NATIONAL QUALITY FORUM

Moderator: EENT Group
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OPERATOR: This is Conference #: 83519483

Welcome everyone. The conference is about to begin. Please note today's call is being recorded. Please stand by.

Shaconna Gorham: Hello, everyone. This is Shaconna Gorham from NQF. I'm here with my colleagues, Reva Winkle, and we also have Amaru Sanchez assisting us today. We like to welcome you to the Eye Care and Ear, Nose, and Throat Conditions Standing Committee Call Workgroup #2.

We have several committee members on the call. Daniel, are you on the call?

Daniel Merenstein: I am.

Shaconna Gorham: All right. So just if you all can just give a quick hello when I call your name. Jackie?

Jacquelyn Youde: I'm here. Thank you.

Shaconna Gorham: Tamala?

Tamala Bradham: Hi.

Shaconna Gorham: Judith?

Judith Lynch: Hi.

Shaconna Gorham: And then we have our measure developers from NQCA, Benjamin Hamlin.

Female: No, NCQA.

Benjamin Hamlin: This is Benjamin from NCQA.

Shaconna Gorham: NCQA. I am sorry. (Jen), are you on the call? No, OK. We also have CDC and the Office of (inaudible), I have (John). And then we have (Sedong) on the call.

(Sedong): Yes, I'm here.

Shaconna Gorham: All right. So everyone welcome to the call today. And I will turn it over to Reva.

Reva Winkler: Great. Welcome, everybody, and thank you for joining us. The purpose of this workgroup call is really twofold. And this is a new committee who is learning the NQF evaluation criteria and process. And we do have measures in two different topic areas so we've split it into four workgroups for ease of evaluation.

So, today, as we go through the four measures on our agenda, what we want to do is be sure that the committee members are clear and comfortable on the criteria and the information that's been provided by the developers to evaluate the measures, and provides an opportunity for any questions. So I'm just going to lead you through each measure through the criteria with sort of the standard question of whether you're understanding what's going – you know, the criteria and the information provided on the measure.

And everyone should feel very free to ask questions on Monday's call with the first workgroup. The committee did ask the developers a large number of questions, and they felt very – they were very happy to have had that opportunity. So this is truly in a session to get everybody up to speed before our in-person meeting in June.

So, are there any questions from anybody from the workgroup and developers before we get started?

Daniel Merenstein: Is there a way to see the surveys we submitted online?

Reva Winkler: Yes, you will – if you go to the SharePoint document, we have embedded the comments into those worksheets that you were working off of. So we are trying to keep all the inputs into those worksheets.

Daniel Merenstein: So the one at the …

Reva Winkler: And we will be…

Daniel Merenstein: OK. I get it now. So the one I saved before, I should save it again because now there's new embedded comments?

Reva Winkler: There's new information. We're also going to be showing that on the webinar, too, but yes that we have been updating those documents as the inputs come in.

Daniel Merenstein: OK.

Reva Winkler: So – OK, so we'll get started with our first measure, and this is Measure 2. As you can see it, it's one of your list measures in NQF. It's appropriate testing for children with pharyngitis. The percentage of children to the 18 years of age were diagnosed with pharyngitis dispensed an antibiotic and received a Group A strep test for the episode. A higher rate represents better performance.

This is a process measure, the data sources' administrative claims with electronic clinical data from laboratory and pharmacy. And the level of analysis is at the health plan or integrated delivery system.

So the first criteria that we look at, Importance to Measurement Report, has two sub-criteria. The first one being evidence. And so, this is a process measure. And so, we are looking for the result of a systematic review of the body of evidence that demonstrates a relationship between the process of care being measured and patient outcomes.

So we'll start off with Dr. Merenstein, Daniel. And, Jackie, you also were a discussant for this. So, Dan, maybe you can start and give us your thoughts on evidence or any questions you have about the criteria.

Daniel Merenstein: I saw – I hope I'm doing this right (as I've done this). But I think the evidence is pretty clear. I think the evidence is strong. The recommendation, as you see right there, was high. Yes, I'm not sure what else to add for that.

Reva Winkler: Yes. I mean – so, Jackie?

Jacquelyn Youde: I'm here.

Reva Winkler: OK. Any additional thoughts on evidence?

Jacquelyn Youde: No, it looks pretty clear.

Reva Winkler: Yes. And again, based on guidelines, and these guidelines do describe level of evidence at either high or a B from ACC. Many measures are based on clinical practice guidelines. And as long as we have a good sense of the evidence underlying them, that usually suffices. So any questions about evidence from any of the other workgroup members about what we're talking about or the criteria? And so, you'd have a pretty good …

(Crosstalk)

Tamala Bradham: … satisfied.

Reva Winkler: OK. You have a good sense of how you would rate it when we get to the inter-person meeting. OK. All right.

So, the next one, Dan and Jackie, your thoughts on opportunity for improvement and any information on disparities?

Jacquelyn Youde: Hey, Reva, would you tell me what document title you're working off of? I want to make sure I'm using the correct one.

Reva Winkler: We're working off a measure worksheet.

Jacquelyn Youde: OK. I just downloaded it and I was looking for the part where it has comments, but I guess I didn't see it.

Reva Winkler: There is a – at the end of each section in pink, if you will.

Jacquelyn Youde: OK …

(Crosstalk)

Daniel Merenstein: So our comments are in pink you said?

Reva Winkler: Yes.

Daniel Merenstein: All right.

Shaconna Gorham: So as the …

(Crosstalk)

Reva Winkler: Can you see them?

(Crosstalk)

Shaconna Gorham: … following the webinar, then on the screen share right now the comments are highlighted pink in the pink box.

Jacquelyn Youde: Thank you so much. I appreciate it

Reva Winkler: No problem.

Daniel Merenstein: So what was your question again?

Reva Winkler: OK. So we were just looking at the information around Criteria 1B, gap and care, or opportunity for improvement as well as disparities.

Daniel Merenstein: So I think from my memory, I thought that there were some disparities in a sense that the Medicaid rates seemed very different, seemed to be lower (as I was reading it right) compared to the commercial rates. But besides that I don't remember any other disparities.

Reva Winkler: All right. Yes.

Jacquelyn Youde: I view it as the same way where the people with Medicaid insurance were tested less frequently than those with commercial insurance. And we're assuming that Medicaid represents disparities. There could be some there.

Reva Winkler: Sure. Does anybody have any thoughts on the fact that – I'm just looking of the 50th percentile as an example, is that over the three years of data presented, we're really not seeing a whole lot of change.

(Crosstalk)

Jacquelyn Youde: Yes, we're really not.

Daniel Merenstein: Why would you expect to see change?

Reva Winkler: Well, we'd hope to see improvement.

Daniel Merenstein: Yes. That's pretty high rate, right?

Reva Winkler: Well that's a good question. I'm going to – I'll bounce that question back to you all.

Daniel Merenstein: Yes. I don't know if you're going to get much higher than that. I don't know. I mean, I guess, there are people that do but …

Reva Winkler: OK.

Jacquelyn Youde: Well, I guess my question is what is the expectation. Is the expectation 100 percent?

Reva Winkler: I think I'll ask our developers. Ben, did you want to comment on that?

Benjamin Hamlin: I mean, no, the expectation is not that everyone gets to 100 percent, but I think the issue with its measure is well there is, I guess, I would call it incremental improvement, really the variation across the different percentiles is really what we're looking at. So we want to – while we are recognizing the high

performance, there's also a significant number of people who are, who need to catch up both in the commercial and in the Medicaid population, so.

(Crosstalk)

Tamala Bradham: Well, if anything, we've seen actually a decrease when you look at the 50th, the median or the mean from 2013 to 2014. This is Tammy. I mean …

(Crosstalk)

Tamala Bradham: … it's slight but …

(Crosstalk)

Benjamin Hamlin: Yes, I think that one of the things to remember, too, here is that this is the entire health plan population. So what this does not really get at is some of the more heterogenous effects of the smaller, you know, localities that maybe doing more significant improvement through small pilot program. The (end) here is plans and not patients. I should reinforce that back.

Reva Winkler: Ben, do you so any regional variations?

Benjamin Hamlin: I need to pull it up. I believe we do, yes.

Reva Winkler: OK.

Benjamin Hamlin: But we don't – the regions again are HHS regions, so they're big regions. So we lose a lot of the smaller market details.

Reva Winkler: OK. All right.

Tamala Bradham: And does it matter – when you're (seeing) it by plan, does it matter if it's like type of practice, like a community versus primary care doctor versus a …

(Crosstalk)

Benjamin Hamlin: Yes.

(Crosstalk)

Benjamin Hamlin: That's exactly the kind of data that we were not able to collect through HEDIS. We only get the plan level. So each plan reports their entire commercial product line to us as an aggregate rate. And so, we have, you know, 400 plans reporting those rates to us. But, you know, what we don't – unfortunately, we don't collect the data at a lower level when (inaudible) HEDIS reporting. So we're not able to discern (the effect of this) at – you know, between provider groups or groups between, you know, community settings …

Reva Winkler: OK.

Benjamin Hamlin: … which would be nice.

Daniel Merenstein: And so, can you just – maybe I don't understand the numbers. This is the percent they tested and were treated, right?

Benjamin Hamlin: Yes, at the plan level.

Daniel Merenstein: At the plan level.

Jacquelyn Youde: So the (N) is number of plans not number of patients? So like there's (260 plus) …

Benjamin Hamlin: Yes.

Jacquelyn Youde: … commercial plans – OK.

Benjamin Hamlin: Yes.

Daniel Merenstein: So, if you're not 100 percent, that means an antibiotic was given but you weren't tested?

Benjamin Hamlin: That's correct.

Daniel Merenstein: Yes. So that was the main problem I have with the whole criteria is that it doesn't ever mention a thing called a center criteria which is pretty well pushed in (family) medicine. That if you qualify for the center you should

just treat and not test. And I'm not sure – you know, if you do that you're never going to get a 100 percent. In fact the rates are higher than I would think.

Reva Winkler: Dan, it sounds like you are getting into the specifications of a measure which would be our next focus. So why don't we look at the measure specifications in terms of what gets counted and how credit is assigned.

Daniel Merenstein: That's fine with me.

Reva Winkler: OK. What are your thoughts on the specs?

Daniel Merenstein: Well, I wasn't sure I understood it. So if I understand it correctly now, I guess I do have some issues with it. Because it seems like a lot people are going to just treat without testing if they qualify with the center criteria.

Reva Winkler: Is that consistent with the guidelines?

Daniel Merenstein: So I don't know if it's consistent with the guideline. The idea (is same guideline). I have to look that up. But it's definitely consistent with recommendations. I think there's even a (Cochran) interview on it. I have to look. I think someone else on the phone probably knows that. No?

Reva Winkler: OK. So I mean let's take a look at – the numerator is that a group A strep test is performed within the seven day period from three days prior to the patient visit through three days after. So you're looking for the performance of a strep test in patients who had an outpatient or ED visit link to a dispensed antibiotic prescription. And I guess I'm looking for the – those of the numerators in children two to 18 who had a visit and were dispensed the antibiotic prior to the six months beginning measurement year. I guess one of the things I'm looking for is, is there a diagnosis criteria anywhere?

Daniel Merenstein: Well, the strep have to positive right?

Reva Winkler: I guess.

Daniel Merenstein: I thought that was implied. I assumed it was.

Reva Winkler: Perhaps Ben can …

(Crosstalk)

Benjamin Hamlin: Yes, that's implied because we don't – this is all through claims so we can actually look for the testing before we can actually look for the result.

Daniel Merenstein: So if that's implied then you're not going to be – the rates are probably higher than we want (to, to be honest). Right? Because a lot of these are negative.

Reva Winkler: OK. Any other questions on the specifications? Is everybody clear on what's being measured?

Jacquelyn Youde: I do have a question on the index episode start date. What do we mean by that? So I'm looking at the numerator statement that we just reviewed the – smaller version of it is Group A strep in the seven-day period from three days prior to the index episodes start date through three days after the index episodes start date. And I may have just missed it. But I'm not super clear on what index episode start date means.

Benjamin Hamlin: Yes. That's covered in a different section on the definitions. So the IESD is the earliest date during the intake period that meets a couple of different criteria. So they've got to – if they look for the dispensing of the prescription or the antibiotic during the time window, they've got to have a negative medication history prior to that date. And that they're also going to have some continuous enrollment in the plan criteria. So that's kind of – when you're doing a claims (scan), you have to look for those, all those meet that criteria to meet that definition.

Reva Winkler: OK. All right. Any other questions about the criteria or about the specifications?

OK. So looking at specifications is the first part of the reliability criteria. The reliability was tested. And in this particular case, they performed data element validity testing which is where they compared the administrative claim against the medical record which we don't see a lot of that so that's really rather

interesting. And so that data element validity testing will count for reliability. And so, whatever you rate it for validity, reliability will be the same.

So we can kind of continue down and look at that validity testing. They looked at five different plans, and the rate of agreement between the administrative data and the medical record data is presented.

So, Dan and Jackie, what are your thoughts on those results?

Daniel Merenstein: Are you showing us the results or – I don't see that.

Reva Winkler: Amaru, are you bringing – if you scroll down. There they are. He had it. Up, up, up.

(Off-mike)

Reva Winkler: OK. Yes, the agreement was around 86 percent ranging 82 to 91, you know. Sensitivity of the administrative data for accurately identifying the Group A strep was 85 percent.

Daniel Merenstein: Yes.

Reva Winkler: So false negative of 10 percents.

Daniel Merenstein: That's – I mean again I haven't done it before. But that seems like it's pretty good data to me.

Reva Winkler: Yes.

Daniel Merenstein: (Inaudible) a lot better.

Reva Winkler: Ben, how does this compare with some of the other administrative codes that you've looked at?

Benjamin Hamlin: It really depends on the type of diagnosis we're looking at.

Reva Winkler: Yes.

Benjamin Hamlin: You know, it's lower than some things like COPD and very specific populations. That it's higher than others that are little less well defined such as dementia, so.

Reva Winkler: OK. That's good. All right, so as we look at validity to rate with it we look at first the testing but other potential threats to validity. And one is exclusions are appropriate – are the exclusions appropriate? Are there groups that have been excluded that shouldn't be? Are they consistent with the evidence? Any thoughts, Dan and Jackie, on the exclusions? Or any questions about the criteria?

Daniel Merenstein: No, I thought the exclusion made a lot of sense.

Reva Winkler: OK.

Daniel Merenstein: Yes, I think there's no problem with that.

Reva Winkler: OK. Jackie, any comments?

Jacquelyn Youde: And I may have not spoken up earlier. But while I was looking at this, I was wondering, are we assuming – are we grouping all sore throat in the pharyngitis? Because when I was thinking about it, I was like, you know, sore throat can present in a number of different ways. You could have (inaudible). You can have just like cough. You could have something like that. So how do we know that we're, that it's pharyngitis, I guess? And perhaps I'm going down a wrong path here. But the exclusions made sense to me. But the inclusions were like how do we know that this is in fact pharyngitis?

Benjamin Hamlin: So we don't generally do (a pair) value sets. I don't know if you have the value sets handy, the value set list handy. I could probably …

(Off-mike)

Reva Winkler: They're in the document sets on your SharePoint document set guides. They have the value sets laid out.

Benjamin Hamlin: So we didn't include all the diagnoses that would count towards pharyngitis in a specific value except for this measure.

Daniel Merenstein: At the Excel files?

Benjamin Hamlin: Yes.

Jacquelyn Youde: OK.

Benjamin Hamlin: (Generally) (inaudible) Excel (inaudible) these days because they get fairly big …

Reva Winkler: Yes.

Benjamin Hamlin: … in some cases.

Reva Winkler: And that's why they have document sets. OK. Does that answer your question, Jackie?

Jacquelyn Youde: Yes. And I (inaudible) value set. I guess some of things that I was looking for was like nasopharyngitis and things like that. And (I am also not) as familiar with the (inaudible), but those are some things that just do stick out to me right away.

Benjamin Hamlin: I think you have to scroll down a little bit more to get to the diagnoses.

Jacquelyn Youde: Yes, like throat pain (784.1) to keep nasopharyngitis – all right.

Reva Winkler: OK?

Jacquelyn Youde: Awesome. Thank you.

Reva Winkler: Great.

(Crosstalk)

Reva Winkler: Part of the benefit – yes. Who is it?

Tamala Bradham: This is Tammy. And so, the list also includes not only the ICD-9 but the ICD-10s, too. I'm assuming that's what your JO3, et cetera.

Reva Winkler: So, OK right. OK. So that's important that everybody knows where all the information is. Good. All right, so we're OK with exclusions. This – it's a process measure, so it's not risk adjusted. And we've looked at this data before in terms of are there meaningful differences? I think you were talking about the range and variation when you looked at gap. So that it kind of applies here that this measure does provide a distribution results that can give us a sense of issues around quality. And then so it's only one data source. So that doesn't apply. And then in the missing data they talked about, they tell you how the data is managed in terms of missing data.

So are there any questions on the potential treats to validity that you would also factor into your rating for validity? And as I said your rating for validity would also apply to reliability on this particular case because of the data element validity testing. So …

Daniel Merenstein: And we give a grade, it's a number or how does that work?

Reva Winkler: It'll be high, medium, or low.

Daniel Merenstein: OK.

Reva Winkler: Or high, moderate, or low. Yes. We'll go over the actual – you'll see in the algorithms the rating scales. But they're typically high, moderate, or low.

Daniel Merenstein. OK.

Reva Winkler: OK. All righty. So moving down in the next criteria is feasibility. This is a measure that's been in use for quite a long time and it uses administrative claims. Does anybody have any comments about the validity, the feasibility criterion?

Tamala Bradham: This is Tammy, I do not.

Reva Winkler: OK. I mean …

Tamala Bradham: They've been doing that, so, yes.

Reva Winkler: … this one is pretty straightforward. They've been doing it. Yes.

Daniel Merenstein: Yes. This is probably the easiest, so.

Reva Winkler: Yes. OK. Then the last criterion is usability and use. And this is – it's really – there's a value judgment associated from different stakeholder perspectives. But, you know, is the measure publicly reported or used for some accountability purposes at – is it – has there been improvement over time? We talked a little bit about that. You know, is this useful from your stakeholder perspective? Is the information something that can be used to foster further quality improvement? So those are criteria under usability and use. And then any potential unintended consequences if you taught there was an issue there would come under this particular criteria. So, again, the rating for this will be high, moderate, or low.

Tamala Bradham: Can you – I have a question. Can you explain what the improvement means? Since there has been about an 8-percent-point improvement in commercial 12 percent, what improvement was measured there, that there are more people getting the strep A testing?

Reva Winkler: Yes. Ben, I think that's …

Benjamin Hamlin: Yes, we think that was tracking the rates over time. So that's a very generalized statement. But …

Tamala Bradham: And where did those differences come from, the 8-point improvement?

Benjamin Hamlin: Well, we – I think it should say 8 percent. I'm not sure why I did 12 percent points.

Reva Winkler: OK. I was just – I copied what was in the submission.

Benjamin Hamlin: Yes.

Reva Winkler: Ben, over what period of time was that?

Benjamin Hamlin: It's just – I think it's – this is – we're going into 10th year right now. So when we're tracking – you know, again, this is a very high level. So we're tracking that, that's the mean improvement. However, you know, what we have

instead maybe should is, is when we do track this by the percentiles, we tend to – we saw a much more even distribution across the percentile whereas we've, you know, seemed more plans that are either clustering around the mean or that is surpassing the mean. Whereas earlier, you know, (inaudible) in plan performance at a more local level.

Reva Winkler: Yes.

Benjamin Hamlin: But nationally, we see, you know, just like I said, a small improvement because the mean to shift, you know, slightly as plans do better in different regions there in different, you know, in different areas, markets.

Reva Winkler: Yes. Ben, some of that information I think would be useful. I know this week at the CSAC meeting on some long-standing measure, they were looking – you know, hoping to see some data a little more granular than the national level to kind of really understand what the impact and effectiveness of the measure is. So some of the …

(Crosstalk)

Benjamin Hamlin: … I know for the last two or three years we have in our data warehouse. I can see if I can get a regional export …

(Crosstalk)

Reva Winkler: Yes, something like that would be helpful.

Benjamin Hamlin: Yes.

Tamala Bradham: And this is Tammy.

(Crosstalk)

Reva Winkler: … appreciate it.

Tamala Bradham: And this is Tammy. And anything else that you could show how this measure is being used to impact improvement I think would be helpful. So whatever data or story that – I just – I feel like I need a little bit more information there.

Benjamin Hamlin: Yes. We actually published – we published these results. We don't do any data collection about specific effectiveness of these results at the plan level. So we don't actually go back and ask the plans for their perspectives other than the plans to provide submissions through our policy clarification support when they ask questions about the measure. But I don't have – unfortunately, I don't have any of the success stories or the other kind of things where these measures specifically driven improvement in a pilot project or in a specific region.

Reva Winkler: OK.

Jacquelyn Youde: And I'm going to second what Tammy is saying, you know, and I know that we only have so much information. But if the measure is aiming for appropriate testing for children with pharyngitis and what we were talking about earlier is that, you know, some providers are just going to give the antibiotic anyway. I'm also curious about what's the rate, I guess, you will, inappropriate listing for children with pharyngitis. Because when I look at this and as a provider, if somebody were to be like, hey, Jackie, you're going to be measured based on, you know, A, if you test, and B, if you provide the appropriate antibiotic after (each test), the first thing that I hear is I have to test. And so, it really puts a burden of proof on the provider. Is this viral? Is this bacterial? But the default when it comes to testing is going to be two tests. So this is going to actually increase cost because we're encouraging testing. And those are some of the considerations that I have as I looked at this.

Does anybody else have thoughts?

Daniel Merenstein: No, I totally would second that. I guess my other concern is I just can't tell from data unless (inaudible) understanding it. How often was given when the test was negative? So it could be over prescribing also. I just don't understand it. And that's …

(Crosstalk)

Benjamin Hamlin: So we actually have a separate measure that looks at appropriate treatment for URI, which I think maybe gets to some of the issues that you were discussing. But, again, I mean, you know, as far as the test goes, it's a fairly low-cost relatively easy test to perform. And so, I don't think we're – you know, first, I don't think we're really driving over utilization whereas on the antibiotic prescribing issue, you know again, that's still relevant national conversation that people are having.

So I don't think that measure was really intended to address that. I think it's really was just trying to confirm appropriate testing if antibiotics are going to be prescribed.

(Crosstalk)

Jacquelyn Youde: Yes. So I – the other part of this that is in my mind is you could provide the test and it's going to be negative. And you can have a patient who is really like they feel satisfied when they get an antibiotic, like if they go to the doctor, they want an antibiotic. How is that accounted for in this, where they get the test, the test is negative, but they prescribe anyway because of some sort of patient demand or whatnot.

And I know that there's a degree of counseling and education in there. So I'd be curious to know the result on that side. If it's negative and the antibiotic is still prescribed, or what kind of lag time there is where the test is, you know, given and they just give the antibiotics anyway before getting test result back.

Benjamin Hamlin: All right. So, our paid our similar or I guess our, you know, sibling measure is pretty appropriate treatment for children with upper respiratory infection. (Inaudible) overused measure so it's basically, you know, do not prescribe antibiotics. So that (inaudible) but I think one of your questions.

The other question is I think we're hoping that, you know, the eMeasure specification for this will actually be able – we'll be able to specify the value of the results. And therefore will be able to actually address the very question that you have concerns about (or we'll) actually, you know, enhance the measure to capture whether not – it's not whether you test, but it's whether or

not you (appropriately) tested and therefore, you know – and what the actions were as the result of that test.

But in the claims, you know, again that we're limited there. So I think we're – we used rely on the overuse measure to deal with the antibiotic prescribing issue, and I recognize the issue that, you know, parents demand the antibiotics anyway for their kids whether it's necessary or not. But, you know, these measures are intended to sort of provide the clinical practice guidelines (so that probably they help move that). And I think that's maybe why they results are changing very rapidly on this measure because there are sort of other factors that are driving both the prescription to antibiotics and then the willingness to test afterwards.

Daniel Merenstein: But the only thing …

(Crosstalk)

Daniel Merenstein: … (is you) imply that it was the correct measure. Promise if you have a, you know, four or five in your center criteria and maybe the correct thing is not do the quick strep.

Reva Winkler: OK. Ben, since you mentioned an eMeasure, when do you think you'll have an eMeasure for this?

Benjamin Hamlin: The eMeasure I did discuss is still, you know, in discussion, so not for sometime. I mean again …

Reva Winkler: OK.

Benjamin Hamlin: … we're not even accepting eMeasures into HEDIS yet. We just have that to approve for the next year. So …

Reva Winkler: Right.

Benjamin Hamlin: … (we're starting with these measures), so.

(Crosstalk)

Reva Winkler: The one thing I did want to point, this was the one measure that got a comment in the pre-evaluation public comment. And I would just make – I want to make sure everybody has chance to read it. It's at the bottom of page seven on the worksheet. And the comment is there's no evidence that this measure can improve care in the emergency setting. Many of the rapid strep screens in the ED aren't reliable and not useful in ED settings. Strep cultures may take time to complete and require contact to be made with the patient days after the ED visit, so.

Benjamin Hamlin: Yes, again I mean I would agree if this was an ED measure. But at the plan level, you know, the plan has responsibility for the services they're paying for to, you know, really, that's really trying to address the quality opportunities here. We can only provide so much to the client's data that we get. But I do recognize that comment.

Daniel Merenstein: I guess I don't understand the comment. Why is it – why is it any different in the ED to test than it is in the ambulatory office? It's the same test.

Benjamin Hamlin: Right.

(Crosstalk)

Benjamin Hamlin: The health plan is responsible for ensuring that the practices and the results are getting to patients and, you know, to provide the quality of care. All we can do is measure whether the tests are being performed or not.

Daniel Merenstein: No, no, I agree with you. I agree with you. I just don't understand the member comment, the public comment.

Reva Winkler: Right.

Daniel Merenstein: I'm not sure why the test is any different than it is in a pediatrician's office.

Reva Winkler: OK.

Daniel Merenstein: Yes.

Jacquelyn Youde: I do have one other question. So, there's a number of population that's just a strep carrier. And they could have a sore throat, carry strep but they actually have a virus. How does that factor into the rest results? r how does that factor into this measure?

Benjamin Hamlin: It does not factor into the measure. I don't believe.

Jacquelyn Youde: OK.

Tamala Bradham: And then a comment back to the ED. The ED issue is that the follow-up. So you have to contract the patient after they have left the ED to tell them the test result calling the prescription because a lot of the patients that are coming in may not have a medical home. And so, is that follow-up? And that is labor-intensive, time-intensive, but I think that's where that member comment is coming from.

Daniel Merenstein: Yes, I know I guess it feels like an excuse. It's no more time-intensive than it is, in a primary care office. I mean I've heard that excuse before. That's just an ER excuse for over prescribing antibiotics.

Reva Winkler: Yes. OK. All right so …

(Off-mike)

Reva Winkler: We've got a chance to go through all the criteria on this measure. And so, we'll essentially be doing something very similar going through the criteria and the discussion with entire committee. This group has had a chance to really take the first path and look at things in details so you'll lead the discussion but others will be encouraged to participate as you go to the criteria to rate it. And then ultimately make your recommendation for continuing endorsement to this measure. So, any last minute questions on this measure or the criteria before we move on the next measure?

OK. So we're going to switch gears and the next three measures are related, and they're all about newborn hearing screening. And we start with Measure 1354, which is hearing screening prior to hospital discharge.

I don't know, Ben, are you still there? If you haven't signed off, thank you very much, appreciate you joining us.

Benjamin Hamlin: OK, thank you.

Reva Winkler: I mean you're welcome to stay on. But I do thank you.

So, anyway, the next one, hearing screening, this is from CDC. And (John) is in the NQF office with Shaconna and Amaru. Shaconna is on the phone. They're the measure developers. And this measure assesses the proportion of births that have been screened for hearing loss before hospital discharge. And so, I think that accountability is at the hospital level and then at the sort of community geographic state level, in the national program.

So, in terms of our criteria we've started out with the importance to measuring report. First part of that is evidence. So, in terms of our discussants, this time it's Dan and Tamala. So maybe, Tamala, you'd like to give us your thoughts on the evidence for this measure?

Tamala Bradham: The evidence for the measure I thought was consistent and appropriate. I mean babies are getting screened in the hospital level. This is a very well oiled, I think oiled machine at this point.

Reva Winkler: Yes.

Tamala Bradham: I think the biggest issue …

Reva Winkler: The evidence – Yes. I just wanted to be sure, the evidence criteria is really doing, you know, what's the empiric evidence that there's a relationship between hearing screening prior to hospital discharge and outcomes for that patient. So, that's – why is it a good thing to do? Is the empiric evidence solid for that?

Daniel Merenstein: So the task force gives it a B. I mean I think pretty good evidence. It's pretty solid.

Reva Winkler: OK. Yes. So, just want to be sure we had a good understanding of the criteria. Any questions? OK. Then again the other criteria and the

importance to measuring report is the opportunity for improvement is included in that is any information on disparities. So we do have some CDC data from their national program. You'll see later as we go through the submission from representative states. But, so it's look like 97 percent newborns in the U.S. are being screened. So, a small percentage don't have – didn't have the final screening.

Do we have any information on disparities? I see they comment on small and rural birthing facilities. Do we know anything more about differences if it's universal in a hospital? I would imagine that for all hospital base birth should be pretty equivalent.

Daniel Merenstein: The data was pretty good. I don't think it was actually equivalent. I think we'll look at that a little bit. But it was close. But, you know, the babies born outside the hospital were the main disparity.

Reva Winkler: Yes, OK. All righty. So those are the two criteria there. It doesn't sound like there's any real question or issue.

So under scientific acceptability to measure properties, reliability. The first thing is the specifications. So, this is specified as the registry measure the national program. And then it's also specified as an eMeasure. We do have the HQMF specifications. Those are the official eMeasure specifications. Our internal eMeasure technical review team looked at the measure. And their evaluation is summarized for you in the preliminary analysis.

And so, the fact it's a specified appropriately all the components to the measure to logic are represented using the appropriate formats and quality data model. The value sets are part of the NLM value set authority center and the feasibility assessment in terms of feasibility for data collection in various EHRs with assessed and provided. So that's the kind of technical review we do for committees when it comes to this specifics about an eMeasure.

So we do have two sets of specifications. Because these measures have been around for awhile and been endorsed for awhile and are embedded in federal programs with their existing NQF number, they will continue to be looked at together. For new measures in the future, we will be separating the eMeasure

from the traditional measure if you will with different numbers so it's easier to distinguish the eMeasure aspect from the traditional measure aspect. But we will maintain this just because it's so embedded in system already.

So, any questions about the specification for this measure? Is everybody pretty clear what's being measured and how it's being measured? The reliability testing, again, we're talking about data element validity testing, which will count for reliability. So, if we go down to validity testing, the registry, the federal program data, what's – a validity testing was done on two different state data sets comparing the charts with the data that was submitted, which is a gold standard review, which is data element validity.

And so, we see the results that in Vermont there were an error rate of 3.3 percent; in Tennessee there, what, 0.2 percent missing or incorrect date and screening method in result that is 0.17 percent. So, fairly low in accuracy is in the data that's being used to calculate the measure from the gold standard source.

Tamala Bradham: And, (John), correct me if I'm wrong, but Vermont does not have mandated newborn hearing and screening like Tennessee does. And so, I think that was one of the reasons why we saw a slight difference. And I think it – first of all, I want to applaud you all for doing it that way to look at a non-mandated state versus a mandated state to look at this reliability measure, but then also knowing that difference isn't that big. And if state that doesn't have mandated, newborn hearing screening in the hospitals, I think that's pretty telling the value of this measure.

Reva Winkler: Right.

(John): Thank you.

Reva Winkler: OK, good. So, we don't have any testing information specific to the eMeasure. Again, these measures are used in programs. But the amount of data that's being collected is still quite limited. And so, we're hoping that it will improve in the future.

So, that's the validity. Our threats to validity, again, there's only one exclusion of patient death before discharge, which sort of makes sense. But this process measure is not our risk adjusted. I think that the data they provided on meaningful differences, they did provide a state level report for New Jersey where they do have data at the hospital level. So, you know, that everyone performing quite well. But nonetheless it isn't 100 percent. And I'm guessing, (John), isn't the goal to hit 100 percent everywhere?

(John): That will obviously be the goal. There's always going to be probably somewhat, you know, a few cases that slip through.

Reva Winkler: So thoughts from anybody on the workgroup, any questions about the validity or reliability of the measure?

Tamala Bradham: The only thing that I kind of was wondering about is that – we know that there's a lot of research out there that's looking at equipment, that's being used that can contribute to the validity and also the – how many times they screen a baby before they get discharged from a hospital because hospitals have protocols where they screen once and then if they don't pass they don't pass. But some may screen them two or three times. So there's inconsistencies (sort of) – I don't want to say inconsistent. But protocols are different. Is that something that you all have looked at, (John), at CDC? Or is that something that we need to be reporting on when we're looking at the reliability and the validity?

(John): It really sort of doesn't necessarily fall to CDC. It's actually being looked at closer by the Joint Committee on Infant Hearing. And we're in the process right now of revising the guidelines. And we're expecting that to be published in pediatrics hopefully very early in 2016.

Tamala Bradham: OK. So that was my concern with this section.

Daniel Merenstein: I have a question. What if a parent refuses the test? Does that count against it, the percent? I'm just wondering why you're not getting 100 percent.

(John): That can be one of the elements. And so, another reason that we don't hit that 100 percent – the only exclusion right now is the infant death. You know, there's – there are multiple ways that we could use (inaudible) we try to go at the simplest as possible.

Tamala Bradham: We've also had cases where pediatricians have refused to have the order created to do the testing.

Daniel Merenstein: Really? Interesting.

Tamala Bradham: Yes, so we have …

Female: (What)?

Tamala Bradham: Yes, so we've had both pediatric practices as well as parents refusing.

(John): And that was addressed by AAP, and they've sent out to basically not recommending that practice that all children actually be screened in the hospital (and not out of an) outpatient basis for their initial screening.

Tamala Bradham: I know but it still happens.

Reva Winkler: Wonderful. OK. All right. Any other thoughts there? I really do appreciate listening to your bird's – your in the field view of these things. It adds a lot of context.

In terms of feasibility for the measure, we do have, you know, think about feasibility for the national program sort of the registry collection as well as potential feasibility for an eMeasure that, (John), I think you're looking forward for the eMeasure to facilitate reporting at the hospital level.

(John): Yes, definitely. We want to try to get that report and reduce the burden on reporting, and then have that reported both for the state EHDI program and then also for the CMS measure.

Reva Winkler: All right.

Jacquelyn Youde: Yes, I think that an eMeasure would add a lot of value here. (Just in that), oftentimes, it's done on a pink slip which is then mailed and faxed to the state, and it's carbon copied on the third copy, and it is very messy. There's different results because sometimes the provider will do the testing on the third time realized that the child hasn't had but somehow that didn't get into the record or it didn't get into the records in an understandable way. So another provider will go and the child passes, and both of those are sent to the states that are kind of like reconciling all of the specific information. So I think an eMeasure will be incredibly instrumental.

Reva Winkler: Yes. Well this eMeasure is part of meaningful use for eligible hospitals. So it is part of a federal program. So hopefully that will encourage use by more and more hospitals going forward.

So usability and use, I think we've talked a lot about the fact this measure is used nationwide particularly looking at state level. And within states, I believe, they're probably looking at it at the hospital level. Any concerns about unintended consequences?

Daniel Merenstein: No.

Reva Winkler: Yes. All right. So those are the criteria in this screening measure. Does anybody have any questions about the criteria or any questions about this measure specifically before we move on to the next one?

Tamala Bradham: Just one question. Did we – and I'm sorry if I don't remember if we included the ICD-10 in the diagnosis categories because I don't – they might have been there. I'm just trying to remember. I did not – I don't remember seeing them though.

(Sedong): Yes, this is (Sedong) from CDC. For the screening measure, we have – the only ICD-10 code that we use is for the population (denominator) for us to identify the live birth, the birth.

Reva Winkler: OK.

(Sedong): For screening, there is no ICD code.

Tamala Bradham: OK.

Reva Winkler: All right. Anything else? And these are exactly the kind of questions that are very helpful to have sorted out ahead of the meeting.

OK. So if we're finished with 1354, then our next one is 1360, and this is a companion measure which is the sort of the follow up which is audiological evaluation no later than three months. This measure assesses the percentage new born who did not pass the hearing screening and have an audiological evaluation no later than three months of age.

So, again, this is a follow-up. This is the registry measure. There isn't any eMeasure. And I guess the account of – the level of measurement is probably more at the state or community level. (John), what is the intention of this measure to be used? What types of entities would be measured with this?

(John): Yes. So the states are collecting this information, and then they're collecting this on an individual basis. That data is then reported to CDC on our OMB approved survey, which is aggregated data that is sent to us.

Reva Winkler: All right. Do you know what the states are collecting or following it up in comparing data hospital to hospital? Or since it's the follow-up kind of measure, is it sort of disconnected from the prior hospitalization?

(John): I would say …

(Crosstalk)

(John): Oh go ahead, (if you can, please).

Tamala Bradham: Go ahead, (John).

(John): Well, I think that depends on a state.

Reva Winkler: OK. Tamala, was that you? Were you going to say something?

Tamala Bradham: Yes. But I was just going to say what (John) said. It's dependent on the state. Some states, I mean, they're really calling the families and sending letters and sending people out. They get EI involved. And then some states don't have those extra resources (inaudible) down the families. And then we have the issues of border families that may – their baby maybe born in the hospital right across the state line but they actually live in the other state. And so, we're trying to work with those situations so we get appropriate follow-up.

Reva Winkler: OK. So …

Tamala Bradham: The thing …

Reva Winkler: Yes, go head.

Tamala Bradham: So are we talking about priority, the evidence at this point?

Reva Winkler: Yes, the evidence for this follow-up at three months.

Tamala Bradham: So the only thing that I kind of stood out for me was that what are your desired outcomes because I didn't think that was clearly defined in your, in statement for the rationale. It's like we want to do an ideological evaluation of this in three months. I mean I know why we want to do it, but it wasn't – I didn't think it was clearly defined.

Jacquelyn Youde: I have to agree with Tammy here. I'm not seeing it. I know why like inside and out as being an audiologist, but reading here I agree with her.

Reva Winkler: OK. Well, given that one of the reasons, we look to your expertise is to be sure that you share with the others what those outcomes are. And so, just for my benefit, perhaps you could just kind of quickly share?

Tamala Bradham: Well, JCIH goal is to maximize "linguistic competence and literacy development" in children who are deaf or hard of hearing.

Reva Winkler: OK.

Tamala Bradham: And they're very careful with how they word that because we are looking for communications. And it doesn't matter how that communication takes place,

but we want them to be able to communicate and we want them to be able to develop literacy skills because we know reading is so important. And so, that's the ultimate goal. And so, we know with identifying that hearing loss or like and getting the intervention like or like actually impacts their overall outcome.

So the research shows that if we don't have the -- and this is the next measure -- intervention in place by six months, then they're not at grade level when they start kindergarten. They are significantly behind.

(Crosstalk)

Reva Winkler: Is the three months something that there's good evidence for? Or is it just – you have to pick a number somewhere?

Tamala Bradham: They pick a number. There have been some discussions about should it be 1-3-6, meaning one week, three weeks, six weeks. There's been discussions about moving things out. The part of the three months is just because they want maybe the fluid to kind of resolve after the baby or getting the appointment time in with the audiologist. Sometimes there's the delay because it's getting an appointment time. But they also want to do it before six months before it's difficult to do because they try to do the testing unsedated. And once they get mobile, a little bit more mobile and sitting up and stuff like that, it gets a little bit harder to do.

(Crosstalk)

Reva Winkler: With the U.S. preventive – yes. The U.S. Preventive Services Task Force does specify in their recommendation that it is before three months. So that probably come from something.

Thoughts from anybody else? John McClay had intended to be with us today as (inaudible) discussant but John gave us a last minute notice that he had a personal emergency and was not able to join us. So, Tamala, thanks very much for kind of carrying it on this one.

So anything else on evidence, opportunity for improvement, the data we have some national level data going back 2007 through 2012. Thoughts there? And we do have a little bit of a data based on racial groups from 2011. I'm assuming these are national aggregates again.

Tamala Bradham: I think this would be a great opportunity to kind of define what an audiologic evaluation is that is not defined in this measure. And I think that needs to be defined.

Jacquelyn Youde: You know, Tammy, I think that's a really great insight here because if we're saying the child is three months old, you know, I think we maybe implying that it's an OAE. But some places are doing unsedated AVR, some places are doing sedated AVR, some places are doing OAE screening, some places are doing, you know, diagnostic OAEs. So what is that we're really looking for here? Are we looking for just like a minimum path or we're looking for an evaluation?

Tamala Bradham: Maybe that's a state by state definition on how they define an audiologic evaluation. I don't know. But I do know it varies from practice to practice and we have a lot of parents that are being misidentified because we have people providing a practice the latest treatment.

(Sedong): Yes. From – this is (Sedong) from CDC. Yes, I agree that this measure needs to be better defined in terms of what the audiology evaluation means. For the measure currency like the national data that you see here that the content data definition here that we get here is, (like the those) numbers, those are not just a simple audiology clinic visit. So basically this data is actually the kids who actually got a diagnosis – or it's either a normal hearing or it's with hearing loss. So they have got some result. They have finished some examination and get the result. Those – if they are still in process and no results yet, those numbers are not in this percentage show here.

Jacquelyn Youde: So what are the results? Like when you say some places get results – and I guess I want to know what the result mean.

(Sedong): Result, it's either a confirmed hearing loss and then we have a different types of hearing loss there. And I think that also includes non-permanent hearing loss and – or no hearing loss (and totally) normal hearing, so.

Jacquelyn Youde: So the measure is just an audiologist seeing the patient and doing some testing. And so, we're just measuring with some testing done. We're not necessarily measuring the outcomes of those tests?

(John): Now, the diagnosis needs to be reported to the state EHDI program for it to be counted. So, the result of that audiological, as (Sedong) pointed out, normal or has a hearing loss. When that's reported to state EHDI program, then that's considered the closing for this measure.

Jacquelyn Youde: I guess when you look at …

Tamala Bradham: But when you look at your numerator, the numerator says it contains the number of infants born in the time window who did not pass hearing screening, so that's from the hospital, and whose age is less than 91 days at the time of the audiologic diagnosis. So, the measure is, is that a diagnosis was obtained whether it's normal or abnormal but a diagnosis was obtained. So, you're just counting the number of children.

(Crosstalk)

Tamala Bradham: Which would include all children that were seen by an audiologist and got a normal or abnormal diagnosis.

Jacquelyn Youde: Yes.

(John): Correct.

Reva Winkler: I think …

Tamala Bradham: But the way to remember the measures coming out, though, is that usually what I see coming out is that these are the number of kids with hearing loss. So, they include the inconclusive and the …

(Sedong): They …

(Crosstalk)

Tamala Bradham: … normal.

(Sedong): They include the normal hearing, and they need to have what kind of – this diagnosis kind of – it's a little bit confusing here. But it's not a real diagnosis of hearing loss. They include both normal hearing and hearing loss.

(Winnie): Yes. This is (Winnie) and I am the audiologist here with CDC, all right? Diagnosis from a clinical standpoint includes normal hearing, OK. So, when the state actually counts its diagnosis, if the audiologist reports to the state that the result is normal, it is a diagnosis.

Reva Winkler: Yes.

Jacquelyn Youde: OK.

Reva Winkler: Yes. This is Reva. I'm thinking that there probably is data that is reported on the percentage of hearing loss as a result of all of this, but this is the performance quality measure on the process of getting those kids evaluated in a timely and appropriate fashion.

(Winnie): Yes.

Jacquelyn Youde: Yes. So, it's basically did the child come back within three months and get a test any test?

(Winnie): Yes.

Jacquelyn Youde: OK.

Reva Winkler: And I do think you're raising the issue of appropriate testing and appropriate evaluation, which is something we're seeing discussed more and more among a lot of different procedures or testing or whatever is the quality of that evaluation. And measures aren't quite there yet to start asking those questions, but they certainly are questions that a lot of stakeholders are raising.

Jacquelyn Youde: OK.

Reva Winkler: All right. So, anything else on evidence or gap? Then, similarly, we'll go down to reliability. We've talked about the specifications. The testing was done as a data element validity testing with agreement on the records in Tennessee. So, they were – you know, how many were found to be in error in terms of their data when it was compared to the charts, some the 2.5 percent. So, that shows the sort of quality of a sample state.

And then I think we've got the issues around threats to validity are relatively minimal. We do have the data on the meaningful differences across the results that I think one of the interesting things around the data is what the average score, it's 62 percent. But then the highest seven performing states are up there in the 87 to 98. But the lowest performing eight states were 0 percent to 33 percent. So, wow. I think this is the kind of data that's very helpful to understand the utility of the measure.

Any comments from the workgroup?

Tamala Bradham: Not at this time.

Reva Winkler: OK. So, feasibility, I think we've talked about the program and the data is collected through the EHDI registry. I don't know if there's anything more to talk about there.

Similarly, usability and use – and I guess here's the question I would have. In terms of performance who, you know – what kind of leverage can be brought to bear on the countable entities to improve performance? You know, how do we use this information to improve it? Where is our opportunity?

Daniel Merenstein: At the state level, right? I mean it seems like the states are the ones not – if there are some states that are 0 percent to 33 percent, they're just not – obviously not stressing it.

Jacquelyn Youde: So, one thing that I've seen happened here in terms of, you know, accountability and whatnot is the states will send parents letters, like, "Hey,

they'll get their hearing tested," "Hey, your kid's hearing test is this, that and the other," and they don't understand the importance of that. And there may be a gap in communication or a gap in information transfer between not only the people who did the newborn hearing screening to the parent or the people who did the newborn hearing screening to the primary care physician. So, there's this big gap and area for improvement. And so, I'm almost wondering, is the state the appropriate source for accountability?

(Sedong): Yes …

(Crosstalk)

(Sedong): You actually raised a very good question here. So, for us, because we at CDC, we don't have – we don' get – they had their (X-rays) from the audiologist at the facility or individual lab where we get the data from the state. That's the only data source we have currently. But for the – like the number you see, 0 percent to 100 percent, for us, we think a very large part of that issue actually they are not – they're not those kids that did not actually get the audiology evaluation. They are actually the audiologists that are not reporting to the state. So, it's kind of (loss) to documentation problem rather than a (loss) to follow-up problem.

So, it's really that we, that the state or the audiologists are not reporting to the state because reporting is not their primary responsibility for audiologist. And in many – most of the states, they are not mandated for reporting …

(Winnie): Yes.

(Sedong): … the hearing data.

(Winnie): Yes, I would, you know, support what (Sedong) has said. You know, I once was worked – I once worked at the state level. And I know that our state level, the compliance is pretty high. But still, I routinely, every month, I've lost 30 percent of my data just because, you know, the providers are just too busy to report it. The kids are seen, but the states do not get the actual number.

One of the projects that I've just started five years ago was building a comprehensive pediatric national register, OK, to figure out who has the capability to see really, really young kids. And we had a survey, and one of the states that was included in the worst performing state found out that according to the provider that I surveyed, 70 percent of those providers actually do not report. They actually literally (on CSAC but they) do not report to the states. So, many of those – so, the actual number that you're seeing in some of the very, very lowest performing state is compounded by the possibility of providers just failing to report the result to the state.

Jacquelyn Youde: I can completely believe that.

Tamala Bradham: Yes. And then it is a state level issue because this, you know, states have mandated hospitals to do the screening but they have not mandated audiologists to do it. And there's also the issue of being able to release data or patient information to HIPAA, and so there's a lack of understanding on how, you know, how do we do that. So, we have to get a consent from the family and then we've got to send it in, and there's whole bunch of extra steps that you have to do. And so, until we can streamline that process, we'll continue to have 30 or higher percentage of audiologists not submitting.

Jacquelyn Youde: And, you know, not all audiologic evaluation, whatever that may mean, aren't done at an audiology office. Sometimes we see, you know, primary care physicians doing some sort of hearing screening, hearing test evaluation at three months, and a child will come back and see me like at age seven or eight months, like, “Hey, I've got a problem here,” and I'm like, "Oh, have you had any test? I see that you failed your newborn hearing screen." And they're like, "Oh, yes, I went to the PCP." And I'm like, "OK, what happened?", and they're like, "Well, we don't know." And so, you can't find anything like that. So, I would hate for everything to fall on to the audiologist report because there are people other than an audiologists doing the testing at three months.

Reva Winkler: OK.

Jacquelyn Youde: Something else I was thinking about in terms of usability is sometimes things that we see are, you know, a kid will come in when they're, you know, 2.5

months old or whatever, and you cannot test these kids because their ears, they've gotten ear infection, they're completely (included). We don't have the access to clean it out at that time, you know, any EENT, PCP family doctor that's nearby doesn't have time to see them that day. The next available appointment is, you know, after that three-month mark.

And so, one thing that does concern me is saying, OK, if we do have to get this done by three months but the child is really is not an appropriate day to test, either their screaming, we can't get them down, their ears are not, you know, ready to be tested, they've got some sort of ear infection, how does that factor in? Because we don't want to test kids that aren't appropriate to test even though they have showed up. So, is there some sort of mechanism to note that this child did show up but wasn't appropriate for testing because I would hate to see us test kids that aren't appropriate just to hit a number, just …

(Crosstalk)

Tamala Bradham: And the other issue is that we have babies that are still in the NICU, pediatric intensive care unit, that aren't viable to test.

Jacquelyn Youde: Absolutely.

Tamala Bradham: And that's one thing that back in the hearing screening and the audiologic evaluation is that it doesn't account for gestational age. I mean that we're not adjusting.

(Winnie): Yes. This is (Winnie). I concur. The fact that this measure did not, you know, (put indeed) that the age needs to be corrected according to (GA) (inaudible).

Tamala Bradham: And most audiologist will correct and …

(Winnie): It makes clinical sense to correct. If you don't do that, you're not a good audiologist, period.

Tamala Bradham: So, we'll never hit 100 percent that way either because we're not going to – yes.

Reva Winkler: OK, great. Good stuff, folks. OK. Anything else we want to talk about before we go to the last measure, which probably is going to be fairly straightforward because they're so related. And the last one is the 1361, which is intervention no later than six months. So, it's the natural progression from the prior to – the measure assesses the proportion of infants with permanent hearing loss who have been enrolled in intervention services no later than age six months. So, in terms of, Judith and Jackie, comments on evidence and then opportunity for improvement?

Judith Lynch: This is Judith. I think the evidence is pretty straightforward. And although somewhat they didn't follow the evidence from the one that we just finished, I do not have any problem with the evidence.

Reva Winkler: Jackie, thoughts?

Jacquelyn Youde: Yes. (It's right on).

Reva Winkler: OK. Is the six months – the evidence for the six months a little bit stronger for this measure than, say, the three months was for the previous one?

Jacquelyn Youde: In my opinion, this is Jackie, I think they did a better job at seeking to outcomes and the reason why we need enrollment than the three-month one. And Tammy very clearly articulated. She did an excellent job saying, you know, why we need to do this by a certain age, and I wish that they would have incorporated that into the measure, the big why, like why am I doing this process, this measure, why do I care, why is this great for my patient. Those are the things that are going to drive adherence. And I would like to see that in the three months, the six months, I definitely saw the reason that we're doing this.

Reva Winkler: OK.

Judith Lynch: I have a very basic question. Are we only talking about audiological intervention here?

Tamala Bradham: And that's – thank you for saying that because I have major issues -- I'm sorry, (John) -- with this particular measure because we're not defining what is EI, because …

Reva Winkler: (I see).

Tamala Bradham: … having a date because the denominator or the numerator or – it's just the date of the IFSP. And many families don't even go into early – through the state early intervention program. They'll do private and early intervention. So, we're not even capturing that. And we show the data definitely there that says that children aren't "getting enrolled by six months of age," but we have not done a good job of defining what is early intervention. And that is the biggest problem that I have with this measure.

Judith Lynch: Yes, me, too.

Jacquelyn Youde: You know, Tammy, that's something that I thought as well. And I don't know if we're quite to that discussion yet, but I also have some thoughts about what we're measuring when we get there. But, Tammy …

Tamala Bradham: OK.

Jacquelyn Youde: … really excellent insight.

Reva Winkler: No, that's good. I mean in terms of – then given that, interpreting the data on opportunity for improvement, the results of this measure. Thoughts, Judith and Jackie?

Jacquelyn Youde: So, if we're looking – and I'm just over at Section 1B, right, the …

Reva Winkler: Right.

Jacquelyn Youde: … the opportunity (inaudible), OK. So, I'm just looking at that information alone, and I'm saying going back to the measure title, which is (called) intervention no later than six months of age, I have to wonder, what is this telling me? Is this telling me that, you know, about 64-ish percent of people

receive some sort of intervention? And of these people, how many of them have hearing loss?

(Sedong): For those who – I think the denominator for this measure is the kids who have hearing loss. So, they should all have a hearing loss, yes. The denominator contains number of infants diagnosed with permanent hearing loss.

Jacquelyn Youde: So, when we look at the denominator codes, we actually see normal hearing and transient hearing included in the code. Would you be …

(Sedong): Yes, I can explain that. And actually, that's kind of oversight by me because the code that I attached to this measure -- actually I just took that from the previous measure, the audiologist measure -- I kind of used the same value sets, which basically you're completely correct, the normal hearings should not be included in the value set there.

Jacquelyn Youde: OK.

Reva Winkler: So, this is an error that should be corrected?

(Sedong): Yes, yes.

Reva Winkler: OK. So, (Sedong) (I won't going to want to do that).

(Sedong): Yes.

Jacquelyn Youde: So, if you confirm then that these children diagnosed with permanent hearing loss, so there shouldn't be any normal code, there should not be any transient codes, there should not be any unspecified codes, correct?

(Sedong): Right, right.

Jacquelyn Youde: OK. Thank you. Because when I was reading that, I was like, "Oh wow." Sorry about that.

Reva Winkler: OK. So, (Sedong), I think it would be good if we made those corrections so to avoid for future confusion.

(Sedong): But I will do that, yes.

Jacquelyn Youde: So, going back to 1B, the performance gap, I still kind of curious on what this means in light of the conversation around what is early intervention. And what does that mean?

(Sedong): So, you raised the point that I don't know whether (John) would want to speak to that. From this – the data that we collected from the states, again, like the other data we used, the annual survey data from the state, so the data definition that we have in our annual survey is the date of enrollment and particularly the data of the IFSP is signed. So, we use that. And the – so, from that, I would just think that it's the developmental intervention that we're talking about here not the audiology intervention.

(Winnie): Yes, I agree. This is (Winnie). When I first look at this document that (Sedong) graciously actually shared, I have to say that I agree. (John) (told me) that there is actually two type of intervention, developmental intervention versus audiology intervention …

(Crosstalk)

(Winnie): … intervention, and those are very specifically a medical device intervention. You know, setting of hearing aid, doing a cochlear implant, doing evaluation for candidacy of whatever devices that …

(Crosstalk)

Tamala Bradham: Or, you know, working with a deaf mentor of a deaf role model or getting sign language and starting to teach the parents. I mean there's all forms of different types of interventions.

(Winnie): Yes.

Tamala Bradham: And so …

(Winnie): Yes. But for this measure, we are, you know, using the Part C developmental early intervention.

Judith Lynch: So, what does that mean? What does developmental early intervention mean?

(Winnie): Unfortunately, it varies by state, unfortunately. It is after the state discretion to how they actually define their own intervention program. And even within the state, program to program could be different. That's how variable intervention is, the whole term about intervention can be. All right?

Judith Lynch: So what – sorry.

(Winnie): You want to do it in a nutshell how to describe early intervention. Basically, what they do is this. When the child has a, you know, permanent condition that is going to affect development, it doesn't matter what it is. If it affects development, you're going to actually work with the family to figure what is going to actually, you know, be provided for a child be it speech language therapy or listening therapy or just something monitoring the development of this child to make sure that they're on target.

So, that's basically in a nutshell what it is, you know? That once identified, it some kind of services as the early intervention can move and actually provide for the family to prevent a developmental delay or, you know, the child that has no delay right now but we're just monitoring for and as soon as a delay is actually noticed because they will do a lot of developmental assessment, then they will actually begin to actually move services for the child.

Jacquelyn Youde: So, when I'm looking at this and I'm listening to the conversation and kind of absorbing as I go. One thing that I notice that we're talking about is an enrollment date versus intervention. And those to me are not necessarily correlated. So, I could enroll my child in X, but it might take me three or six months to actually get in the door and to have that done.

(Winnie): Yes.

Jacquelyn Youde: And so, what are we measuring? It looks like compliance to enrollment rather than intervention.

(Winnie): Why – how about if I answered it this way, OK? There is also another concept called referral date. OK. Now, this is also is actually (motivated) by

law. The providers, any providers, actually required to actually refer a child who has a permanent condition to this Part C early intervention within seven working days. That's one referral date.

As soon as the referral hits the early intervention, the intake person has 48 hours to respond and connect with the parent, and that's written in the law, 48 hours. So, the fact that is enrollment then will actually begin after the whole family is being assessed.

Tamala Bradham: But then, technically then, it should be, say, four months rather than six months because if the audiologist has to diagnose by three months, then within nine days essentially, that family should be contact – I mean there should be contact then with that family.

(Winnie): Yes, if it is referred, if they are referred.

Reva Winkler: OK. All right. Excellent discussion on, you know, the kinds of issues we like to see highlighted and brought forth in detail. So, I think you were talking about the specs. So, that's really an important aspect to reliability. And I think there are some concerns about the lack of specificity.

Again, the reliability testing is going to be the same as we've seen in the other measures at the data element validity testing. And we had a similar data presented on the tracking of the data within the system. So, Judith or Jackie, did you have any questions or comments on the validity testing results?

Judith Lynch: I thought that the test sample was fairly small. And I didn't know if that was something to be concerned about.

Jacquelyn Youde: You know, I saw that, too, where – what was it, 49 of the 75 actually had diagnosed hearing loss? So we're basing – what we're looking to generalize is measure on 49, (an N) of 49.

(Sedong): Yes, this is only from one state. Yes. And because we make – on the nationwide, like the EI data is, like the EHDI program needs to link or talk with the EI system to get the enrollment status, so not every state is currently doing a good job on that. So, from the data collection standpoint, so it's not

doing a test well as the other two measures. So, that's why we see some difficulty in obtaining the data, but this is only from one state. And we also get some data from several other states, but even smaller state like Rhode Island, data sample is even smaller than that, this is Tennessee.

(Winnie): Yes. And part of the reason, as I say, oftentimes when this measure is built along a specific agency, (COPASI) early intervention, and they are educational agency. They're governed by different sets of law for release of record. The record that they hold is considered educational record. It is not medical record.

So, different rules are set behind that. Educational record meaning that you have to have a parent release in order to actually obtain the data itself. And that's – and typically when you talk about EHDI program, a lot of our EHDI programs is a public surveillance program. It is under surveillance. That is under public health. It's really not educational. So, unless EHDI programs – and fortuitously, luckily, EHDI was housed under Department of Education within the states, then they would be able to have no, you know, obstacles and barrier in sharing, you know, these intervention data at all.

Reva Winkler: OK. All right. Thank you. Lovely discussion. I do think this measure has issues that we see in other areas when the denominator is thankfully small because we really are only talking about the infants with established hearing loss. So, you know, the samples I think even on the state basis are hopefully not going to be too terribly big, even in some of the larger states, but it does cause some statistical issues for sure.

So, any other comments on validity testing for this measure?

Jacquelyn Youde: I don't have any on validity, but I did have one last question on sex. We can skip it or …

Reva Winkler: Go ahead.

Jacquelyn Youde: OK. Awesome, thank you. So, when I was looking at the specifications and the codes necessary, I noticed some interesting qualifiers next to the codes, and I know that we're not using normal and I know that we're not using

(transit). But some of the things that I notice is that bilateral hearing loss is coded as a disorder, whereas unilateral is the situation. And I notice that there are some different qualifiers between severe, moderate, profound, and the things behind them. Could anyone possibly explain to me, you know, why those differences exist?

(Sedong): OK, I'll try. So, those are those qualifiers for the severity of the hearing loss. Those are the SNOMED code. The – so, actually, contrary to this, we don't have a better way to code the severity of the hearing loss. So, those codes are selected like from the SNOMED database. So, that is the best match we can find. So – but why they are defined in this qualifier or situation or other concept domain, I don't know. So, that will (sort) only to the best concept that we can find, the best match we can find from the SNOMED database. And those values that are actually used – so we also use the same codes in our other HIT projects like the (IHE) or HL7 project that deal with the data exchange for hearing-related data. So, that's – yes, how SNOMED defined concept, that I don't know.

Jacquelyn Youde: OK. So, let me ask a silly question then. So, when we look at unilateral versus bilateral, we're seeing disorder versus situation. Does that change the analysis at all? Does it work – if we're saying that hearing loss is a disorder where what – we're having a – this would basically say that, OK, hearing loss is a disorder, yes, we know that, but it's basically saying that unilateral hearing loss is a situation rather than a disorder. Does that impact the analysis or …

(Crosstalk)

(Sedong): Well, I don't know how like the use of the code, like in reality, like in the EHR system how would – this is not eMeasure, by the way – in rally, how this code will be used. But the four – that health – particularly how SNOMED code will be used in reality. But for unilateral hearing loss, the – like currently, I also see one of the questions raised by like not year specific because we actually have different ways to kind of represent your specific information and one of those is, again, in SNOMED. You can use those post-coordinated code for that. But, again, reality, in HIT world, there is up-to-date

no – basically no practice of using those post-coordinated code, like you'd specify the site where the disorder occurs.

So, if we – although the SNOMED provide that capacity for you to build those codes, but in reality, nobody use them. So, that's kind of issue that we face. So, we just choose. Again, we choose – we found the unilateral hearing loss code from the SNOMED database. So, we just pick them and put that in our value set. And so, if we don't have that, then probably we can do specified hearing loss as a disorder and then specify site where the disorder occurs by using the post-coordinated codes. But when in comes to implementation and we may face some difficulty implementation.

So – but again, I – personally, I don't have experience of using those code in the EHR system or in the clinical information system. So I really don't know how those work or whether it will affect the measure application.

(John): Yes, I think the simple answer is just the way SNOMED categorizes their (prescriptors).

Jacquelyn Youde: OK. Thank you, guys, for the explanation. I really appreciate it.

Reva Winkler: Thanks. OK. So, we've talked about reliability, validity. I think the feasibility, you've talked – I think some has been definitely wrapped into that in terms of collecting the data and similarly on use and usability. Does anybody have any comments or questions on either of those criteria for this measure?

Judith Lynch: I'm still confused on exactly what the intervention is going to be. I keep going back to this, and I know you said it's developmental. But I'm still not sure who's going to be entering the data and where it's going to be entered, et cetera. And it could be just me, but I keep coming back to that.

Jacquelyn Youde: No, it's not just you.

Tamala Bradham: The states typically entered the data to the EHDI program, and the EHDI program could either be in the health department or in the Department of Education, but the EHDI program actually works with this Part D program of

IDEA to collect that data. And then sometimes the state ICC, Interagency Coordinating Council, will help collect maybe the regional data. It depends on the state and how it's set up.

(Winnie): This is (Winnie). Yes, I gave this, you know, comment a long thought, and I think, you know, what is being said is absolutely true. But I would add on into, you know, maybe walking back to ask a clinical point. It is the responsibility of the provider as you refer any child who may be (developing) at risk until delay. So, that's, at that point, it is the provider's responsibility to do so, OK, to begin to initiate that referral. And once the referral is actually into the system of Part C, the Part C now has responsibility of that child, OK, and they have only eight hours to do so. Now, upon assessing the child if they are found eligible and should be enrolled, they're technically responsible for the child for the next three years, OK.

Now, when the EHDI coordinated codes in, it varies by state. It's depending on the discretional – it's how they defined where the responsibility ends and where the responsibility begins. Some states, you know …

Tamala Bradham: Right. And just to add to that a little bit. It's not for three years, but it's up to the age of three. But in some states, they have rules like if a child gets referred like 2.5 years of age, they won't provide technologies or support services because they would be in that transition stage two, the Part B program. And so, then, there's even further delay for intervention.

(Winnie): Yes. And now, the states – so where is the state responsibility? As I say, it really depends on state. So some states (inaudible) responsibility as I just need to make sure that the kids are referred, period. And then some states basically said that my responsibility is ensuring the kids is enrolled. And some states goes even further. I am going to work with Part C to get developmental intervention result.

(Crosstalk)

Tamala Bradham: So, (John), (Winnie) in CDC, it's your goal with this measure is to capture when a child's (dark) intervention, early intervention? Or do you have a

different goal for this measure? I mean what is your ultimate goal with this measure?

(John): Well, we needed a performance measure for 136, all right? And so, this is the measure for 6. We had this – as you pointed out, this is somewhat of a proxy. If the child's referred to private sector we're probably not going to get that information in terms of an enrollment date, but this does give us a measure where we can see how states are performing.

Tamala Bradham: And so, does it help you with leading to improvement? This measure, this proxy measure?

(John): We believe it does, yes.

Tamala Bradham: And is there any way that you could provide some trend data to show that it's made improvement because I think you only provided 2012 data? I mean if we're going to go in and make a few modifications and maybe …

(Sedong): We have data from 2007 or 2008 field.

Tamala Bradham: Because it might help (solve) the case a little bit more.

(Sedong): Yes. We have trend data.

Tamala Bradham: OK.

Reva Winkler: Thank you. All right. Well, it's been a very terrific discussion from everybody. I really thank everybody. Are there any last minute questions for any of the measures? Or any of the criteria or the evaluation process we're going through?

Jacquelyn Youde: I think I want to question on that, just to make sure that I'm prepared for the in-person meeting. And if everybody else already knows this information, I hope that you get, you know, a little bit more from listening to it a second time.

Daniel Merenstein: No, I'm about to ask the same question, so go ahead.

Jacquelyn Youde: OK, perfect. So what are the expectations of me and other workgroup members when we are in the D.C. discussing this? What do I …

Reva Winkler: Sure.

Jacquelyn Youde: … need to prepare for, what should I expect? That'd be helpful.

Reva Winkler: OK. Really what we're going to do is very similar to what we've done today. We'll go through each measure. We will go through each of the criteria in order. And we'll need to stay focus within the criteria because after the committee discusses, you will actually vote on how the committee wants to rate that criteria. That's what's going to be different there.

So, if you're the lead discussant and this was – you know, by assigning those, we're spreading the workload out among all the committee members, we will ask you to present the information about the measure. And then be the first lead off better if you will in the discussion for each of the criteria. If there are two lead discussants, you can alternate who's going to be first. But – so, you know, briefly describe the information, the measure, as I did a bit today. And then talk about – OK, evidence is our first criteria. Here is – you know, what information is available, here is how I think it meets the criteria or not, you know, others can chime in. There will be questions from the committee to be sure everybody has any – as all the information they feel they need, and then we'll call for a vote on that criteria. And then we'll move on to the next and pretty much repeat that going down the list of criteria to the end. And then the whole group will vote on whether to recommend the measure for endorsement, and in this case, it's maintained endorsement.

So does that answer your question?

Jacquelyn Youde: Yes. Just to make sure, so the lead discussants on the measure will lead the discussion much like you are today and you (inaudible) or will you be there?

Reva Winkler: Oh, I'll be there. But also the co-chairs will be doing a great deal of this in terms of just facilitating the meeting.

Jacquelyn Youde: OK.

Reva Winkler: But in terms of the lead discussants, everybody is a lead discussant, everybody on the committee. So, it's a way of making sure everybody that there – a discussion starts, that there are folks that are really looked at the information in-depth for the measure. You guys have had the opportunity to have an initial conversation. You're hearing some of the issues. You're going to want to share that with the larger group because those are the thing that will everyone will need to inform their voting on the criteria.

Jacquelyn Youde: OK. Got it. Thank you.

Reva Winkler: Does that make sense everybody?

Jacquelyn Youde: Yes.

Judith Lynch: Yes.

Reva Winkler: So by having the workgroups and by having the lead discussants, everybody has to participate, and that shares the workload among everybody in the work – on the committee.

Jacquelyn Youde: Well, it sounds like will you have much problem on participation from this workgroup.

Reva Winkler: Super. We love it. We love it. So …

Tamala Bradham: I want to thank the CDC for being here today.

Reva Winkler: Yes. It's really important to have the conversations with our measure developers to get a better understanding of the measures and they will be at – in attendance at the in-person meeting as well, or exactly the same kind of …

Jacquelyn Youde: (Oh great).

Reva Winkler: … information transfer. Oh yes, there will be there, too. Absolutely. And it is a public meeting. So, you know, any number of folks to neither attend in-person or call in and listen to the conversation. So, it is a public meeting so keep that in mind.

Jacquelyn Youde: Is there a dress code for the meeting?

Reva Winkler: I'm sorry?

Jacquelyn Youde: Is there a dress code for the meeting?

Reva Winkler: Well, you know, only (inaudible) in Washington D.C., the dress code is really, you know, business casual.

Jacquelyn Youde: OK. Thank you.

Reva Winkler: Sure. No need to get overly, you know, uncomfortable with dress.

Tamala Bradham: So is anybody else still on the call besides the committee members?

Reva Winkler: I don't know. The folks from CDC are still with us?

(John): Yes.

(Sedong): Yes.

Tamala Bradham: OK.

Reva Winkler: OK.

Tamala Bradham: I just want to make sure that …

(Crosstalk)

(Sedong): … that we need to modify. So I just modify and e-mail to you?

Reva Winkler: Let's do this, I think you have to do it in the online submission, so we'll have to open that up for you to do that. So, I think Shaconna can do that for you.

(Sedong): All right, thanks.

Shaconna Gorham: Yes.

Reva Winkler: So any other questions about the process or the evaluation or the criteria getting ready for the in-person meeting? Dan, any questions from you? As one of the co-chairs we will be having a separate call with you and Kathleen prior to the in-person meeting to kind of go over meeting logistics and meeting management. But – because this is kind of what the workgroup is for, it's sort of the first run, give everybody a chance to kind of get their feel for things.

But if not, then I don't see any reason why finishing early is not a bad thing. So, thank you all very, very much for your time and your thoughtfulness. Clearly, you've spent some time looking at all the information. The discussion was great. I encourage you to bring that to the in-person discussion to share with everybody else on the committee so they truly understand the issues. And if you have any questions between now in the in-person meeting do not hesitate to get in touch with, shoot us an e-mail, give us a call, whatever, we'll be happy to answer any of your questions along the way?

Female: Reva?

Reva Winkler: Yes?

Female: We do have a public comment period.

Reva Winkler: Right. OK. So that's the committee. Thank you for the reminder.

Operator, would you see if there's anybody out there listening who might want to offer a public comment?

Operator: Thank you. At this time, if you have a comment, please press star then the number one on your telephone keypad. We'll pause for just a moment.

And there are no public comments at this time.

Reva Winkler: Thank you. As Shaconna reminded me to do for all of our public meetings and you will see this at the in-person meeting, we will take time out to ask for public comment pretty typically at the end of each half day during our

meeting. So, we do welcome public audiences and feedback during the meeting, so that just another aspect of it.

So unless there are any other questions, I think we can conclude today's call. And, again, I thank you all very, very much for participating. I hope you have a very pleasant weekend. And I look forward to meeting all of you in-person in June.

Daniel Merenstein: Thanks.

Jacquelyn Youde: Have a great one, guys.

Tamala Bradham: Same here.

Daniel Merenstein: Bye.

Tamala Bradham: Thank you.

Reva Winkler: Thanks, guys.

Tamala Bradham: Bye-bye.

(Sedong): Bye.

Shaconna Gorham: Have a good weekend.

(John): Thank you.

(Sedong): Bye.

Tamala Bradham: Bye.

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

END