patterns seamlessly to increase efficiency. CATI tailors the sequence of the questions based on the answers of the respondent, resulting in few – if any – skip errors, and automatically provides text fills within questions based on responses to each question. Data collected via CAWI and CATI are also automatically stored electronically, eliminating the need for manual data entry.

Initial invitations to complete the survey will be sent via mail and email (when email addresses are available). For the Participant Survey, respondents who do not complete the self-administered web survey will receive follow-up prompts via email and/or mail. Mail prompts will also include a self-administered paper questionnaire (SAQ) that respondents can choose to complete and send back in a pre-paid envelope. Non-

respondents will then be prompted (using trained interviewers) via telephone to complete the web survey, and will be offered the option to complete the survey via telephone if preferred by the respondent. For the Non-Participant Survey, respondents who do not complete the self-administered web survey or the telephone survey will also be prompted via email and/or mail.

Key Informant Interviews. The key informant interviews will be semi-structured interviews conducted on a virtual web-platform with study respondents. Up to three respondents can participate in the interview at one time, allowing for both individual and group interviews. Because most interview questions are open-ended to allow for in-depth exploration of issues, electronic submission of responses is not a viable option.

4. Efforts to Identify Duplication

This is the first assessment of the Network. The Network may have generated internal reports, which will be used as a source of material for this assessment. About 1,500 nursing homes that are being targeted by other federal data collection efforts will also be excluded from the survey frame to minimize respondent burden.

5. Involvement of Small Entities

The information collected may involve small entities, as some of the nursing homes may qualify as such. For this project, only items that provide critical information for conducting the assessment will be included, and the information being requested has been held to the absolute minimum required for the intended use.

6. Consequences if Information Collected Less Frequently

This is a one-time collection.

7. Special Circumstances

This request is consistent with the general information collection guidelines of 5 CFR 1320.5(d)(2). No special circumstances apply.

8. Federal Register Notice and Outside Consultations

8.a. Federal Register Notice

In accordance with the Paperwork Reduction Act of 1995 (Pub. L. 104-13) and Office of Management and Budget (OMB) regulations at 5 CFR Part 1320 (60 FR 44978, August 29, 1995), AHRQ published a notice in the Federal Register announcing the agency's intention to request an OMB review of this information collection activity. This notice was published on December 8, 2021, Volume 86, Number 233, page 69649, and provided a sixty-day period for public comment. A copy of this notice is attached as Attachment F. During the notice and comment period, the government received no requests for information or substantive comments.

8.b. Outside Consultations

AHRQ has and will continue to engage experts and key stakeholders for the Network initiative and assessment. AHRQ and NORC, AHRQ's Coordinating Center contractor,

are consulting with the following experts in nursing home quality and patient safety to design the assessment:

- Lilly Engineer, MD, DrPH, The Johns Hopkins University School of Medicine
- Brad Winters, MD, PhD, The Johns Hopkins University School of Medicine
- Tamara Konetzka, PhD, University of Chicago
- Robin Jump, MD, PhD. Case Western Reserve University

In addition, AHRQ meets monthly with a variety of stakeholders to inform the Network, including:

- **Nursing Home Industry and Professional Groups:** National professional nursing home associations, trade organizations, and professional organizations.
  - *Purpose:* To exchange information about Network activities; to stay abreast of state, regional, and commercial/private COVID-related initiatives and industry resource or training needs; and to identify or develop mechanisms for broad dissemination of the Network's tools and resources.
- **Technical Expert Panel:** Scientific experts in infection control, COVID-19, quality improvement, nursing home management and financing.
  - *Purpose*: To exchange information about Network activities, gather feedback on new materials or documents developed by the NHCCC, and provide information on evidence-based practices related to infection control.
- **Group C: Federal Partner Workgroup:** Representatives of federal agencies working on issues related to COVID-19 in nursing homes
  - *Purpose*: To facilitate the exchange of information about Network activities, as well as news and information on activities that federal agencies are undertaking to address COVID-19 in nursing homes.

These groups will provide input on the topics for the interview guides and interpretation of secondary data analysis, as needed.

9. Payments/Gifts to Respondents

There will be no remuneration to respondents.

10. Assurance of Confidentiality

For the survey respondents and all key informant interviews, individuals and organizations will be assured of the confidentiality of their replies under Section 934(c) of the Public Health Service Act, 42 USC 299c-3(c). They will be told the purposes for which the information is collected and that, in accordance with this statute, any identifiable information about them will not be used or disclosed for any other purpose without their prior consent.

Key informant interviews. During the key informant interviews, NORC will collect the respondent's name, phone number, organizational affiliation, and title for case tracking purposes or for clarification call backs. They will not collect any other information about either the respondent or any individual in the establishment, outside of their role at the nursing home. All electronic files will be password protected and accessible only from a secured network. When not in use by project staff, all printed information or materials

that could potentially identify participants in the assessment will be stored in locked cabinets that are accessible only to project team members.

All respondent involvement will be voluntary. Verbal consent for participation will be obtained from respondents. Respondents will be informed that: (1) copies of the interview notes will not be shared with anyone outside of the team; (2) respondent comments may be included in reports and publications but will not be attributed to specific individuals or organizations; and (3) the interviewers have a system to mark specific comments in interview notes as off-limits for reports and publications when notified to do so by the respondent.

All data will be collected by AHRQ's Coordinating Center contractor, NORC, and will be stored on NORC's secure servers.

11. Questions of a Sensitive Nature

No questions of a sensitive nature will be asked through the survey or interviews. Further, during the introduction to the interview, respondents will be informed that their participation is voluntary and that they can refuse to answer any question.

12. Estimates of Annualized Burden Hours and Costs

Survey. The nursing home survey will have two survey instruments:

-**Participant Survey** for nursing home facilities that participated in the Network
-**Non-Participant Survey** for nursing homes that did not participate in the Network

For the Participant Survey we expect that 1,662 participants (20% response rate) will agree to participate on behalf of their facilities and that the survey will take about 20 minutes to complete. For the Non-Participant Survey, we expect that 556 participants will agree to participate (20% response rate) on behalf of their facilities and that the survey will take about 5 minutes to complete. This estimate is based on prior provider survey experience and the response rate for the Customer Satisfaction survey which was approximately 20%.

Key Informant Interviews. Key informant interviews will be conducted with up to 32 nursing homes (up to 96 staff) involved in the Network. We will use one protocol (see Exhibit 6). Attachment C includes the interview recruitment materials and thank you e-mail template, and Attachment D includes the information sheets. Attachments E includes the interview protocol. All interviews are expected to last 60 minutes, including time for respondents to provide verbal consent for participation and ask any questions at the start.

The total annual burden hours for the survey and key informant interviews are estimated to be 688 hours, as shown in Exhibit 3.

Exhibit 3. Estimated Annualized Burden Hours

Form Name	Number of respondents*	Hours per response	Total burden hours
Attachment B: Survey instrument - participant	1,662	.33	548
Attachment B: Survey instrument - nonparticipant	556	.08	44
Attachment E: Nursing Home Key Informant Interview	96	1	96
Total	2,314		688

* The number of respondents per data collection effort is calculated by dividing the expected number of respondents by three to capture an annualized number.

Exhibit 4 shows the estimated annual cost burden associated with the respondents' time to participate in this information collection, which comes to $41,837.28

Exhibit 4. Estimated Annualized Cost Burden

Form name	Number of respondents	Total burden hours	Average hourly wage rate**	Total cost burden
Attachment B: Survey instrument - participant	1,662	548	$60.81[1]	$33,323.88
Attachment B: Survey instrument - nonparticipant	556	44	$60.81[1]	$2,675.64
Attachment E: Nursing Home Key Informant Interview (Management)	96	96	$60.81[1]	5,837.76
Total	2,314	688		$41,837.28

**Wage rates were calculated using the mean hourly wage from the U.S. Department of Labor, Bureau of Labor Statistics, May 2020 National Occupational Employment and Wage Estimates for the United States, https://www.bls.gov/oes/current/oes_nat.htm

[1] Average rate for Nursing Care Facilities: Management Occupations

13. Estimates of Annualized Respondent Capital and Maintenance Costs

There are no direct costs to respondents other than their time to participate in the interview.

14. Estimates of Total and Annualized Cost to the Government

The estimated total cost to the Federal Government for developing, programming, and administering the nursing home surveys, developing the key informant interview guides, key informant data collection, and conducting the analysis is $810,101. Exhibit 7a provides a breakdown of the estimated total and average annual costs by category.

Exhibit 7a. Estimated Total and Annualized Cost

Cost Component	Total Cost	Annualized Cost
Conduct survey and follow-up and analyze results	$725,000	$725,000
Development of Assessment Plan and Key Informant Interview Guides	$21,275	$21,275
Conduct Key Informant Interviews and Analyze Results	$63,826	$63,826
Total	$810,101	$810,101

The estimated annual cost for AHRQ oversight of the assessment is shown in Exhibit 7b.

Exhibit 7b. Federal Government Personnel Cost

Activity	Federal Personnel	Annual Salary	% of Time	Cost
Project oversight to include data collection oversight and review of results	Project Officer (GS-14)	$ 143,064	10	$14,306
Project oversight to include data collection oversight and review of results	Technical Lead (GS-15)	$176,300	10	$17,630
Review of agreements and compliance	Program Manager (GS-14)	$ 143,064	5	$14,306
Total				**$46,242**

Annual salaries based on 2022 OPM Pay Schedule for Washington/DC area: https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/salary-tables/22Tables/html/DCB.aspx

15. Changes in Hour Burden

This is a new collection of information.

16. Time Schedule, Publication and Analysis Plans

Time schedule and publication plans. The anticipated schedule for this project is shown in Exhibit 8. Once clearance from the Office of Management and Budget is obtained, AHRQ's Coordinating Center contractor, NORC, will begin outreach to respondents to complete the survey, as well as identifying appropriate respondents for the key informant interviews and scheduling and conducting interviews.

Results of assessment will be made available through reports from coordinating center, ad-hoc requests from the department, and presentations to the department and summary data/results may be presented on AHRQ's website, in national conferences, publications in peer-reviewed journal articles and white papers.

Exhibit 8. Anticipated Schedule

Activity	Length	Estimated timeline following OMB clearance
Conduct Survey and Analyze Survey results		

Conduct survey and follow-ups	16 weeks	Month 1-4
Analyze survey results	8 weeks	Months 3-4
Conduct and Analyze Key Informant Interviews		
Interview nursing home leadership and staff	8 weeks	Month 1-2
Qualitative data analysis of key informant interviews	8 weeks	Months 3-4
Performance Assessment Report	20 weeks	Months 5-9

Analysis plans.

Survey. The assessment will employ post-stratification weighting procedures, such as raking to produce survey weights. The analysis will utilize appropriate survey analysis specifications and the survey weights to produce estimates that are representative of the target population and subpopulations. Analyses will include survey-weighted univariate and bivariate analysis to assess implementation and employ appropriate statistical tests to assess difference in responses across subpopulations.

Key informant interviews. The assessment team will systematically code transcripts of interviews to identify factors that contribute to reach, retention, and engagement with the Network; implementation approach, gaps and barriers; and impacts as a result of participation.

Codes will also correspond to concepts identified from document review of information provided by the Network. Once documents are examined, we will meet to review excerpts and establish agreement in coding. Emergent codes will be considered to respond to unanticipated patterns among responses, and emergent codes will be added if the prevalence of these themes merit their inclusion. The team will then develop a codebook of existing (from the interview guide) and emergent (from responses) themes.

In order to establish strong inter-rater reliability and test the reliability of the codebook, two coders will independently code one-third of the interview notes for each type of interview data. Codes will also correspond to concepts identified from document review of information provided by the Network. Discrepancies will be discussed and resolved by the data analysis team and the codebooks will be revised as necessary. The analysis team will seek to achieve a kappa of >.60.[7] Once inter-rater reliability has been established to the satisfaction of the data analysis team, the remaining transcripts will be coded by one coder. To ensure quality control, however, a small random sample of the remaining transcripts (e.g. 10%) will be coded by two coders and the responses compared. Once coded, we will tabulate the data using Dedoose software to identify important themes, patterns, and illustrative quotes both within and across qualitative data sources. We will also analyze the themes that are identified

Coded data will be used to develop narratives that answer the assessment questions. Analysis of findings within codes will reveal similarities and differences in the perspectives of key informants, as well as the range of opinions and experiences on a given topic. Analysis of the relationship between codes or among a combination of codes

will examine the interrelationship between themes or concepts. Comparative case analysis will also be used to help understand differences across the nursing homes participating in the Network, and to supplement the quantitative findings on variability in outcomes.

17. Exemption for Display of Expiration Date

AHRQ does not seek this exemption.

List of Attachments:

Attachment A: Survey Recruitment Materials
Attachment B: Survey Instrument
Attachment C: Key Informant Interview Recruitment Materials
Attachment D: Key Informant Interview Information Sheet
Attachment E: Key Informant Interview Guide
Attachment F: Federal Register Notice

References

[1] Agency for Healthcare Research and Quality. Healthcare Research and Quality Act of 1999. January 6, 1999. Accessed February 8, 2021. https://www.ahrq.gov/policymakers/hrqa99a.html

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[4] Agency for Healthcare Research and Quality. AHRQ ECHO National Nursing Home COVID-19 Action Network. October 2020. Accessed November 18, 2020. https://www.ahrq.gov/nursing-home/index.html

[5] Agency for Healthcare Research and Quality. AHRQ's Quality & Patient Safety Programs by Setting: Long-Term Care. October 2019. Accessed November 18, 2020. https://www.ahrq.gov/patient-safety/settings/long-term-care/index.html

[6] Centers for Medicare and Medicaid Services. Current Emergencies. November 18, 2020. Accessed November 18, 2020. https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

[7] Mchugh ML. Interrater reliability: the kappa statistic. Biochemia Medica. 2012:276-282. doi:10.11613/bm.2012.031