NATIONAL QUALITY FORUM

Memo

TO: Perinatal and Reproductive Health Standing Committee

FR: NQF Staff

RE: Post-Comment Call to Discuss Public and Member Comments

DA: July 20, 2016

Purpose of the Call

The Perinatal and Reproductive Health Standing Committee will meet via conference call on **Tuesday, July 26, 2016 from 3:00 – 5:00PM ET**. The purpose of this call is to:

- Re-vote on one "consensus not reached" measure.
- Review and discuss comments received during the post-evaluation public and member comment period.
- Provide input on proposed responses to the post-evaluation comments.
- Determine whether reconsideration of any measures or other courses of action is warranted.

Standing Committee Actions

1. Review this briefing memo and the Draft Report.
2. Review and re-discuss the measure where consensus was not achieved to see if consensus can be reached.
3. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table and additional documents included with the call materials).
4. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Committee dial-in #: (844) 833-5553 ***(Committee only.*** *No conference code required.)*

Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?376766

Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?376766

Public dial-in #: (844) 852-2433 *(No conference code required)*

In order to vote, Committee members should use their individual webinar links sent via email.

Background

For this project, the 27-member Perinatal and Reproductive Health Standing Committee evaluated 9 newly submitted measures and 15 measures undergoing maintenance of endorsement review against NQF's standard evaluation criteria. The Committee recommended 18 measures for endorsement, did not reach consensus on 1 measure, and did not recommend 5 measures.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from March 22-April 5, 2016, for all 24 of the measures under review. A total of 7 pre-evaluation comments were received, the majority of which pertained to, and were supportive of, the 3 newly-submitted contraceptive measures. All of these pre-evaluation comments were provided to the Committee prior to their initial deliberations.

Post-evaluation comments

The Draft Report went out for Public and Member comment from June 7-July 6, 2016. During this commenting period, NQF received 178 comments from 10 member organizations:

Consumers – 3	Professional – 2
Purchasers – 0	Health Plans – 2
Providers – 2	QMRI – 1
Supplier and Industry – 0	Public & Community Health - 0

Although all comments are subject to discussion, the intent is not to discuss each individual comment on the July 26th post-comment call. Instead, we will spend the majority of the time considering the measure that did not reach consensus, the four themes discussed below, and the set of comments as a whole. Staff have flagged particular comments or measures that require discussion by listing the proposed Committee response as "to be discussed". Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion. Additionally, please note measure developers were asked to respond where appropriate.

We have included all comments that we received in the excel spreadsheet posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and the developer or NQF response, where appropriate. ***Please review this table in advance of the call and consider the individual comments received and the proposed responses to each.***

"Consensus Not Reached" Measure

The Committee should review the comments that were received, and then re-discuss the measure. During the in-person meeting, the Committee approved the evidence criteria by exception and consensus was not reached on validity (M-14; L-10; I-2) or on the overall recommendation for endorsement (Y-12; N-14).

1517: Prenatal & Postpartum Care (PPC)

The measure received 10 comments; 6 were in support, 3 did not support, and 1 did not specify. Many of the comments noted that the quality of the visits is not being assessed and urged NQF to “raise the bar”; comments suggested issues that should be addressed within the visits. Of the comments in support of the measure, urging the Committee to recommend it, commenters noted the importance of the measure in ensuring access to both prenatal and postpartum care, and “it doesn't matter how high the quality of care is if women do not access care early enough to benefit from it”. Other comments suggested that holding health systems at least partially responsible for access to prenatal care is crucial, and that to not do so “contradicts national efforts to reduce maternal morbidity and mortality.” Noting the lack of measures in this area, commenters urged the Committee to recommend this measure in the interim while improved measures are developed.

Comments urging the Committee not to recommend the measure noted that the schedule of both prenatal and postpartum visits is based on expert opinion, not evidence, and the content and quality are not evaluated. Several commenters suggested new timeframes, and noted the need for earlier postpartum visits for breastfeeding support or caesarean section wound care as well as the difficulty of gathering this data via billing codes.

Commenters also recommended splitting the measure into two separate measures, one on prenatal care and one on postpartum care.

Developer Responses:

We agree that measures addressing the content of perinatal care are needed. We hope to develop better perinatal measures in the future in order to complement this current access/availability of care measure, which we believe is still useful in the meantime.

There is variation in recommendations for timing of postpartum visits. Organizations have typically recommended a visit 4-6 weeks post-delivery unless there are specific complications or risk factors. Our advisory panels recommended a 3-8-week timeframe as appropriate for capturing timely postpartum care without inadvertently counting visits for post C-section wound checks, which they concluded did not meet the intent of the measure. ACOG notes that a comprehensive postpartum visit should include a full assessment of physical, social and psychological well-being, with guidance given on issues such as contraception and postpartum concerns.

The measure is currently reported as two rates: timeliness of prenatal care and postpartum care. Results for each rate can be viewed separately in order to understand a plan's performance on each.

> **Action Item:** After reviewing the comments received, the Committee will discuss and re-vote on both validity and a recommendation for endorsement for measure #1517.

Comments and their Disposition

Three general themes were identified in the post-evaluation comments, as follows:

1. Support for Harmonization of Related/Competing Measures
2. Concern around Patient Choice
3. Measure Gaps

Theme 1 – Support for Harmonization of Competing Measures

This project reviewed 3 competing measures of bloodstream infection: *#0304: Late sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)*; *#0478: Neonatal Blood Stream Infection Rate (NQI 03)*; and #*1731: PC-04 Health Care-Associated Bloodstream Infections in Newborns*. After extensive discussion at the in-person meeting, the Committee was unable to select a "best-in-class" as each of the measures had both strengths and weaknesses. Ultimately, the Committee recommended all 3 measures with follow-up on harmonization or consolidation in 18 months. One commenter submitted one comment on each of the 3 measures agreeing with the Committee's decision to recommend, but urging the developers to coordinate or combine measures.

The Committee recommended all 3 measures at the in-person meeting. Measure #0304 passed all criteria and was recommended by the Committee, Y-21, N-3. Measure #0478 passed all criteria and was recommended by the Committee, Y-22, N-1. Measure #1731 passed all criteria and was recommended by the Committee, Y-23, N-0.

Developer Responses:

Agency for Healthcare Research and Quality*: AHRQ appreciates the suggestion to compare the AHRQ, The Joint Commission (TJC), and Vermont Oxford Network's measures of neonatal blood stream infection, AHRQ's NQI 03 Neonatal Blood Stream Infection Rate (NQF 0478), TJC's PC-04 Health Care-Associated Bloodstream Infections in Newborns (NQF 1731), and Vermont Oxford Network's Late Sepsis or Meningitis in Very Low Birth Weight (VLBW) Neonates (NQF 0304). These three NQF endorsed measures were each developed for specific and different purposes and for different data sources, which has led to deviations in specifications. As noted in the NQF submission materials to the Perinatal Committee, AHRQ engaged with TJC to harmonize the measures NQF 0478 (AHRQ) and NQF 1731 (TJC) where possible. In some cases, differences in the data source or intended purpose of the measures favor measures that are not fully harmonized. In other cases, harmonization is feasible while maintaining the integrity of the measure for the intended use and data source. As suggested by the committee, AHRQ will continue to explore the feasibility and desirability of further harmonization of the measures.*

The Joint Commission*: Thank you for your feedback. We have done extensive work and these measures have been harmonized to the extent possible at this time.*

Vermont Oxford Network*: Thank you for your comment. The developers of the three infection measures agreed to work together to harmonize these measures before the next submission period. This measure is specific to Vermont Oxford Network members, but we do work with health systems and plans to provide reports of our measures with appropriate permissions from our members.*

Proposed Committee Response:

The Committee agrees that harmonization of these 3 measures is important to reduce the burden of reporting. The developers have been directed to work together over the next 18 months to arrive at a single measure with supporting data, to be presented to the Committee during an off-cycle review.

Theme 2 – Patient Choice

Many of the comments on the contraception measures focused on the importance of patient choice. Both the breastfeeding and contraceptive use measures received numerous comments noting the need for patient preferences to be considered.

Proposed Committee Response:
The Committee agrees that patient choice and the need for person-centered decision-making is paramount. Comments regarding specific measures have been referred to the developers for a response. Thank you for your comment.

Theme 3 – Measure Gaps

Many of the comments noted the lack of measures for perinatal and reproductive healthcare and were strongly supportive of the submitted measures. Despite the weaknesses of some of the proposed measures, the commenters urged the Committee to recommend them while new, improved measures are created.

Several comments suggested specific areas for measure development. If the Committee agrees, the following will be added to the list of measure gaps:

- A woman-reported "balancing measure" of experience of receiving contraceptive care;
- Rate of vaginal birth after cesarean (VBAC);
- Measures related to care for women who do not need extensive intervention
- Access to care at the appropriate level;
- Measures of culturally sensitive care, or care that accords with the women's desires;
- Measures of the quality of prenatal care;
- Measures examining outcomes and rates of longer-term breastfeeding;
- A measure assessing gestational age at birth ;
- A measure requiring documentation of HIV testing upon entry into prenatal care, and documentation of maternal treatment and infant prophylaxis with anti-HIV medication;
- Measures of intrapartum nursing care of childbearing women and newborns;
- Measures indicating whether women have access to a choice among pharmacologic and non-pharmacologic methods of comfort and pain relief and support for their methods of choice;
- Measures of many underused evidence-based intrapartum care practices, including: guidance on delaying admission to active labor, use of intermittent auscultation, access to and use of tubs and showers, support for being upright and moving about in labor, use of non-supine positions for giving birth, and early maternal-newborn skin-to-skin contact;
- Composite woman-reported measure of outcomes of the full episode of maternity care collected at about six weeks postpartum;
- Measures of maternal depression screening, referral and treatment;
- CAHPS Maternity adaptations of CAHPS facility, clinician/group and health plan experience of care surveys for maternal-newborn care;
- Measures at the level of maternity care clinician and group for prenatal, intrapartum and postpartum phases of maternity care, including those that align with existing measures at facility, health plan and other levels;
- Measures of shared decision making across all phases of maternity care;
- Measures of shared care planning and care coordination across the full episode of maternity care;
- Measures that can evaluate the impact of different payment and care delivery models on women's reproductive health;
- Measures related to the provision of options counseling that includes abortion care for women with an unintended pregnancy;

- Measures related to the access and availability of abortion care including medication abortion, and post-abortion access to contraceptives and contraceptive counseling; and
- EMeasure versions of endorsed measures

Proposed Committee Response:
The Committee agrees that there is a lack of measures in this area, and your suggestions have been added to the list of measure gaps. Comments regarding specific measures have been referred to the developers for a response. Thank you for your comment.

Measure Specific Comments

0033: Chlamydia Screening in Women

This measure received 6 comments, generally supporting continued endorsement, but also raising some concerns focused around the exclusions and suggestions for updates, as well as how "sexually active" is defined. Comments recommended improvements such as expanding the age range, including males, and establishing appropriate benchmarks. This measure passed all criteria and was recommended by the Committee, Y-27, N-0.

Developer Response:
The measure's age range aligns with the US Preventive Services Task Force screening recommendation and corresponds to the age groups with highest chlamydia prevalence. In females, the highest chlamydia infection rates occur in those aged 20-24 years, followed by those 15-19 years (CDC. 2012 Sexually Transmitted Diseases Surveillance. Atlanta, GA: U.S. Department of Health and Human Services, CDC; 2014. Accessed at www.cdc.gov/std/stats12/default.htm).

The measure uses two administrative methods to identify sexual activity: claims/encounters that suggest sexual activity (pregnancy codes, sexual activity codes) and pharmacy data (contraceptives). For those who qualify based on a pregnancy test alone, if the test was used to rule out pregnancy for x-rays or retinoid prescription, those females are excluded. This method to assess sexual activity using an administrative algorithm was tested and found to reasonably identify sexually active females. Women who have sex with women and meet any of the criteria specified would be included in the denominator.

Proposed Committee Response: Thank you for your comment.

Action Item: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure #0033?

0469: PC-01 Elective Delivery

2829: PC-01 Elective Delivery [eMeasure]

A total of 12 comments were received on both versions of the measure. Generally, the comments were in support, and several noted that while rates have improved, much remains to be done. However, a pair of comments noted concerns with the measure exclusions. A second pair of comments noted that elective delivery/induction may be preferable in very rural areas that lack access to secondary and tertiary facilities. Both of these measures passed all criteria and was recommended by the Committee; 0469: Y-25; N-0 and 2829: Y-22, N-3.

Developer Response:

Over the last several years The Joint Commission has responded to suggestions from the obstetrics community to adjust the specifications for PC-01: Elective Delivery to allow for a wider array of exclusions. Some of these have resulted in new ICD codes being added and others have required the addition of new exclusions that can only be determined by chart reviews (an unfortunate but currently needed situation). The Joint Commission continues to receive numerous requests for "appeals" and new exclusions which are uncommon or rare conditions justifying the need for an early-term elective delivery. While many of these conditions have been incorporated into the current PC-01 specifications, medical issues are varied enough that it is impossible to enumerate 100% of the potential circumstances that could justify an early-term elective delivery. For example, a mother with a malignancy and need to start chemotherapy might require a delivery before 39 weeks. Although these cases are rare their occurrence can be such to generate an early-term elective delivery rate of 2-4%. This supports the rationale for not expecting this measure to consistently reach 0% elective deliveries. The Joint Commission has worked closely with a technical advisory panel (TAP) since the inception of this project. The TAP is comprised of leading national perinatal care experts including obstetricians, pediatricians, neonatologists and nurse clinicians. Recently, the TAP reaffirmed the goal of 5% which is supported by the 2013 study by Clark, et. al, validating the denominator exclusion criteria for PC-01.

There are currently 2 sets of ICD-10-CM diagnosis codes on Table 11.07 which should be used for pre-labor (preterm) rupture of membranes: the first set is O42.011, O42.012, O42.013, O42.02, O42.911, O42.912, O42.913 and O42.92 and for prolonged rupture: the second set is O42.111, O42.112, O42.113 and O42.12. The coders should be applying these codes when there is appropriate documentation that SROM occurred without commencement of labor. As a result the case would be excluded from the measure. Documentation of spontaneous rupture of membranes without onset of labor should be taken at face value according to ACOG. The 2013 ACOG definition of Preterm Rupture of Membranes (PROM is rupture of membranes before the onset of labor. Membrane rupture that occurs before 37 weeks of gestation is referred to as preterm PROM. Membrane rupture that occurs at 37 weeks of gestation or later is referred to as term PROM. In 2014, ACOG re-named premature rupture of membranes to pre-labor rupture of membranes in order to further clarify the meaning of PROM. We consider ACOG an authoritative source. Based on the ACOG definition one of the codes from the first set applies to all cases with SROM regardless of gestational age, and only the absence of labor should be required to use this code. If the ruptured membranes are >24 hours then one of the codes from the second set applies."

Requiring gestational age and careful scrutiny (chart reviews) for exclusions does preclude the use of claims data but there is progress in creating an eMeasure version. However, because of the small sample size for this measure for a given health plan within a given hospital it will unlikely be a practical measure at the plan level.

Thank you for the support. We agree that measures of patient engagement and documentation of consent would be an attractive next step but we don't have measures fully developed in those areas yet.

While this has been proposed as a potential concern, rural hospitals in general have done very well on this measure. In general there are few logistical reasons that truly need elective delivery prior to 39 weeks of gestation. In any case, the federal mandate for reporting of this measure for MediCare P4P specifically excludes Critical Access Hospitals.

Proposed Committee Response: Thank you for your comment.

Action Item: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measures #0469 or #2829?

0470: Incidence of Episiotomy

This measure received 4 comments, all in support of endorsement. One comment suggested the additional exclusion of fetal distress requiring more rapid delivery. This measure passed all criteria and was recommended by the Committee, Y-27, N-0.

Developer Response:

Fetal distress requiring more rapid delivery should NOT be an exclusion for this measure. This is a hospital level measure and the inclusion of these cases will not have a material impact on a hospital's rate and runs the risk of over coding fetal distress.

Proposed Committee Response: Thank you for your comment.

Action Item: No Committee action required.

0471: PC-02 Cesarean Birth

The developer has provided updated specification for this measure that removed the age stratification. Committee members can find the updated measure worksheet here.

This measure received 25 comments during the post comment period. Of these, 7 organizations commented in support of the Committee's recommendation, noting continued disparities in care, the risks associated with cesarean sections, and evidence-based processes to reduce Cesarean birth rates safely.

The measure received 17 comments from 11 individuals disagreeing with the Committee's decision to recommend the measure. The concerns raised focused on two issues: the lack of risk adjustment in the measure and concerns over the Healthy People 2020 target rate of 23.9%. While this target rate was not set by the measure developer or by NQF, a number of commenters indicated that without risk adjustment, this may not be the correct rate. Commenters urged the measure to include risk adjustment for patient factors that impact the likelihood of Cesarean birth, including patient characteristics such as age or obesity, or medical factors such as diabetes, hypertensive disorders, LGA or SGA fetuses with/without growth restriction, etc.

One commenter noted the need for more exclusions to cover cases where Cesarean births are medically indicated, such as “mal-presentation that could not be corrected, placenta previa, contracted pelvis, previous perineal reconstruction, fetal anomalies incompatible with vaginal birth, or other contraindications to vaginal birth.”

One commenter raised an issue with conflicts with the some Committee members and NQF staff advising the Leapfrog Group on implementation of this measure.

This measure passed all criteria and was recommended by the Committee, Y-26, N-1.

Developer Responses:
The Joint Commission has had numerous, detailed communications with the commenter on this subject, and is of the opinion that current evidence contradicts his contentions. The final decision to remove all risk-adjustment from this measure was made after submitting the measure to NQF and is based on evidence from two recent studies [1],[2] which have shown that hospitals with a high maternal age population also have a low body mass index (BMI) and conversely, those with low maternal age have a high BMI. When tested against a more robust risk adjusted model (age, BMI, race, hypertension, diabetes), the studies found differences limited to 1-2%. Because age and BMI tend to cancel each other out in the risk-adjustment models in these studies, and because BMI often cannot be calculated because height is often not recorded in the medical record, the Joint Commission’s Perinatal Care Technical Advisory Panel has recommended using the simple cesarean birth rates without further risk adjustment. Therefore, effective with discharges beginning July 1, 2016, The Joint Commission has removed all risk adjustments until such time as data are available demonstrating the need for risk adjustment and the feasibility of collecting any risk factors required. The Joint Commission also notes that the commenter seems to be principally concerned with promoting his own proprietary and competing “measure” rather than with substantive issues with this measure.

[1] Caceres IA, Arcaya M, Declercq E, Belanoff CM, Janakiraman V, et al. (2013) Hospital Differences in Cesarean Deliveries in Massachusetts (US) 2004–2006:The Case against Case-Mix Artifact. PLoS ONE 8(3): e57817. doi:10.1371/journal.pone.0057817
[2] Main E. (2014) Nuliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rates: extreme hospital variation is not changed by adjustment for case-mix. Oral Presentation: Pacific Coast Obstetrics and Gynecology Society

The Cesarean Birth measure (PC-02) is designed to measure the rates of cesarean births among a subset of the general obstetric population of women while also keeping the burden of data collection to a minimum. The measure focuses on mothers having their first birth who are at the highest risk of primary cesarean birth when compared to mothers who have experienced a previous vaginal birth. By setting aside twins, breech presentations, and premature births, this measure focuses on a more homogeneous group of women where the greatest improvement opportunity exists. Because the measure focuses on nulliparous women with a term, singleton baby in a vertex position, the only exclusions to the denominator population are multiple gestations and presentations other than a vertex position, which are realized through the use of specific ICD-10-CM diagnosis codes found on Table 11.09 in Appendix A of the Specifications Manual for Joint Commission National Quality Core Measures. Extensive testing by The Joint Commission made it clear that there is no need to exclude for all known indications for performing cesareans, since these types of medical conditions are less common and would not

significantly increase a hospital's adjusted cesarean rates. Maternal age, race, and weight are known cesarean risk factors for individuals but commonly cancel each other when analyzing for hospital PC-02 rates. Thus, including a comprehensive set of maternal medical exclusions would add data collection burden without commensurate benefit.

There are also no ideal target rates for this outcome measure. Instead, the measure is designed to be an accurate way for leaders to identify whether a hospital's rate of cesarean births for women included in this select population is consistent with the rate of cesareans within this same population at another hospital. Hospitals whose cesarean birth measure rates are higher than they wish them to be are encouraged to explore and evaluate differences in the medical and nursing management of women in labor.

Since there is currently no risk adjustment for this measure, inclusion of expected versus observed results is not indicated.

The Joint Commission has not set this as a target for cesarean birth rates, nor does it establish benchmarks for any of its measures. The intent of this measure is for hospitals to understand their baseline rate of performance in order to determine if performance improvement efforts are indicated and, when they are, effective over time.

NQF response:

NQF encourages and supports implementation of NQF endorsed measures. NQF staff provides technical assistance to measure implementers, such as Leapfrog, whenever requested. NQF seeks Committee members with experience and expertise in measure implementation to provide feedback on implementation, impact of measures on those being measured and any unintended consequences.

> **Proposed Committee Response:** To be discussed by the Committee during the July 26 call.
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> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure #0471?

0475: Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge

This measure received 4 comments, generally supporting endorsement. One comment noted that the measure as specified does not adequately reflect the immunization of infants who had deferred vaccination until the infant's first visit to the pediatrician. Another comment raised the issue that babies who are transferred for a higher level of care are often transferred prior to the birthing facility having the opportunity to administer the vaccine; the comment urged the exclusion of newborns who are transferred to a tertiary care facility. One of the supportive comments suggested that the measure be modified to "recommend educational material be provided to parents regarding efficacy of vaccines since some parents decide to not vaccinate". This measure passed all criteria and was recommended by the Committee, Y-27, N-0.

Developer Response:

We thank you for your response and agree that educational materials for parents are helpful. Vaccine Information Statements are required (by federal law) to be given to the patient, parent, or legal representative prior to administration of certain vaccines, including HepB vaccine. The

Vaccine Information Statements provide information about the benefits and risks of specific vaccines, and include general information on vaccine efficacy (note that Vaccine Information Statements are generally written at a 10th grade reading level). Hospitals or birthing facilities may elect to provide additional information to parents regarding HepB vaccine efficacy.

We appreciate this comment. While we are open to excluding newborns who are transferred to a tertiary care facility from the denominator, we feel that this is unnecessary. Overall, the number of infants transferred out of a hospital (compared to the total number of infants born at a hospital) is low. The numerator specifies number of infants administered HepB vaccine prior to discharge, or within 1 month of life if the infant had an extended hospital stay. The majority of infants needing a transfer will have an extended hospital stay, and therefore have ample opportunity to receive the birth dose at the receiving hospital. The birthing hospital could obtain records regarding HepB vaccine receipt from the receiving hospital and/or an immunization registry. As such, this issue should not affect the measure in any meaningful way.

We thank you for this comment and agree that the measure would not reflect immunization of infants who had deferred vaccination until the infant's first visit to the pediatric office. However, delay of the HepB birth dose should occur only in very rare circumstances. The Advisory Committee on Immunization Practices states "on a case-by-case basis and only in rare circumstances, the first dose may be delayed until after hospital discharge for an infant who weighs greater than or equal to 2,000 grams and whose mother is HBsAg negative." Administration of a birth dose in the hospital (even without HBIG) serves as a safety net to prevent perinatal infection among infants born to positive mothers who are not identified because of errors in testing or reporting. Administration of a birth dose has also been associated with higher rates of on-time completion of the HepB vaccine series and improved completion rates for other vaccines.

> **Proposed Committee Response:** Thank you for your comment.
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> **Action Item:** After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure #0475?

0476: PC-03 Antenatal Steroids

Of the 5 comments received on this measure, 4 were fully in support. One comment raised serious concerns with the measure's numerator and denominator: first, with the denominator exclusion of "a documented reason for not giving steroids", pointing out that this could allow exclusions for serious facility structural issues, knowledge deficiencies on the part of the provider, or an "improper attitude" on the part of the provider or hospital unit. The comment also raised the issue of potential gaming, noting that the numerator captures use of steroids at any time, but they are optimally effective if given 24 hours to 7 days prior to early preterm birth. This measure passed all criteria and was recommended by the Committee, Y-26, N-0.

Developer Response:

Thank you for your feedback. The purpose of the measure is to evaluate that patients at risk of preterm delivery at >=24 and <34 weeks gestation receive antenatal steroids prior to delivering preterm newborns. The measure is not constructed to evaluate other aspects of established guidelines. Hospitals would need to use other measures or evaluation methods to determine adherence to additional guidelines.

Proposed Committee Response: Thank you for your comment.

Action Item: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure #0476?

0480: PC-05 Exclusive Breast Milk Feeding

2830: PC-05 Exclusive Breast Milk Feeding [eMeasure]

A total of 13 comments were received on both measures. Comments were generally supportive of both the electronic and paper versions of the measure, but a number of concerns were raised, including issues around maternal choice, exclusions for the measure, and the need for implementation within a family-centered decision making process. Commenters also encouraged the development of a measure on longer-term breastfeeding. Both of these measures passed all criteria and were recommended by the Committee: 0480: Y-21, N-2; 2830: Y-18, N-2.

Developer Response: *"Thank you for your feedback. This measure was designed as an in-patient quality measure. The Joint Commission has no means of tracking this post-discharge activity. Much evidence has now focused on the prenatal and intrapartum period as critical for the success of exclusive (or any) breastfeeding. (Centers for Disease Control and Prevention [CDC], 2007; Petrova et al., 2007; Shealy et al., 2005; Taveras et al., 2004).*

PC-05 does not exclude maternal medical conditions. These conditions are unusual (~2% of patients), and they cannot be modeled in the electronic Clinical Quality Measure (eCQM) version of PC-05. The removal of measure exclusions will also significantly reduce the burden of data abstraction. The revised measure is similar in construct to PC-02: Cesarean Birth, which reports the cesarean birth rate with no exclusions. As a result of some mothers declining exclusive breast milk feeding and by removing exclusions, The Joint Commission does not anticipate or expect that measure rates for PC-05 will reach near 100% as has been the case for many other measures. Available evidence suggests that a 70% threshold may be a more reasonable target for many organizations.

It is important to note that The Joint Commission does not establish benchmarks for any of the core measures. The goal is for hospitals to understand their baseline rate of performance for each measure in order to determine if performance improvement efforts are effective over time when their baseline is higher or lower than the national performance (depending on the desired direction for improvement)."

Proposed Committee Response: Thank you for your comment.

Action Item: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measures #0480 or #2830?

1382: Percentage of low birthweight births

This measure received 4 comments, 2 of which were fully supportive. One comment suggested replacing birthweight with gestational age, as that is now widely available. The fourth comment did not agree with the recommendation for endorsement, noting "this measure has not influenced outcome over the past several years in US", and that "Additional maternal and neonatal info would be necessary to provide any meaningful outcomes." This measure passed all criteria and was recommended by the Committee, Y-26, N-0.

Developer Response:
Agree, gestational age is now a better measure of outcome and should replace this measure.

Proposed Committee Response: To be discussed on the July 26 Committee call.

Action Item: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation of measure #1382?

1391: Frequency of Ongoing Prenatal Care (FPC)

This measure received 3 comments agreeing with the Committee's concerns and their decision not to recommend the measure for endorsement. The measure did not pass Evidence (H-1; M-1; L-9; I-15). Two commenters disagreed with the Committee's recommendation. One comment agreed there are shortcomings with the measure, but noted that it is considered a basic measure of appropriate maternity care and there are no alternatives to replace it; this commenter urged the development of an improved measure as soon as possible. The final commenter raised concerns stating that the measure has been the basis for successful public health programs since the 1930s, and noting that gaps in care remain. In addition, the commenter stated, the loss of the measure could "lead to further disregard of PNC utilization in US healthcare plans, diminished primary and preventive care for women during pregnancy, and exacerbate reproductive health and health care inequity in the US." This commenter also suggested simplifications to improve the measure.

Developer Response:

NCQA has opted to remove the Frequency of Prenatal Care (#1391) measure from consideration for re-endorsement.

NQF Response: This measure has been withdrawn from consideration. Endorsement will be removed.

Action Item: No Committee action needed

2893: Neonatal Intensive Care All-Condition Readmissions

This measure received one comment supporting the measure, but not providing any additional data. During the in-person meeting, this measure did not pass reliability, a must-pass criterion (H-1; M-7; L-17; I-2). The Committee had a number of concerns, including that the measure is specified at the hospital/facility level, but not all of these may be able to track readmissions to other facilities. The measure relies on hospital data linked to vital statistics, which may not be available in all locations. The Committee was concerned that the measure does not account for planned readmissions or planned transfers and does not differentiate between a hospitalization and an observation stay since both are included as readmissions.

Proposed Committee Response: Thank you for your comment.

Action Item: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure #2893?

2902: Contraceptive Care – Postpartum

This measure received 25 comments, all supporting the endorsement of the measure. A number of the comments highlighted the gap in contraceptive measures, noting there are no currently endorsed in the NQF portfolio. Several of the comments also noted some concern with the measure, including: the need to ensure women's choices are informed and respected and the need for the balancing measure of woman-reported experience of contraceptive care currently under development; these comments reiterated that the performance should not be 100%. In addition, commenters submitted requests to align the timing for postpartum coverage with other measures of postpartum care and for minor changes to the age range. One commenter stated this is not appropriate for a health plan level measure "given that health care decisions are best made between the providers and their patients"; another noted "that the contraceptive measures as currently specified are most appropriately reported at a population level and are not appropriate for "pay for performance" programs." This measure passed all criteria and was recommended by the Committee, Y-24, N-3.

Developer Responses:

We appreciate the reviewer's support for the measure. The reviewer has raised an important issue, which OPA will be delighted to consider over the coming years as we gain more experience using the measure and consider whether any changes are needed when it goes before NQF for maintenance review in 3 years. Our intention is to form and convene an Expert Work Group in the interim period to review the use of the measure in various settings (Medicaid, Title X, other programs) and give us advice on what changes may be justified.

The reviewer is correct in noting that Medicaid and other health plans that rely on claims-based reporting of the measure would not capture 'free contraception' -- however, this is likely to be a very small number of patients. Programs such as OPA's Title X program that do provide 'free' contraception can adapt the measure to their own data systems so that the 'free' methods are identified. We will consider submitting a Title X adaptation of the contraceptive measure to NQF when we submit for measure maintenance in 3 years.

We appreciate the reviewer's support for this measure, and share their concern that contraceptive care be offered in a client-centered manner. Of note, existing research has shown that method effectiveness is important to many women and, as such, is one of many aspects of client centered care. For example, a recent study showed that nearly 90% of women reported that method effectiveness was an 'extremely important' characteristic (Jackson 2016).

We do not fully understand the context of the comment that the measure is appropriate for population level but not health plan level, and welcome additional information from the reviewer. The primary purpose of the measures is to encourage removal of barriers to contraceptive access in the provider- and systems-level so that women are offered a wide range of methods in a client-centered manner, preferably on a same-day, onsite basis. It seems to us that these barriers could exist in a health plan, and therefore could be addressed at a health plan level as well as at the population level. We agree that benchmarking for this measure will require careful consideration so that comparisons across reporting units are done in a fair manner that does not put undue pressure on providers to 'coerce' women; we intend to convene an Expert Work Group in the intervening period before measure maintenance review, to help us consider the issue of benchmarking. If we are overlooking some other important aspect, we welcome additional information from the reviewer.

We can see the potential benefit of aligning the postpartum contraceptive measure with the HEDIS postpartum measure, and will be delighted to consult with the Expert Work Group about this as preparation for submitting for measure maintenance in 3 years. However, the 3 day window is important to ensure women have access to contraception in the immediate postpartum period. This is a period in which there have been a number of barriers to providing the full range of contraceptive methods.

Proposed Committee Response: Thank you for your comment.

Action Item: No Committee action required.

2903: Contraceptive Care – Most & Moderately Effective Methods

This measure received 23 comments. As with measure #2902, the comments were all in favor, but highlighted the importance of ensuring that women are not coerced into using contraceptives and the need for a women-reported contraceptive access measure. In addition, commenters requested the exclusion of women who refuse contraceptives. This measure passed all criteria and was recommended by the Committee, Y-20, N-5.

Developer Responses:

Our intention is to form and convene an Expert Work Group in the interim period to review the use of the measure in various settings (Medicaid, Title X, other programs) and give us advice on what changes may be justified.

We do not fully understand the context of the reviewer's comment that the measure should exclude members that refuse listed contraceptives, and welcome additional information from the reviewer. If the member refused the listed contraceptive because their preferred method(s) were not available, then we think this may be a barrier that could be reduced by use of the measure over time. Some clients will choose to not use any contraception at all – and the measure is designed to respect their right to do so – but those refusals would be captured by setting a benchmark below 100%. If there is some other nuance that we do not currently understand, we will be delighted to consider some other alternative.

We share their concern that contraceptive care be offered in a client-centered manner. Of note, existing research has shown that method effectiveness is important to many women and, as such, is one of many aspects of client centered care. For example, a recent study showed that nearly 90% of women reported that method effectiveness was an 'extremely important' characteristic (Jackson 2016).

OPA is fully committed to doing everything it can to ensure that the performance measures are used in a manner that supports the delivery of client-centered care. As the measure steward, we will take every opportunity (e.g., on the steward's measure webpage, in presentations, in publications) to explain how the measures are intended to be used. Key messages will include: no specific benchmark has been set for the most/moderately effective method but OPA does not expect it to reach 100%; the interpretation of the LARC measure should be focused solely on identifying areas with extremely low levels of LARC provision and should not be used to encourage high rates of use; and it is not appropriate to use the LARC measure in a pay-for-performance context. We will also highlight the importance of following Federal recommendations, especially CDC-OPA's recommendations for how to provide quality family planning (QFP), for how to provide contraceptive care in a client-centered manner.

We also agree with the reviewer's note of the need for a measure of client experience that will 'balance' the current measures focused on contraceptive provision. In fact, OPA recently awarded a 3-year cooperative agreement to the University of San Francisco to develop a patient-reported outcome performance measure (PRO-PM) for contraceptive care. The PRO-PM will focus on the client's experience with care and identify situations in which the woman's preference was not respected; it will serve to 'balance' the current measures that focus on what contraceptive methods were provided. A rigorous plan of testing and validation of the PRO-PM measure is planned, and we expect it will be ready for submission within 3 years. We look forward to learning more in the coming years about how to best use the two sets of measures in tandem so that women receive high quality, client-centered care.

It seems to us that these barriers could exist in a health plan, and therefore could be addressed at a health plan level as well as at the population level. We agree that benchmarking for this measure should be voluntary; no specific benchmark has been set for the most/moderately effective method but OPA does not expect it to reach 100%; the interpretation of the LARC measure should be focused solely on identifying areas with extremely low levels of LARC provision and should not be used to encourage high rates of use; and it is not appropriate to use the LARC measure in a pay-for-performance context. We will be consulting with our Expert Work Group on this over the coming years, and welcome additional input.

Proposed Committee Response: Thank you for your comment.

Action Item: No Committee action required.

2904: Contraceptive Care – Access to LARC

This measure received 24 comments. Almost all of the comments were supportive, and many raised similar concerns as with #2902 and #2903. Concerns were raised for this measure, including the fact that some insurers and health systems restrict access to LARC. One comment noted that IUDs and implants require different insertion skills and the measure should differentiate between them. Commenters both agreed and disagreed that this is a measure of access; one noted a concern that it may be misinterpreted and encourage providers to provide LARCs without appropriate counseling.

One comment noted continuing concerns such a measure has the "potential to encourage coercion, which remains an ongoing reality for many, including low-income women, women of color, young women, immigrant women, LGBT people, and incarcerated women. We request that this measure be paired with a woman-reported "balancing measure" of experience of receiving contraceptive care. Such a measure can be expected to help identify and/or check inappropriate pressure from the health care system. We understand that OPA is developing

such a measure and encourage its rapid completion and submission for endorsement. We recommend that proposed measure #2904 be held back until the measure of the experience of receiving contraceptive care is in place."

This measure passed all criteria and was recommended by the Committee, Y-20, N-5.

Developer Response: *The developer responded with the same information as above plus the following:*

For purposes of simplicity and because we did not want to imply one LARC method was preferred over the other, we combined both methods into a single LARC measure. However, there may be benefits to looking at the methods separately in the future as the measure is used more widely, to ensure that women are being given a choice of both IUDs and implants. We will consult with the Expert Work Group that will be considering the measure over the coming years, and welcome additional input.

Proposed Committee Response: *To be discussed*

Action Item: After reviewing the comments received, and the developer's response, does the Committee wish to reconsider its recommendation on measure #2904?