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NATIONAL QUALITY FORUM

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OPERATOR: This is Conference #: 66719408.

Welcome everyone. The webcast is about to begin. Please note, today's call is being recorded. Please standby.

Suzanne Theberge: Good afternoon everyone and welcome to the first Perinatal and Reproductive Health Workgroup Call, where we'll be looking at the reproductive health and pregnancy measures in this project.

This is Suzanne Theberge, the Senior Project Manager on the team. And I'm joined on the phone today with the rest of the NQF team, Reva Winkler, Nadine Allen and Kaitlynn Robinson-Ector. And we want to thank you all for joining us.

Before we begin, I'd like to just do a couple of quick health keeping notices and then I'll check and see which workgroup – make sure all the workgroup members are on the phone, and then we'll go ahead and get started.

So, as with our other orientation calls, just a quick reminder to put us on mute if you're not speaking. And make sure that if you are on both the phone and the streaming webinar, that you turn the volume off on your computer so we don't get feedback. But please note that if you would like to speak, you do need to be called into the phone line. And we'd also like to ask that you'd not put us on hold so we don't get your hold music on the line.

So, I think that's all of our housekeeping items. And as always, if you have a question or a comment, committee members, please do jump in or raise your hand on the webinar and we'll try to get your question addressed.

And with that, I will do workgroup member attendance. Ashley Hirai, are you here? Ashley?

Ashley Hirai: Hi, Suzanne. I'm here. I'm sorry. I was just on mute.

Suzanne Theberge: Great, thank you. Yes, the mute button. John Keats?

John Keats: Present.

Suzanne Theberge: Thank you. Sarah McNeil?

Sarah McNeil: I'm here.

Suzanne Theberge: Great, thank you. Naomi Schapiro?

Naomi Schapiro: Yes, I'm here.

Suzanne Theberge: Great. Marisa Spalding?

Marisa Spalding: Hi, I'm here.

Suzanne Theberge: Thank you. And Sindhu Srinivas?

All right, well hopefully Sindhu will join us shortly. Before I turn it over to Reva to begin the content of the call, I just want to see, are there any other committee members who will be listening in today?

Greg Goyert: Greg Goyert. I'm sort of lurking to learn how to do this.

Suzanne Theberge: Great.

Sheila Owens-Collins: Sheila Owens-Collins, (ditto).

Suzanne Theberge: Great.

(Crosstalk)

Carol Sakala: And hi, this is Carol Sakala.

Suzanne Theberge: Hi, Carol, fantastic. We're glad to have the other members of the committee on the call today.

And with that said, I will just turn it over to Reva to begin the content of our call. Reva?

Reva Winkler: Thanks everybody and thank you all for being with us. Today, we're beginning the evaluation of six of the measures in this perinatal and reproductive health project. We have three new measures that recently developed and have never been evaluated by NQF before, all around the topics of contraception. And they're all brought to us by the U.S. Office of Population Affairs.

Who do we have from the developer on the line to answer any questions about these measures? (Lori), I think I saw you.

(Lori Gavin): Yes, I'm here, (Lori Gavin). And then my colleagues, (Bill Hastings) and (Brittany Frederickson) are also on the line.

Reva Winkler: Great. Thanks so much for joining us today.

All right, and then we then have two – three other measures that are endorsed measures that are undergoing their maintenance of endorsement review. And as we've talked about in our introductions, we will be looking at these slightly differently though the criteria is the same. How we look at them will be a little bit different. You'll see an example of that today.

All three of these measures are from NCQA. Do we have somebody from NCQA on the line? OK, maybe not yet because we're going to do the contraception measures first.

OK. So, let's go ahead and get started. One thing though, would anybody object if I rearrange the order of the contraception measures and did 2903

first? Would that work for everybody? In looking at the measures, that one seemed maybe a little bit more straightforward and might be a good one to start with. Does that work for everybody? Anybody object?

OK. So that's what we're going to do. So, Sarah McNeil and Mimi Spalding, you are the lead discussants on this.

And so, what we want to do is first, provide a brief description of the measure. What is it we're measuring? Who's being measured? And then we'll move in to looking at the criteria in the order that it's laid out for you in your worksheet, and that means we start with evidence.

So, I'll flip an imaginary coin and ask Sarah to go first, if she's – if that's OK with you. And give us a little bit of an introduction of the measure and then your assessment of the evidence, and how well this measure information meets the criterion.

Sarah McNeil: I'm so sorry. I was not prepared to be the first person so I have …

(Off-mike)

Sarah McNeil: … on my computer.

Marisa Spalding: Yes, Sarah, totally. We have a hot – we're the first guinea pigs, so I understand. This is Mimi.

(Off-mike)

Sarah McNeil: I'm so sorry. It's going to take me two minutes to like get …

Reva Winkler: OK, Mimi …

Marisa Spalding: I'm …

Marisa Spalding: … pull it up.

Reva Winkler: … as alternative.

Marisa Spalding: I'm so sorry.

Reva Winkler: OK, all right.

Marisa Spalding: I can do a brief description while, Sarah, if you want to look for the evidence or?

Reva Winkler: OK

Naomi Schapiro: Yes.

Reva Winkler: That sounds good.

Marisa Spalding: OK. So, as you'll see on the webinar. So, the brief description of this measure is taking a look at the percentage of women of reproductive age who saw that women age 15 to 44, who are at risk of unintended pregnancy, and are provided either the most effective, so that's sterilization, implants, IUDs, or IUS. Or moderately effective, so that's injectables, oral pills, patches, rings or diaphragms. And these are all FDA approved methods of contraception.

And this is considered an intermediate outcome measure because – I don't necessarily want to read this, but it represents the decision that's made at the end of a clinical encounter between a provider and a patient about the kind of contraceptive that is most – that best fits that particular patient's needs. And there's also a strong association between the use of either most effective or moderately effective uses of contraception and the risk of unintended pregnancy.

Reva Winkler: Great …

(Crosstalk)

Marisa Spalding: So, does anyone have any questions? Oh sorry.

Reva Winkler: No, that's fine. So, that's kind of set you up for, you know, discussing the evidence and how well the measure meets the evidence criterion.

So Sarah, are you in – are you up for that yet?

Sarah McNeil: I am just not finding the right link, but I can – I can discuss the evidence on reading through and then my knowledge of the evidence.

Reva Winkler: OK.

Sarah McNeil: So, there has been large studies that have very clearly delineated effectiveness of different contraceptive methods, and shown that Long-Acting Reversible Contraceptives are significantly more effective than pill, patches, rings as mostly effective contraceptive methods, more effective than condom, withdrawal and abstinence. So, that is one body of evidence that is sighted.

And then the other body of evidence that is sighted is around different methods of counseling, that when women are counseled "appropriately" or with effectiveness as the primary outcome, that the majority or more women choose the most effective forms of contraception or LARC method. So, those were the two big bodies of evidence that were sighted.

Reva Winkler: OK. So, in terms of the evidence criterion, just as a reminder, what we're looking for, for this process or intermediate outcome measure is that it's based on a systematic review and grading of the body of empirical evidence, where the specific focus of the evidence matches what's being measured? So, do we have a systematic review of the evidence?

Marisa Spalding: Yes.

Sarah McNeil: So, my feeling is – this is Sarah again. My feeling is that there is a systematic review of the evidence that's in line with effectiveness, but that is a different – that's a different set of evidence than what is being measured, which is the percentage of women that decide on, you know, most or more effective birth control methods.

Reva Winkler: OK, Mimi, your thoughts?

Marisa Spalding: Yes, I would agree with Sarah on that. But I do think that there's also – that this measure is also based on clinical practice guidelines, right? And so, I think – does that also contributes to the body of evidence?

Reva Winkler: Yes, it does.

Marisa Spalding: Yes, so there are clinical practice guidelines from CDC, ACOG and AAP that recommend, you know, education and counseling for patients based on the options of contraceptive measures.

Reva Winkler: Just to respond to Sarah, just one of the things about the evidence that we're looking for is the demonstration that the evidence shows the relationship of what's being measured to patient outcomes. And this is where the diagram that the developers have provided for you can be helpful. And so, in this particular page, the diagram shows the intermediate outcome of use of the most effective forms of contraception. And that the outcome is really avoidance of unintended pregnancy. And so, you know, the evidence around that relationship is what we're looking for. I agree with you that the evidence around the effectiveness of the counseling to get that decision to be made is also important.

So, how would – how do you …

(Off-mike)

Marisa Spalding: And the measure isn't looking at unintended pregnancy. It's just looking at LARC and more effective provision.

Reva Winkler: Right. So, we also are at the evidence is asking about the relationship to the outcomes. So, how would you rate the evidence in terms of meeting the criterion for this measure?

Marisa Spalding: This is Mimi. I said that I thought the evidence in – it was high. I rated that as high. I'm trying to find my notes on why.

Reva Winkler: Sarah, what do you think?

Sarah McNeil: Yes. I think that there's a large body of evidence that is – there are very good data that exists. So, I rate the evidence as high. I'm just – I'm concerned about the, well, the association between the evidence and then what the

measure would ultimately – how the measure would ultimately affect patient care, I think.

Reva Winkler: OK.

Sarah McNeil: Yes. S, just to your question, I think that the evidence is good. Yes.

Reva Winkler: OK.

Sarah McNeil: It's a high …

(Off-mike)

Reva Winkler: OK. How about other workgroup members, any questions, any thoughts, anything you'd like to contribute to the conversation around evidence for this measure?

(Crosstalk)

John Keats: This is John Keats. I have a more general question. I mean, who is this measure meant to be applied to? For instance, how will it be used?

Reva Winkler: Well, we'll get to that when we – in the next criterion, under scientific acceptability.

John Keats: OK.

(Off-mike)

Greg Goyert: I will go back to some of the earlier comments. This is Greg Goyert. Nobody's going to argue that LARCs and others are effective contraception. That's not really what the measure addresses. We're seeing what's the uptake by the patient at the time of this visit for these methods of contraception.

So, like several other measures in the whole group, and somebody's going to be evaluated on the basis of patient decision making over which the provider does not have control. So, you can argue with the evidence that, yes, LARCs

are highly effective, but that's not really what the measure is addressing, and that's my concern.

Reva Winkler: OK, all right. But right now, we're just talking about …

Female: Yes, and …

(Crosstalk)

Reva Winkler: Yes. Right now, we aren't getting into the specifics of the measure. We're just talking about the evidence of contraceptive effectiveness.

Naomi Schapiro: OK. This is Naomi Schapiro. So, I mean for me, and I work mostly with adolescents, so on our end, what we see is people start but they don't stay on. And so, just if you're really looking at the tripling outcomes of reduction in teen unintended pregnancy, it's not just what people pick. It's what they not only pick but they actually start using for the moderately effective methods and what they keep using. You know, how many people are discontinuing because of the side effects and things like that.

So, it's not just because we, you know, we have an agreement that, yes, you're going to pick up your prescription for birth control pills or you're going to start the ring or we even hand it to you in the moment. Or, if you get the implant and you're happy with it when you walk out of the clinic, does it mean that people aren't coming back several months later and have things removed or don't actually use them.

And maybe that's not what this is supposed to measure, but if we're really looking at uptake at the visits of moderately or most effective methods of contraception to be sort of a proxy measure for reducing pregnancy, it's not quite that simple.

Reva Winkler: All right, OK. Quick comments. Anything else on evidence before we move to another criterion? I just – I'm keeping an eye on time.

All right, so let's move on to opportunity for improvement. What do we know about current performance? So, Sarah and Mimi?

Sarah McNeil: Mimi, do you want to go?

Marisa Spalding: Yes. Let's see, so the performance (operate). Yes, I think that there – so it seems like through – so some of the rationale behind this is that across the board, there are, you know, millions of women of reproductive age. And yes, there are continued to be unintended pregnancy, I think, at 51 percent plus. And so, this represents opportunities to improve of course. In certain populations including young people and I think women who have never been married, those are particular populations where there are – there can be benefits from this type of measure because there are like disparities in those areas.

Is that kind of along the lines of what …

Reva Winkler: Yes.

Sarah McNeil: Yes, I agree. I felt like it was clear that this is an area that warrant a performance measure, and that there are definite disparities that exist and needs to be addressed. Yes.

Marisa Spalding: One thing I will say that I was surprised at is that there weren't racial and ethnic disparities, but I don't know if that will be addressed later in the conversation.

Reva Winkler: Well disparities and looking at what is known about potential disparities in any of the measures is part of opportunity for improvement. And so, we see the information provided by the developer around disparities. Certainly, one of the important contributions you as committee members can make is your own knowledge and expertise around some of these topic areas. So, if you have something else to contribute to the discussion around, you know, disparities, please don't hesitate.

Ashley Hirai: Hi, Reva. This is Ashley Hirai. And on that line, I did want to comment that it did seem like a flag to me and I think some other committee members that we were expecting to see those racial ethnic differences. And in fact, there are for the ultimate outcome with unintended pregnancy.

And I went to actually look at the data provided and it did seem like there was actually an error in how they calculated statistical significance, and they were using a very conservative test of overlapping confidence intervals, not a difference between two-point estimates. And so, confidence intervals can actually overlap by as much as a third and still be statistically significant in the point estimates. And so, I actually did try to calculate it and we found that there were significant black white differences. So an eight percentage-point difference, and it was statistically significant by my calculation.

So, I don't know if that's a possibility to add an addendum to this. But I do think there was an error in this. And actually the other measure on LARC, I calculated both of them, and there were statistically significant differences.

Reva Winkler: That's why we have people like you on our committee. Luckily, somebody usually likes to play with the numbers. So, thank you very much. This is exactly the contribution and critical thinking that we're looking for the committee members. So, we certainly will want to add that in to the discussion and the conversation, so thank you.

Any other from anybody else on opportunity for improvement or disparities?

OK. So, as you can see, as we slide down, the next criterion that we're going to look at. Oh, just to – I want to point to you as it's shown on the webinar. The responses to the surveys that you guys did prior to the workgroup call, we've embedded those responses in here, so that, again, we're trying to collect all the information and inputs. So, all of this information is going to kind of pull a list and come together for the in-person meeting when you make your final recommendations. So, right now, we're in the, you know, maximum information gathering stage.

Just again in the interest of time, I do want to move down to scientific acceptability, the measure of properties. And the first thing we look at under reliability is specifications. And specifications are sort of the critical part of any measure. So, it's important to understand, you know, who is being measured, how are – what kind of data is being used, and then the nuts and bolts of the enumerator and the denominator.

And one thing I just wanted to point out because John brought it up earlier is the level of analysis for this measure is facilities, health plans, or population such as regional or states. All right, so it's a relatively high level of analysis or level of analysis for this measure.

OK, Sarah and Mimi, what are your thoughts on the specifications for the measure?

Sarah McNeil: This is Sarah. One of the questions that I had was how is those women who are at risk of unintended pregnancy determined? Is that just all women are at risk of unintended pregnancy? Or, how is – yes.

Marisa Spalding: I have that same question.

(Crosstalk)

Marisa Spalding: And I also have another question. I'm not sure if they could be handled at once, but – or maybe someone can clarify this. But one of the exclusion categories is those women who had a live birth in the last two months of the measurement year, maybe it's just because I'm not a provider, but I just didn't understand why those women were excluded.

Reva Winkler: I think these are good questions for our developers, (Lori) or one of you all could respond to their questions?

(Lori Gavin): Yes, I can do it. This is (Lori). The issue related to the last two months of that measurement year, we wanted to make sure that women who gave birth had enough time to receive contraception. So, if they were pregnant for most of the year and then they didn't have time to get contraception at that six-week post partum visit, then we didn't feel like we could consider them at risk. So, that's where the two months comes in. And we can try and explain that more visually at the in-person meeting if that's helpful.

On the denominator, how we defined at risk? We did the best that we could given the limitations of claims data. So we – you know, again in the meeting, we can talk, walk through the specifications and the groups that we were able

to exclude. But you're right, some of women who are not at risk probably included the denominator just because we can't identify. The claims data doesn't have information about pregnancy intention, history of sexual activity. And in this measure, we don't have previous assertion of LARC or sterilization.

So, what we are doing is two things. We think the measure, the room for improvement is so huge that we are trying to emphasize the need for focusing on just on improvement. And we've analyzed, we prepared some tables and NSFG, National Survey of Family Growth analysis, that will help those who want to kind of come up with the prevalence estimate for their population to kind of adjust for those limitations to the claims data.

Sarah McNeil: On page 22, there's a statistics that 44 percent of women aren't in need of contraception. But is your point that, perhaps, for that population study, it was 44 percent. But for other subsets of people, for other population studied, it might be less or more.

(Lori Gavin): You know which page? I'm sorry. I'm not looking at the right page 22. My numbers are (different).

Sarah McNeil: Oh yes, sorry, all of the numbers are different now.

(Lori Gavin): Which section is that? Is that in the …

Sarah McNeil: I just wrote, sorry, when I was doing my notes, so I just wrote down the page numbers which are now not useful at all.

Marisa Spalding: It's 1B2, so the performance scores on the measure. I'm trying – right? Is that what page it is, wait, 22, 20, 21.

(Off-mike)

Marisa Spalding: Yes, it's right. It's like two paragraphs above 1B3.

(Lori Gavin): Hang on a minute. Let me try to find that.

Sarah McNeil: Yes, which is now on page 24.

(Lori Gavin): Yes. So, that's illustrating how we're proposing to adjust for these limitations of the measures. And we have – the way we analyze NSFG data is we use just the overall. We showed you the results for all of them in adult women. But the NSFG analysis, you can – it's other kinds of stratification. So, it's by age. It's by race, ethnicity, so dependent by marital status. I think by – I have to look at, I think, by educational level, by income. So, depending on the population that you're serving, you could – those estimates may vary depending on your population.

And you can look at NSFG and try to adjust for that. Again, I think this is – will help you kind of give you a sense of what, you know, your actual percent at risk is. But again, the overall for most people, we think that just looking for a 10 to 15 percentage point improvement in the next three to five years is what the main focus should be on while we work on an eMeasure or hybrid measure.

Sarah McNeil: And because the measures have to be based on claims data, we have to look at provision of methods. Is that right?

(Lori Gavin): That's right. But let me quickly address as the earlier point. But yes, that's exactly right. With the evidence statements, we looked at the work that's been done by Jim Tressel. And he calculates two estimates. One is the perfect use failure rate which we did not view here. I mean, he has a typical use failure rate where he factors in things like inconsistent use and incorrect use. So, the measure is based on the typical use rates that Jim Tressel's been calculating. So it address for that in perfect use.

Sarah McNeil: Yes, but what I'm more focused on is the – I'm worried about measuring provision versus, in my mind, the measuring – at one point, the measure we're talking about access, for example, which I think is really important. And the percentage of women who are offered a method but we're having to look at provision because we don't have the ability to just look at how was the counseling done or what was counseled. So instead, the surrogate measure is what we're looking at as a provision because it's a claims measure. Is that right?

(Lori Gavin): Yes. I think that's a great point. And it's also because we think provision is closer to the outcome of the health outcomes, unintended pregnancy, then counseling them because you get, you know, counseled, then a decision is made, then the client is provided the method. And so proximally, it's closer to that outcome also.

And I can I just address the access issue. The access issue is especially important for the LARC measure. It's important for both of them, but the access issue is primarily a focus on the LARC measure.

Sarah McNeil: Yes. The problem with unintended pregnancy – I mean agree, we are looking at unintended pregnancy. The problem with looking at unintended pregnancy is that it's good on a population level, but it's not good – or when I'm trying to address health disparities for my one patient in front of me. Because for some women, unintended pregnancy can actually be an acceptable outcome, and thinking about the importance of patient autonomy with provision of contraceptive decision making just gets lost in the idea of thinking about population specifics of unintended pregnancy.

So, I'm in support of the idea. I just think that there, we need to – well, it might be what we can kind of address right now based on what is available to measure. We really need to be very cognizant of the fact that this isn't and I don't think that this is an ideal measure, and we really need to work on ways to create more of an ideal measure in the future, even if this year, this is kind of the best that we can do.

(Off-mike)

Greg Goyert: Along the same lines, whereas supposing that a higher uptake is a good outcome, correct? Right? That's a given?

(Lori Gavin): Some limits, we explicitly not set benchmarks for the reason …

Greg Goyert: Well, but just in general, the higher the uptake, the lower the risk of unintended pregnancy is the posit here, correct?

(Lori Gavin): Yes.

Greg Goyert: So, going back to the previous speaker's comments – oh by the way, there's a substantial minority of patients in our country who view this as directly contrary to their religious beliefs. I don't happen to agree with them but – so you can see where this has the opportunity to be painted as in opposition to patients' moral beliefs. So, I'm not quite sure how you factor that in because I think to say, to ignore that point entirely is, perhaps, naïve.

(Lori Gavin): Right. So can I – should I address this or should I wait until our meeting in-person? Reva, is this – can I address this now?

Reva Winkler: Yes, just briefly. But we do have to, you know, just want to be sure we get through everything. So, briefly I think is reasonable.

(Lori Gavin): These are really important points and we will definitely address them in our in-person presentation. The kind of client preference, you don't have anyone who agree with you more than people at OPA. The guidelines that we sited and which is why we thought it was so important to put it into that logic model are all kind of – with a strong emphasis on client-centered care. So, we can talk more about why we think that's important.

I think the fact we're also not setting a benchmark is explicitly due to the fact because we know that this – it shouldn't be 100 percent. We think it should be higher than 63 percent, but we totally agree. And there's, you know, research showing that one woman have a choice. They will. A lot of them will choose these methods, but we can go into more in-person.

I hear you and I think we have a good argument against it. But I think between the guidance that we're recommending people follow, that was written by CDC and OPA, and ACOG, and AAP. And also, the fact that we're not setting a benchmark of 100 percent, and we will be doing a consultative complicated process so we can address the religious objections, people who don't – who choose not to is how we're proposing to address that.

Greg Goyert: Thank you.

Reva Winkler: OK. Any other discussion points on specifications because I'd like to move down on the actual testing of the measure for reliability and validity. And so one of the things that's important about testing is that we are expecting the measure to be tested at the level of analysis that's specified. And so, you should be looking for how the – you know, what level of analysis was the measure tested.

So, Sarah and Mimi, do you want to – your comments on the testing for reliability of this measure?

Sarah McNeil: I thought the reliability was high.

Marisa Spalding: Yes, me too. I agree.

Reva Winkler: OK, thoughts from anybody else on the committee? Do you have any questions about the liability testing, the method and/or the results that are reported?

OK. In this case, the measure was tested at the health plan level using Medicaid data. So, we are looking at more population level for this measure, as well as data from PPFA, which will bring you down more to a clinic facility level as well. So, that correlate – that aligns with what the specification say the level of analysis is.

OK, then we move down to validity. And the questions around validity are the specifications being consistent with the evidence. Any comments or concerns there, Sarah or Mimi or any other member of the workgroup?

Marisa Spalding: This is Mimi.

Sarah McNeil: One of the …

Marisa Spalding: Oh, go ahead.

Sarah McNeil: Go ahead Mimi.

Marisa Spalding: No, I was – go ahead.

Sarah McNeil: I was just going to say one of the panel of experts says, the quality of the indicator will, in part, depend on how well unintended is characterized, which I agree with. But otherwise, I think that it needs validity testing.

Reva Winkler: OK.

Marisa Spalding: Yes, same here. I think it's pretty high validity testing, like, I rated that as pretty high.

Reva Winkler: OK. Again, say – validity, I mean, we would dearly love to see empirical validity testing, and we are seeing it was some measures, and you'll see it with some of the others. But a good systematic assessment of face validity is an acceptable validity testing for the measure score as long as the question asked was, do you believe that these measure results represent quality? And so, the description of the – as face validity assessment they did was presented. Again, because it's only face validity rather than empirical validity, the highest rating you can give this measure for validity will be moderate. It doesn't qualify for a high rating without empirical testing.

But then we look at several of the threat – potential threats to validity around several things like exclusion and all this.

Greg Goyert: Can I – just wondering, for one second, going back to the, first, to validity. So, if you can scroll up just a little bit from the Webinar, so I'm concerned because this says the measure score correctly reflects the quality of care provided. Again, so that we're saying that if regardless of the counseling, regardless of the care provided, if the patient elects not to pick one of these methods of contraception, she, therefore, receive poor quality of care. I think that's dangerous because that's what we are implying.

Reva Winkler: Yes. I think that's going to be an important conversation to have with the entire committee in terms of what the results of the measure will mean. And it's a – and how that will influence its potential use and usability.

Greg Goyert: OK, great. Thanks.

Reva Winkler: OK. So, as we look down under threats to validity, we have an analysis of the number of patients excluded during the calculation. Does anybody on the workgroup have any comments or questions or concerns about the information provided around exclusions? Mimi, Sarah, you're good?

Sarah McNeil: Yes, I'm good. She answered my question about that, so.

Reva Winkler: OK, and …

Naomi Schapiro: This is Naomi, I …

Reva Winkler: … this measure …

Naomi Schapiro: I just had a question. I think this is similar for the measure I was looking at. So, for adolescence, are they using – all adolescence, are they like using the statistical data from teens who's never had sex to include them, or – I'm just curious.

Reva Winkler: (Lori), I think that question is for you.

(Lori Gavin): And we're looking at 2B3-2 of the exclusion table. So, that the history of sexual experience is not available from claims data unfortunately, so that is something that include here some teens who'd never had sex, which is, again, that's why we're proposing to adjust with the NSFG. But yes, that's correct.

Reva Winkler: OK. OK. So, not all of the potential threats to validity affect each measure. This measure is not risk adjusted. We do want to see that the results when calculated can provide meaningful differences about different providers, and the table of results looks at those differences.

Any comments from any of the committee members, Mimi or Sarah?

Sarah McNeil: No.

Reva Winkler: OK, all right. So, all of those together with the validity testing uses the – you use the algorithm to kind of think about all of those questions. So, if you believe the specifications do reflect the evidence and you feel that all of the threats of validity have been assessed, then in the absence of safe or empirical

validity testing and appropriate face validity assessment, then the appropriate rating on this measure for validity according to the algorithm would be a moderate reading.

Does anybody have any questions about that or disagreements?

OK. I just want to be sure that everybody understands how that works. OK. Again, you can see comments from folks. And you're going to want to spend some time looking at those prior to the meeting.

The next criterion is feasibility. And really, feasibility is about the extent to which the specifications and logic required data that are readily available or can be captured without undue burden and can be implemented for measurement.

So, Sarah or Mimi, what are your thoughts on feasibility?

Marisa Spalding: Since this is claims data, it seems like it wouldn't be an undue burden, so it does seem feasible.

Sarah McNeil: Agreed.

Reva Winkler: Thoughts from anybody else? OK. So, we'll go down to usability and use.

And in general, usability and use is more theoretical for a new measure that hasn't been out in the field. You'll see that it's quite different for measure that's been endorsed and has been implemented and used. We really want to know what's been happening. So here's the information provided. NQF look to endorse measures that are planned to be used for accountability purposes, including public reporting of the measure results that the entity is being measured.

So, any thoughts about usability and use of this measure, Mimi, Sarah?

Sarah McNeil: I thought, you know, the big thing for me is I think that it will be helpful to look at the results of this measure as it comes out. But the potential harm of leading towards their practices is certainly high on my radar, not accounting for patient autonomy in the exam room at the time of decision.

Marisa Spalding: Yes, me too. I definitely want to second that concern about patient autonomy and/or coercion, yes.

Reva Winkler: Thoughts from anybody else? OK.

Naomi Schapiro: I agree. This is Naomi. Also, I think this is also where it would be helpful to make sure we have statistically accurate look at disparities and uptake of different kinds of birth control among different women, especially, you know, women who historically have – are worried about, you know, forced sterilization or experimentation, maybe less likely to have something in their body that they can't take up themselves. And just, you know, just sort of looking at that whole issue a little bit more holistically.

Sheila Owens-Collins: This is Sheila Owens-Collins. I agree with that, that you should look not only basically but culturally and definitely as a (group), and also by age too, because teenagers may be totally different than young adults when you're stratifying the data.

Reva Winkler: OK. All right, any other thoughts on this measure before we move on to another one? OK.

Ashley Hirai: This is Ashley. I just have a question. I think somebody earlier on mentioned this that this isn't really capturing discontinuation, except it did look like very LARC, that they were adjusting for removal of the IUD for other method. And that just – it seemed to be a little bit inconsistent because there weren't adjustments for having LARC in the previous measurement, you know, because they are a long-acting. And there weren't, you know, efforts to account for discontinuation of other methods. So, that was just the question I had. I don't know if that will just wait until in-person meeting, but I think somebody else kind of raised that as well.

Reva Winkler: (Lori), did you have a brief response to that, perhaps?

(Lori Gavin): Yes, we can definitely – I think it's another great point. You guys are picking all the words on these great measures.

We did – there was just, again, limits of what you can do with claims data. We have data. We did try doing a look back and I can talk about it more at the meeting. But you have different source (inaudible) introduced them because you do a population, your measurement year, the further back look shrinks. So, you're still not really capturing the full population and still undercounting the previous LARC insertions and sterilizations. And we just don't know right now how to capture using claims data, method consistent and continuous to use – correct and consistent use of the other methods. We are – again, we are proposing that a hybrid eMeasurable fix most of these problems. It will require a hybrid measure with electronic data.

Reva Winkler: OK.

Ashley Hirai: OK. So, you're just adjusting to the one that you are able to, I guess.

(Lori Gavin): Yes, exactly.

Reva Winkler: OK. So, we have two more contraception measures that – and I think there's going to be a lot of similarity and overlap that we may not have to repeat the same discussion. Which one do you want to do next? Do you want to do 2904 access to LARC? Or, do you want to do postpartum?

Marisa Spalding: Let's do 2904. This is Mimi.

Reva Winkler: OK, sounds good. Mimi voted. Bless you.

(Off-mike)

Reva Winkler: OK. So again, I think that we can look at this. So, why don't you tell us a little bit about this measure and how it's – the specifics of this one. And then we can look to see as we go through the criterion, what's specific to this or what have we already kind of talked about before.

Marisa Spalding: Sure. So, this measure is different. And that it's the percentage of women of reproductive age, so age 15 to 44, at risk of unintended pregnancy that is provided LARC or a long-acting reversible contraception. So, that's implants, IUDs or IUS'. Yes.

Reva Winkler: OK. And so in terms of the evidence, is there something specific to this measure that we haven't already talked about in terms of evidence?

Naomi Schapiro: This is Naomi. I assume it's another discussion on this. And I'll just out start out by saying that I was not able to get access of the full measure. I've had a lot of problems with my website access. But from what I was able to look at, I think the biggest issue for me is the stratification between like 15 to 21 and then – or 20, and then 21 to 44 as the two age cutoff. And this is one where I really think it would be helpful to look at minor adolescents as a separate category, at least just into 18, just because of so many issues.

Reva Winkler: OK.

Naomi Schapiro: If you're looking at access, there're so many issues around pain for contraception, and parental requirements or parental consent, and waiting periods, and really state by state variations, and access to that age group.

Reva Winkler: OK, Naomi. But in terms of – is there anything additional or different to talk about evidence? Or, is it pretty much the same as the other measure?

Marisa Spalding: This is Mimi. I think it's pretty much the same as the previous measure.

Reva Winkler: OK.

Marisa Spalding: So, systematic reviews and then the guide like practice guidelines, and then a very, yes, a very deep body of evidence.

Reva Winkler: OK, anyone else on evidence?

OK. Let's look at opportunity for improvement. Again, we've got data from the Medicaid plans and PPFA, and also some Title X facilities.

So, any comments there, Mimi and Naomi?

Naomi Schapiro: I have a question about this and I don't – and maybe just because of when we are collecting data, it doesn't really matter yet. But now, you know that there's really been a mandate with the Affordable Care Act that commercial insurance provide contraception as a free benefit. I'm wondering if we're

really looking at the commercial versus Medicaid. If there's like an uptick in more people getting it through commercial plans. But it may be that during the period we're looking at for evidence, you know, that wasn't as much of an issue.

Reva Winkler: I think that in terms of the data that's provided, this is the data that was used during testing, and it doesn't look like they tested the measure on any commercial data sets.

(Lori), can you comment on that?

(Lori Gavin): Yes, that's exactly right. We were not able to test them in commercial data sets. But that (year), the 2013 and 2014 were years under which the Affordable Care Act provisions really made the contraception more in effect. I mean, some organizations are being grandfathered in, but this does kind of reflect care that's being provided within the – most constructs of the ACA.

I'm not sure I captured your accurately, though. Did that answer it?

Naomi Schapiro: Well yes, it answered that. That could have been available, but it just seems to me that there's a, well, if we're looking at access, there's a potential population out there that wasn't using Title X or Medicaid clinics.

Reva Winkler: Yes. No, if …

Naomi Schapiro: Not my population but there are people.

(Crosstalk)

Naomi Schapiro: We would love to look at this in commercial plans too. We just weren't able to do it. So, we did the Medicaid MCOs but didn't have commercial analyzed.

Reva Winkler: One of the hopes of NQF-endorsed measures is that they become more widely-used after they're endorsed. And so while we have limited data in a new measure, usually about what was used for testing, hopefully, you know, next time we look at this measure, it would have greater experience and more broad use and we would have, you know, data a little bit more broadly.

So, I think, can we move down to specifications in terms of the questions about those? And I think those – this was where your question around stratification, Naomi, comes in.

Naomi Schapiro: Yes.

(Lori Gavin): Do you want me address? This is (Lori). The reason we did the age cutoff, your comments was – makes total sense. So 15-year-old to 18-year-old would be a very logical cutoff. For the testing of the first round of the measures, we decided to align it because Medicaid was interested using it with the age cutoff that Medicaid does. That it would kind of fit into their framework. But I think you're right. In the future iteration, we could definitely be testing for the 15-year-old to 18-year-old, and it would make complete sense.

Reva Winkler: OK. Any other comments, Mimi and Naomi, on the specifications for this measure or this, you know?

Marisa Spalding: None from me. I think we discussed them with the other measure.

Reva Winkler: Right.

Sarah McNeil: Yes.

Reva Winkler: OK. Yes. All right. Similarly, let's move down to reliability testing. I think, you know, testing was done very similarly. The method was similar as to previous measure. And so any comments on the results of the testing for this particular measure? No?

Sarah McNeil: No.

Marisa Spalding: No. No.

Reva Winkler: Any questions from anybody in terms of what the testing means, or how it was done, and what the results indicate?

OK. You're all comfortable with that because part of the goal of these workgroup calls is to be sure everybody has a handle on the type of information. OK.

Similarly, about validity – yes, question.

Naomi Schapiro: I do sort of have a question about access, kind of, like conceptually, maybe it's the wrong time to ask and maybe we should talk about it when we meet. But, you know, access could be, "You give it to me". Or, access could be defined as, "If I want it, I can have it". So, that can look at physical proximity, you know, who lives within X number of miles of a clinic where they can get. Or, you know, who has insurance that would cover it. Things like that. And so I just – we're trying to measure access in school-based health centers, and so we've been looking at these issues a little bit, not so much about birth control but other things. So, I just kind of wonder, does access equals provision here?

(Lori Gavin): This is (Lori). Yes. I mean, obviously, this measure can act to really directly measure whether people have geographic access to care or clinics. But it's measuring access to method once they walk in the door. And the assumption, again, is that we're definitely not looking at a high benchmark here or high. We're looking at, you know, the people that see that the health facilities or health plans where there's almost no access or no access. And we use 1 percent or 2 percent or below that or well below the median compared to a group of peers.

Reva Winkler: OK. That makes sense.

Sarah McNeil: A recent editorial on this specifically talks about having a benchmark of just 1 percent LARC uptake access as a mechanism of determining access. So, if 1 percent of our clients are – if zero percent of clients are walking away, it would work, then that should be a red flag as in measure of access.

(Lori Gavin): Exactly. OK. Thank you.

Reva Winkler: All right. So, in terms of reliability and similarly for validity, we've got the same face validity assessment, and then the threats to validity are described pretty much in the same way. Does anybody have anything they wanted to discuss that seems different or unique about this measure that you have questions or want to bring out?

So, is everybody comfortable with the testing for reliability and validity of this measure? I know we talked a bit about it for the measures and the methods are similar. OK.

Sarah McNeil: Yes.

Reva Winkler: Yes. All right, similarly for feasibility, again, I think the conversation is likely to be quite similar. Anything additional for this measure that might be different? OK. And similarly for the usability and use criteria? OK. So, is there anything else about this particular measure, the access to LARC measure, for any of the criteria that didn't get discussed that you have questions or want to bring up?

OK. We have one more contraception measure. And again, I think because these are all so very similar, I think we want to focus in on how this measure is different. And so, if we move on to 2902, Contraceptive Care for Postpartum, we have Ashley and John …

Sarah McNeil: I'm really, really sorry. This is Sarah. I just wanted to – one thing for 2904.

Reva Winkler: OK.

Sarah McNeil: Was there any discussion about whether we should also be talking about long-acting in the postpartum period that's lumping together long-acting reversible methods and the pill, patch, ring more effective forms of birth control. You know, I'm just nervous that this is focused on just LARC is not as patient-centered as it could be. But if we also added to 2904, that we were looking at postpartum, long-acting reversible methods or more effective methods, then it would allow fore more patient autonomy.

(Lori Gavin): Reva, this is (Lori).

Reva Winkler: (Lori), did you want to comment?

(Lori Gavin): Yes. I'm not completely sure I'm following it. The way – but let me just explain to you. I mean, I understand where you're trying to get, but my brain is going different directions.

The way we structured the applications was to distinguish between the most to moderately effective and the LARC because the interpretation is so different. So, the first measure we looked at, the most to moderately effective among women at risk, all women at risk is includes LARC. And that's where we are seeking a higher benchmark. We don't know what it would be, if it's 80 percent or 85 percent, or whatever it is, but we are seeking a higher, and that includes LARC plus the pill, patch, ring, shot and sterilization.

The LARC measure, we did want to call it out as a separate measure because the – it's a new method that there have been a lot of barriers to providing. And we wanted to make sure – we wanted to have a measure that would act, capture a measure just focused on access to LARC. So, we pulled that out of the most to moderately effective to highlight those particular methods. So, and LARC is in kind of both place. And I think your concern about being more claim-centered, which I completely agree with, is you would look at the most to moderately effective measure. That first one we looked at if you're looking that. You would only use this LARC measure if you're concerned about access to those methods.

And then when you go into the postpartum population, that's what the third application is. It's those same two measures, this just apply to the postpartum population. So, for the same reasons, we want to make sure that postpartum women have access to LARC, but that they're also offered a full range of methods in a client-centered manner. So, that's why we have both kinds of measures in the postpartum population.

Does that make sense?

Sarah McNeil: Yes, it makes sense. I'm not totally convinced that separating – yes, I agree that access to LARC is important. I'll just have to think about it some more. Thank you.

(Lori Gavin): OK.

Reva Winkler: OK. All right. So, if we'll move on to 2902. John and Ashley, I think, is there any new or anything unique about the evidence for this measure that we haven't already discussed from the others?

John Keats: No, it's a duplicate.

Reva Winkler: Right.

John Keats: Or triplicate in those case.

Reva Winkler: OK. All right. OK. Is there anything – how about the discussion around the opportunity for improvement 1B? Here, we have data for the two Medicaid plans.

(Off-mike)

Male: OK.

Reva Winkler: OK.

Male: Let me make sure I'm on mute. OK. So, we need to include the medical director. I'm sorry, I mean the CMO for the …

John Keats: Is someone making a comment or …

Reva Winkler: I was going to say, John – yes.

Male: Let me send the invite – let's talk about it tomorrow.

Reva Winkler: Somebody needs to be on mute.

Male: And then just send them the e-mail, so remind me to do.

Reva Winkler: OK. All right. So, any comments on opportunity for improvement for this measure?

John Keats: Again, you know, this is really – I mean, it's almost like a combination of the other two. It's really two measures in one. It's moderate, you know, most and moderately effective versus just most effective or LARC. You know, well I guess it's separate, but it includes another – it's just LARC. That's right. The first one includes sterilization which, of course, the other measure didn't. And again, this is focused strictly on postpartum. So, it's sort of a combination or a

variation on the theme of the other measures that are looking at postpartum. So, the evidence is the same. And then you were asking about was it one …

Reva Winkler: The opportunity.

John Keats: Oh, the opportunity for improvement. No, it's essentially the same as the others. So I mean there's high opportunity.

Reva Winkler: OK. All right. So in terms of the specifications, any comments here in terms of specifications?

John Keats: So, you know, it's …

(Crosstalk)

Reva Winkler: Yes.

Ashley Hirai: This is Ashley. There're just – I think there are actually four measures here because it's the most and moderately to LARC, and then they're both measured at three days and at 60 days. So, it just seemed like there's a lot here for one measure. But in reviewing some of the other ones, it's the same, just like frequency of perinatal care but there's a bunch of different indicators or subgroups within that – or categories right there. But they do that 100.

But it is – and then I guess within the application, that does seem like, you know, all four were mentioned that the primary focus seemed to be the most and moderately effective at 60 days, because there were comments throughout that maybe the three-day had some reliability concerns, and then the LARC potentially a validity risk, somebody worried about breastfeeding.

(Crosstalk)

Ashley Hirai: So, I guess, this is a little confusing, right? There were so many components of it. And some were being requested for endorsement and others, for provisional endorsement.

Reva Winkler: I'm not sure that that's quite accurate. There is no such thing as a provisional endorsement.

Ashley Hirai: It seemed to be an application that it was mentioned.

Reva Winkler: OK. Yes.

John Keats: To clarify the measure of the specifications, we're talking about the patient received or was offered. It says provided a method of contraceptives. So we're saying, we're offered or actually took it. So again, it gets to the point, are we talking about patient decision making over which we have minimal control, or are we talking about the services we offered, specifically to counseling? What does measure specifically measure?

(Lori Gavin): So, this is (Lori) and I'll try to address both the comments. It measures provision. So if they were inserted, we know if the LARC was inserted or removed or the sterilization procedure performed. In the case of something that was like a pill, patch, ring or use of dependent methods like that, we know that the prescription was filled. So, it's a provision.

We don't know from this measure whether the woman who filled the pill prescription went home and took it everyday. We're kind of relying on the trust and external analysis for that piece. That's why it's an intermediate outcome rather than an outcome like we think. So, we do think it's the measure of provision of what the provider did.

John Keats: No, it's a measure of what the patient decided to do, not necessarily the information that the provider gave the patient, but got it. Thanks.

(Lori Gavin): Yes. It's the result of that interaction, what they decided to do at the – by the end of that interaction. But it's a measure of what the provider did and that they kind of provided a prescription, for example, and the patient filled it. But you're right, that it's definitely involved what the client and provider discussed. There's that interaction that we can't measure. We're just measuring the outcome of that.

And on the – some of the data, we found some of the rates of use were so low. So the LARC policy, although they are in place in several states now for immediate postpartum insertion of LARC, the uptake is so low that we found

it very hard to really assess reliability in many cases. And with that, we included it here because we are eager to hear about what the committee thought about it, and we think it's an important policy and issue that is moving forward, but the data is not quite there yet because people aren't implementing that policy yet. So, there are some challenges with the analysis for that, that part of the measure.

Reva Winkler: Yes. (Lori), this is Reva. Just a clarification, I mean a measure is the number of women who were provided the effective methods. And then you're looking stratify those results by, was it received within three days or within 60 days.

(Lori Gavin): Yes.

Reva Winkler: Is that correct?

(Lori Gavin): Yes, and by age.

Reva Winkler: OK. All right. Any other questions or comments on the specifications? So, everybody is clear on what the measure is about.

Is there anything you wanted to raise, John or Ashley, about the reliability testing or the validity testing for this measure?

John Keats: Not for me.

Reva Winkler: No? OK. I mean I think it's laid out. The method was very similar with the other measures and the results are provided. And similarly, is there anything about feasibility and usability in use that's different or unique about this measure that we haven't already talked about? OK.

John Keats: Again, not that I see.

Reva Winkler: OK. So, we've looked at …

(Crosstalk)

Ashley Hirai: I guess, I will just say that I think just being in the postpartum period, this might. And I'm not a (little) expert here, but it may be more or less subjected

to some of the issues with the global population of, you know, not being able to fully address although trying to do with NSFG for the population at risk. Whereas the postpartum period, I think we can more appropriately assume that a woman, you know, trying to get pregnant within two months, and so there's less of a need for that kind of adjustment, I think. So, it seems a little stronger in that sense.

And then I still did have the same issue with the IUD removal because it's supposed to be, you know, uptake within 60 days. And it looks like the IUD removal is with that for a whole year. And I would – it just seems to me, I would rather have peer measure of uptake and alone and if you can't get a discontinuation, that's not where you're measuring. You're measuring the uptake in the measurement period.

Reva Winkler: OK. All right. Any other thoughts before we move on to another measure?

John Keats: But what about the issue that was raised that there should be some accounting for and maybe some exclusion based on breastfeeding? I didn't quite understand what – those went up with the expert panel. I wasn't quite sure what point was trying to be made there.

(Lori Gavin): I can try and briefly address that and it would be a great topic to discuss about in-person meeting with, hopefully, well, some ACOG representatives. I think that issue arose based on some people who interpreted the ACOG recommendations for the six-week postpartum visit differently than we do. So, we contend that women, there are clear federal CDC and ACOG recommendations encouraging the use of postpartum at the six-week visit and many, many methods can be used that do not interfere with breastfeeding.

So the fact – so if you follow ACOG guidelines, there is no inconsistency. Women can use hormonal or use birth control and also simultaneously breastfeed. Some providers kind of perceive that that is not – that women can't handle that and will get confused by those two methods. And we think that they won't. And so, again, I think this would be a great conversation to have at the meeting. But we think that the guidelines are completely consistent with ACOG guidelines.

One thing that we'll suggest to do, so we could look at for the version of the measure is to do the two age cutoff that we've proposed, but also do it at three months, where people feel there'll be less confusion about breastfeeding. And so, that would be another option is to kind of do this three-day, 60-day and three-month also, again, in the iteration of the measure.

Reva Winkler: OK, anything else on contraception? We really want to move on to the last three measures. And these three measures are all currently endorsed measures. These are all measures from NCQA. Do we have anybody from NCQA who joined us?

Sepheen Byron: Yes, hi Reva. It's Sepheen Byron.

Reva Winkler: Oh hi, Sepheen. Thanks for joining us.

Sepheen Byron: Sure.

Reva Winkler: All of these measures are currently endorsed. And so, we will be looking at them slight – with different focus because we have much more experience with them. Hopefully, many of you have had experience using them. And they, by enlarge, are health plan and integrated delivery system measures.

So the first one we'll talk about is measure 33, which is Chlamydia screening. And our discussants are Ashley and Sarah again.

So, would either of you like to kind of just briefly introduce the measure and kind of go through the criteria? We'll talk about the different focus because this is an endorsed measure, just undergoing its periodic maintenance review.

Ashley, do you want start off?

Ashley Hirai: Sure. So, this is the percentage of women, 15 to 24 years of age, who were identified as sexually active and had a test for Chlamydia during the measurement year. And it's been important because it is affiliated to pelvic inflammatory disease. Chlamydia has developed infertility and adverse birth outcome. And it does have strong evidence – are we getting into the validity – I mean, the importance?

Reva Winkler: Yes. Well, we can start talking about evidence, yes. Go to the evidence.

Ashley Hirai: Yes. It just have U.S. Preventive Services Task Force recommendation. And I did try to look at that actually, and it seems like it might have been downgraded from having like strong evidence to moderate evidence in public comments, I guess. And there is this one study that was added since the previous recommendation and it was – it has a strong effect, that it just seemed to be underpowered.

So, if anything, I would have thought that might have been an A over a B. But regardless, I think it's, you know, it definitely pass to that.

Reva Winkler: OK. Sarah, anything from you?

Sarah McNeil: I agree that I looked at it. I would raise the evidence as moderate to high.

Reva Winkler: OK. Yes. Again, this measure is endorsed. It's been through an evaluation. And, you know, the evidence may have changed just a little bit. But the question will post as whether we really need to spend a lot of time revisiting this at the in-person meeting.

What we do want to focus in on though is the data on current performance, because this is of much greater focus measures that have been endorsed for a while, so opportunity for improvement and any information around disparities.

So, Ashley and Sarah, your thoughts on the information provided there?

Sarah McNeil: I was most surprised by how low the numbers are. And, you know, there is a trend of improvement overtime. And I haven't looked at this other measures overtime, so I don't know what general trends and improvement are. But in one of the many things that I read over the weekend, it was stated that this was like a low trend in improvements. So yes, I just think that that's ongoing. There's ongoing need for measurements and improvements.

Reva Winkler: Sarah, any comments from you?

Ashley Hirai: That was Sarah and this is Ashley.

(Off-mike)

Reva Winkler: Oh, I'm sorry. Oh, I'm sorry. I'll learn your voices. Anything from you, Ashley?

Ashley Hirai: No.

Reva Winkler: OK. All right. Anybody else from the workgroup? OK. So, we move down to the specifications. Again, any thoughts from Sarah or Ashley on this particular criterion?

Any questions or comments from anybody else on the workgroup?

Sarah McNeil: Hi. Is this the right place to talk about exclusion criteria?

Female: No, that's further down.

(Crosstalk)

Reva Winkler: Well, yes, it can be either specs or threats to validity. Go ahead and raise it.

Sarah McNeil: Yes. So, I had two pieces. One is in just thinking about screening, I'm not convinced that the importance of – I'm not convinced about the importance of identifying people who are sexually active, for example, in Pap testing, we just do routine screening for everybody. So, I think that only identifying women who were sexually active takes out of a proportion of the population who should also be screened, in my opinion.

And then in terms of the exclusions, there's an exclusion for those who are …

(Off-mike)

Sarah McNeil: … I think. Yes, who received a pregnancy test – oh no, but women who are pregnant are included. Is that correct? I think that because the evidence suggest, you know, there are strong evidence to suggest that Chlamydia screening should be done in pregnancy, that I think that pregnant, there should be no exclusions around pregnancy.

Sepheen Byron: Hi, it's Sepheen. I can address this question.

Sarah McNeil: Yes.

Sepheen Byron: So, around the why sexually active only, that is primarily because the U.S. Preventive Services Task Force recommendation really says "screen only in sexually active women". So well, I personally agree with you about, you know, the opportunity to screen everyone the way we do cervical cancer screening. It's really about adhering to that U.S. Preventive Services Task Force, which, you know, we look at as really a gold standard for national guidelines around care. So, that's why the measure is specified for sexually active.

This measure does – it does include pregnant women, and the reason why you saw that in an exclusion with really around – I'm trying to actually – hold on. Let me pull up the spec. So the issue was this measure uses claims to identify sexually active. And one way to do that is to, say, a pregnancy test. So, that kind of helps presume if someone is sexually active. So, I don't think you saw it in the exclusions but it may have been – oh, actually, here, this is what you're looking at.

A pregnancy test and a prescription for isotretinoin means that it's possible the person was getting a pregnancy test in order to put on that prescription for Accutane. And so, we're trying to remove people who might be identified only through a pregnancy test, when really they were just trying to get an Accutane prescription.

Sarah McNeil: I see. OK.

Sindhu Srinivas: This is Sindhu. How – I mean, it seems like pharmacy data like the, sort of, the denominator, meaning that you have to have pharmacy data for contraceptives, or a claim and encounter data seems they would also like miss a lot of people, all those women that are not on contraceptives that are sexually active. But it seems like those patients wouldn't be included.

Sepheen Byron: Yes. The way we look at it is we actually use two methods to identify sexually active. So, pharmacy data is one way. And we also look, you know, pregnancy value set is another way. And, you know, unfortunately, this is the best way we can do it through claims. And in order to keep this as a claims measure, which helps it to be a little bit more feasible for health plans to report on, those are the primary ways.

So, you know, I mean, if we went into charts, we might – could identify more people. But it testing, when this measure was first developed, we did find that claims was a good approximation of finding sexually active women.

Sindhu Srinivas: You know what percentage or how many people were like – so if you used – if you needed, I mean, obviously you can't – doing a chart review as different kind of – different sort of feasibility issues. But if you were trying to capture as many people that should be screened is just claims, and using identification in this way, missed a bunch of people. That using just an age range would be more appropriate where you'd – I guess, you're saying that you would then have a bunch of people that shouldn't be screened, and that you could look for it on the measure.

Sepheen Byron: Yes. I mean, it gets tricky. I don't have the original data in front me. But when this measure was tested that we found that claims was a pretty reliable way to identify women.

And, you know, I think that really we've heard – you know, we've done a little bit of – we've looked at this measure in a couple different way across different projects, and we actually did look at it in EHR for a different project. And I will say that you missed some but it's not so much that you feel that it would be affecting the measure, and especially at this health plan level that this measure applies to. So, I can try to get more information for the bigger group. But, you know, really where it comes down to is that the original testing found that claims was OK.

Sindhu Srinivas: If we could bring that to the big – to the in-person meeting, that would be great.

Sepheen Byron: OK.

Reva Winkler: All right, anything else? So, I'm just keeping an eye on time. Anything else about the specifications for this?

So, could we quickly take a look at the testing for reliability and then the testing for validity for this measure, Ashley and Sarah? Anybody from the workgroup have any comments about it?

Sarah McNeil: This is Sarah. I thought that the reliability testing was good. It was – my rating was also high for it. And for the validity testing, again, because of absence of empirical validity testing, it was moderate.

Reva Winkler: Right, OK, any thoughts or comments from anyone else? Then we could quickly go on to feasibility. Anything there, Ashley, Sarah?

Sarah McNeil: I thought it was straightforward and feasible and that it's been – the data has been collected on as a previous measure.

Reva Winkler: OK. So, because this is a maintenance measure, we do want to put a little bit more focus on looking at usability and use. We should have some more information on how this measure is being used. Is it being public reported? Is it being used for an accountability program? The information provided by the developer in terms of how the measure is being used. And then I would ask all of you, if you have any experience of either being measured by the measure, or your health plans being measured with this measure, or any personal experienced you might have with this measure as well.

Male: You want that now or …

Reva Winkler: Well, you know, you can …

(Crosstalk)

Reva Winkler: Well, either one, you know. We have a couple of minutes. We could talk a little bit about, you know, is this measure being used and usable?

Male: So, you know, I work for Cigna and we use this measure for our quality metrics for our ACO program.

Reva Winkler: OK.

Female: Yes, I'm at Johns Hopkins and we use it also. I don't recall now what are – how well we did it. I think we did it well. But if we have an opportunity to comment later, I would like to do that because it is something …

Reva Winkler: OK.

Female: … if that comes up. If you could tell us how do that. Yes.

Reva Winkler: Right. Yes.

Naomi Schapiro: And this is Naomi. And certainly, I'm in Alameda County. I work for FQHC, you know, as a faculty. I'm in FQHC, school-based health center. This is a big issue in school-based health, because school-based health do way better on testing than the parent FQHC. So this is, you know, often an issue that we're trying to show how the value of school-based health centers in improving this performance, but it's definitely when it looks at and like if – if that's interesting to people, I can get you some data about that.

(Crosstalk)

Naomi Schapiro: But I think I have an interest in seeing this continued as a measure because I think it's an important standard. And I think mostly, we're not meeting the standards across the country, especially for teenagers.

Reva Winkler: OK, any other comments on this measure? Again, we will be talking more detailed. But was there any other discussion points anyone wanted to raise around the Chlamydia screening measure?

Ashley Hirai: This is Ashley. I guess – I thought that it was used a lot. And that, you know, it's an NCQA measure and many other programs are using it, including pay-for-performance in California. And so, I would I have thought that – I mean, I see that the initial waiting here is moderate for usability and use. I just wonder where – how do you decide, that I kind of – would've maybe gone for high, it might be just because it hasn't – that's only shown modest

improvement. But I'd be curious to know with the p-for-p, if they had more success in improving it.

Reva Winkler: I think that's why it'd be useful to hear from everybody, but you're absolutely right. That was our thinking around the moderate was the fact that it hasn't really improved much overtime. But that's why, I think, getting other feedback would be particularly useful in understanding how well this measure is performing out in the field.

All right, any other comments on that, because we do want to spend just a little bit of time on the two measures around prenatal care. And so, if we could go to 1391which is the next measure, and John and Sindhu, you are the discussants for this.

Would one of you like to just quickly describe the measure and briefly kind of go through the various criterion. Sindhu, do you want to give us it a shot?

Sindhu Srinivas: Sure.

Reva Winkler: And John jump in.

Sindhu Srinivas: So, this is a measure that was already endorsed previously as I think Reva mentioned before. And, you know, the basic premise of that, it's looking at, you know, the premises at proper perinatal care is associated with improved birth outcomes.

What proper perinatal care should be is sort of based on expert consensus and opinion, and largely by some of the guidelines from the American Congress of OB-GYN, admittedly, doesn't have a strong sort of empiric evidence base. But the measure is basically particularly focusing on Medicaid deliveries and of live births. So, any non live births were excluded. And looking at the percentage that patients, they get – the expected number of visits as prescribed by ACOG in terms of every four weeks until 28 weeks, and then every two to three weeks, and then every week.

Reva Winkler: OK. So you mentioned – you briefly went into evidence. So, in terms of meeting NQF's evidence criterion which is, that it's based on a systematic review and grading of the body of empirical evidence.

Sindhu Srinivas: Right, it doesn't meet that criteria for that.

Reva Winkler: OK. Does anybody – does everybody agree? Anybody have any questions about that because this puts us in a different situation. It's important to understand the – that we do ask you to, whether it meets the criterion. And so in this case, if it's only consensus, then it would be insufficient. However, there is the opportunity for the committee to say, "OK, we agree the evidence is insufficient to meet the standard criterion. However, we are willing to grant an exception if we believe that it's appropriate, acceptable, a good thing to hold providers accountable in the absence of empirical evidence." And that is a choice you all can make.

But it will be a two-vote process. So, if greater than 60 percent of you, you know, agree that the evidence is insufficient, then we can ask a secondary question, do you wish to grant the exception? And so, that's how that works. Anybody have any questions around that?

Female: I have a question. I don't know where this would fit in. But I agree that the evidence is insufficient, but they're also – it's also a reflections of the programmatic issues with Medicaid in general. In terms of eligibility, when women enroll into the program and how late they enroll into the program. So there are a lot of things that are beyond the control of the health as well as the provider that ensures that measure.

Reva Winkler: OK. Perhaps, that's a little bit more about the usability of the measure.

Female: Yes, OK. That's fine. OK, and I wasn't sure about that. So, I'll …

Reva Winkler: Yes.

Female: I'll say it again then.

Reva Winkler: OK. So, we want to move on quickly, again, and looking at the opportunity for improvement. Again, we do have some data to look at. What are your thoughts, John and Sindhu, about the data on current performance or on recent performance?

Sindhu Srinivas: I mean, since – what struck me about this is that it doesn't – despite it being a measure, it doesn't seem like the – there's been much movement or improvement in the percentage of eligible or the percentage – the patients who are getting the percentage of required visits. And so the measure doesn't seem to have created, sort of, the improvement that one would have hoped by making it a measure, and I don't – I think we could talk about, you know, why that might be, but I'm not sure that that's for this call.

Reva Winkler: Yes. John, any thoughts from you?

John Keats: Yes. I've got to tell you when I read this one, I was surprised it's ever became a measure to tell you the truth because, again, as we talk about those with the whole set about the contraception, this is patient choice.

I mean, you know, I think any trained OB-GYN or family physician knows you're supposed to see the patients every four weeks, then every two weeks, then every week, but you have no control over whether the patient show up. But then, you know, I think most people have a system where if a patient doesn't show up, you call them up and remind them or ask them why they didn't show up or what have you.

But at the end of the day, you can't force a patient to come to these visits, which is why I'm not shocked there's been no improvement with this measure. Like I said, I think there's also some evidence out there which I'd have to research because I know I've seen it before. It's not even clear that this is necessary to come in this often during pregnancy to have a good outcome.

I think there's evidence that you have no prenatal care, you're much higher risk for preterm delivery and other bad outcomes, but it's not clear that you need exactly this level of prenatal care or this number of visits to avoid those kinds of complications. So, I was confused by this whole thing when I went through it to tell you the truth.

Sindhu Srinivas: I actually – John, this is Sindhu. I actually agree with you. I'm sort of surprised that became a measure as well. And I guess the two other things that I'll just throw out there in terms of just the overall theme of the measure is if it is a good – if it is a metric or it should be a measure, then it's focused specifically on Medicaid patients. I'm not – I don't totally understand, like if it – we should be measuring how often – if we think prenatal care is important to some level and we – that's debatable too in terms of it's association with outcomes.

And then, you know, and then separately, I think now sort of more contemporaneously, lots of people are doing interesting innovative things to reduce visits that are unnecessary with, you know, innovation, texting, like other sorts of ways. And so, this sort of prohibits that from even being something that might be a good idea because it sort of puts this burden on in-person visits to a level that I'm not sure.

So I mean I'm just throwing those couple of ideas out there. I agree with you.

Reva Winkler: All right.

Female: Yes, I would just chime. Because the last time I looked at this, you know, it's not totally clear what happens during a prenatal visit that makes the difference. Or again, how many prenatal visits, you know, are necessary to prevent a preterm delivery. And so, you know, I agree with what everybody else was saying.

Greg Goyert: This is Greg Goyert from Detroit. I echo those thoughts. And the question comes up, what this really is a surrogate for is poverty, period. I mean, these are – this is the Medicaid population. And when you see patients, "Mrs. Smith, how many buses did you have to take to get here today?" Well, that's what this is reflecting.

And to John's point about the necessity of number of prenatal visits, I mean when you look at the performance of group prenatal care in the relatively excellent outcomes associated with that in the Medicaid population combined

are compared with traditional methods, and scheduling of prenatal visits. This is not a reflection on the provider. This is a reflection on this particular patient population's struggle for resources.

Naomi Schapiro: This is Naomi. As I said, the flip side which is that this is a measure, then patients expect that they're supposed to have visits that often. And I had sort of the opposite experience of a (inaudible) my daughter who had a baby recently and went to a, you know, very well respected HMO and was given the schedule that's less often that this, and she was worried because she thought she's being seen more often. So, it has that kind of effect of, you know, and all her birth (inaudible), everybody said, "Oh, you're still (inaudible) seen more often." So, it has this effect of also influencing patient expectation so that they're necessarily being evidence.

Reva Winkler: OK, all right.

Sarah McNeil: This is Sarah McNeil. I agree, same sentiments. I'm concerned that we don't actually know that more visits is better.

Reva Winkler: OK, and I think that it's actually, you know, really is centered around a lot of the evidence, and the fact that there isn't empirical evidence around the amount of visits, so that's something to keep in mind as we look at the measure.

Any comments around the reliability and validity testing of the measure?

And they've done empirical reliability testing in the measure score and the different strata, and none of these testing was new from its previous evaluation. And also, there were a face validity, a couple of comments from the prior committee are included for your consideration.

OK. Anything – any comments on feasibility or usability? I think usability maybe were some of the questions that you're raising also might apply.

Female: Yes, I won't repeat what I said but I think it really is an issue. And the states plan to incentivize health plans to see these women as early as possible by admitting cases, giving them a (kicks) payment for the pregnancy or, you

know, for (pure) neonatal outcomes. But even inside of that, I think because of, you know, the transient nature of the population and the going and back and forth between different health plans and the lack of sharing of information between the health plans, makes it problematic.

Reva Winkler: OK. All righty.

Ashley Hirai: This is Ashley. And I also agree that I don't think that this a strong measure. And I think it was mentioned in the validity about the case mix concerns because you need more visits if you have certain conditions and risk factors, and that's not adjusted for. And consistent with what other people are saying, I think it's more about getting any care and possibly the timeliness. So, if we're going to move on to that measure, I think that's a better measure.

Reva Winkler: OK.

Ashley Hirai: Yes.

Reva Winkler: If anybody's got any objections, otherwise, let's look quickly at measure 1517 which looks at prenatal visits, postpartum visits just a little bit differently. So, Sindhu and Naomi, this is a measure for you. Do you – one of you wanted to describe the measure and begin to share your thoughts?

Sindhu, go ahead.

Naomi Schapiro: Sure, this is Naomi. Oh Sindhu, go ahead.

Reva Winkler: OK, go ahead, Naomi. I'm just trying to move it along, so all right.

Naomi Schapiro: So, this is about looking at the timeliness so the percentage of deliveries that receive a prenatal care visits as a member of the organization in the first trimester or within 42 days of enrollment, and then also the percentage of deliveries that had a post partum visit on or between 21 and 56 days after delivery, so looking at timely prenatal and postpartum care.

And again, this is sort of – one of those measures where the outcomes, hopefully, have a healthy baby. So, you know, less preterm birth, less low

birth weight babies if you have timely prenatal care where there is an association. And then the outcomes score for the postpartum visit could be provision of contraception, assessment of depression, things like that. So, which I think is probably harder to measure than the birth outcomes.

So – and this is one where also the – I was sort of horrified by the postpartum visit, how low the postpartum visits were in Medicaid clients. So, this actually does compare Medicaid and commercial plans, both. And there's relatively similar rates of timely prenatal care. Not wonderful but above 80 percent. And postpartum care, really only in the 70 percent for commercials plans. And then the 60 percent – below 60 is for Medicaid plans.

Do you want to add something, Sindhu?

Sindhu Srinivas: No, I agree with you.

Reva Winkler: OK. Anything – you mentioned just briefly a little bit about the evidence that, again, it seems to be mostly around consensus, so we have the same situations with the other measure.

Naomi Schapiro: Right. Right.

Reva Winkler: But you had mentioned that there might be some more – there might be a relationship. Is that based on empirical evidence or is that just a good thought?

Naomi Schapiro: I actually run through this again, but I think there's more evidence around in association of prenatal care with better birth outcomes. And I'm not sure like how early or how often, but I think there's – it's much harder to measure the outcomes we're looking at for postpartum.

Reva Winkler: All right.

Sindhu Srinivas: Yes, I think that there – as many mentioned before, it seems like – I mean more of the evidence lies in kind of the no prenatal care or what people sort of inadequate care, like, in terms of, like, the number of visits total versus when it was actually initiated.

Reva Winkler: OK. All righty.

Female: OK, so.

Reva Winkler: So question, yes?

Female: Well, I had a comment to make about the postpartum visit and it may be in the usability, so I'll wait for that.

Reva Winkler: All right. Well, we're going to – you know, with time kind of being short, we're going to quickly go through these. So, we've touched on gap.

Specifications for the measure, does anybody have anything about how this measure is specified? It is a health plan or integrated delivery system level measure. Comments or questions there? OK.

Comments or questions about the reliability testing? Again, there is empiric reliability testing of the score, nothing new. It's from our previous evaluation. And also, some face validity of the measure also. So, does anybody have any comments or questions about the testing? OK.

Naomi Schapiro: So I have – I just have one comment which is around the Medicaid because it's so low and I just wonder if, you know, a lot of them were, otherwise, uninsured. Are insured only to their pregnancy and for the first three days of the baby's life? And often, the postpartum visit is we think of as six weeks, so they may have lost coverage and then maybe going to other places for care or no place for care, and that may not be being tracked well.

So, even though it was said that the reliability in the data was really high, I just really wonder if there are other ways to track what happens to Medicaid ensured women a little bit further out than a month.

Female: And I think it would be interesting to see what happens, so just in terms of the mother and her outcome, as well as the baby, if they get this – that exam at six weeks. I think there is a school of thought that if they get it at two weeks or three weeks, that especially in mothers, they have C-sections, that's when they usually get their exam and they tend not to come back. That, you know, the

outcome is the same, that her health is not impaired because of different timeframes.

Naomi Schapiro: And some people even suggest that the six weeks is actually too late. Like when you're talking about postpartum depression and other …

Female: Right, right.

(Crosstalk)

Naomi Schapiro: … that should happen, that actually waiting that long is actually kind of not a great idea, and that should be kind of a more – so it almost seems like the measure should be like kind of a visit within a month or within six weeks versus may not, that it has to be that far out.

Female: Right, right, right, right.

Sindhu Srinivas: Yes. Yes.

Female: I mean, and that would give the O.B. more flexibility. Also, I think this is another great instance where a case mix would be appropriate. If the women has type one – I mean if the women had gestational diabetes and you want to follow her disease, she really has – doesn't have type two in six weeks is appropriate. But for every woman with, you know, with otherwise uneventful pregnancy, I think, you know, those – that it's too cumbersome, and it doesn't move the needle. That's the other thing. I don't think that it's been proven that it improves or impairs the health.

Naomi Schapiro: Yes, I mean I'm wondering if we should be looking at, I think, just the specific outcome. So, are women getting contraception? Are women getting screened for postpartum depression? You know, there's a big move in pediatrics and other screen, every parent of a new baby for postpartum depression.

Female: Right.

Naomi Schapiro: So, is that happening, is it effective, as opposed to necessary saying whether it's just a visit.

Sindhu Srinivas: Right.

Female: Well, I think that should happen during the whole pregnancy, not in just one visit. And it should be should continue, you know, in the pediatric office too. So, I think, you know, I think that putting everything on that one visit at six weeks is a bit much. Unless the woman is at high risk, you know, and so they should be screened for that too. And if she is a risk then (strictly) because more important.

(Crosstalk)

Naomi Schapiro: It seems like this is something – sorry. It seems like this is something we should be talking more about at the meeting. Like for me, the one thing I would worry about in terms of saying, "Oh, it doesn't matter how quickly women get to prenatal care". Is that one of the things that's really great at least in my population, that it's very – not completely insured is that they get preventive (Medi-CAL) right away right away as soon as they test pregnant, which means they can access care.

And if we said, "Oh, it didn't really matter", then these women would have more of a gap in their healthcare coverage, perhaps. Maybe they wouldn't get preventive (Medi-CAL) so quickly because it didn't have to go so quickly. You know, and again, that's sort of treating both the mother and just as a vessel to the baby and not as herself. But I think, you know, we have to kind to look at what the implications would be the same. It doesn't really matter how early people go.

(Crosstalk)

Female: Well, you know, and I think that …

(Ashley Hirai): There is face validity for that, I mean but the earlier you go, the more time you have to do that counseling and behavioral change. And there are, you know, critical periods in the first trimester, so I think – and there's definitely rationale for that. And then last time, matter of fact, I think for the postpartum, it's 20 to 56 days is when they're actually assessing it. So, they're excluding visits that might be early for a C-section check up or something.

And then I think they are – it is restricted to continue with enrollment. So – and this is an access measure. I know we all want that content and quality there, but it is an important access measure, but at least women are getting the right care and theoretically getting an opportunity for quality, which can be measured in other measures.

Female: OK, so …

Sindhu Srinivas: Yes, I don't disagree. I think that it's worth discussing, you know, the way this sort of specific definition of the measure or and the numerator and the denominator, and how it's being measured now that some access measure to prenatal care frequency isn't a good idea. But I think that there's some areas for discussion about the way that this one is sort of written in particular.

Female: Yes, you know, at Johns Hopkins where I'm the Medical Director now, our postpartum rate is 57 percent, and we have not been able to budge against that no matter what we do. And I was also the American – and that's part of our quality evaluation initiative. So, we are penalized if we don't get into the subject percent range and we have been year after year.

In Texas, we had the same initiative but we were able to convince the legislature that that was not the best measure, and we had it removed as a (inaudible) incentive.

And, you know, the other issue is that we, on the health plan side, we've had issues with OB buy ins. That there are many OBs that just didn't buy in and we couldn't get them to cooperate with that narrow window, because they really didn't see the usefulness of it. They saw the usefulness of a postpartum visit but the narrow window, not so much.

So I think that's probably a usability issue, but it definitely comes into place. And I've heard that the chief of O.B. at Hopkins doesn't believe in it also, so anyway …

Reva Winkler: OK.

Female: … something to consider. Yes.

Reva Winkler: All right. OK. This is Reva. It looks like we're probably going to have some really good conversation when we get together in May. And I'm really looking forward to it. So, especially in the in-person meeting, we're going to be going through this systematically. The committee will vote on the various criteria to come to your final rating and recommendations. So, this gave you a bit of a rehearsal on looking at measure, thinking about them against the criteria, and how we'll be going through them.

So as with – before we close out our call, we want to open the lines for any public comments. All of our discussions are public meetings, and so we do provide an opportunity for any public comments. So operator, would you see if anyone wants to make a comment at this point?

Operator: And at this time, if you would like to make a public comment, please press start then the number one.

And I have no public comments at this time.

Reva Winkler: OK. Well, thank you all very much for some great discussion. I think there's going to be a lot of further great discussion when we meet in early May. We will, however, will be looking at 24 measures over two days, so unfortunately, we're not going to be able to really spend lots and lots and lots of time with each individual one. But where it's necessary, we will do that.

In the mean time, please, you know, take a look at the measure worksheet as we get new information. We've included the survey results from the workgroup members, for your review. We've included some public comments for your review. And this will be your main materials that you will use at the in-person meeting.

Because there's a lot of volume here, we do strongly recommend that you don't print them. You will run – kill too many trees. Run out of – you can't lift them. And bring your laptop with you to the meetings so that you'll be able to access these documents for the discussions.

So, are there any last minute questions from any body from the committee in terms of what we're doing, how the evaluation is going, and what is expected of you?

Female: I just have housekeeping question that I can – you could talk to me offline. I was able to see the webinar but I wasn't able to access the link.

Reva Winkler: OK.

Female: And then maybe because I don't have a flash player or something.

Reva Winkler: OK.

Female: But will it be available after today?

Reva Winkler: Oh yes. I mean, all of these worksheets, all of the measure information worksheets are on your SharePoint site.

Female: Yes, OK, I'll look there.

Reva Winkler: And so …

Female: Maybe I just need to spend more time. I saw the agenda several times and the committee composition.

Reva Winkler: Yes, well – OK, scroll down.

Female: Yes.

Reva Winkler: Scroll down.

Female: OK, I will. OK.

Female: So, this is another housekeeping question which is just sort of I'm having – I've been frozen out of the SharePoint site and …

Reva Winkler: OK.

Naomi Schapiro: … had some problems getting back in. Who is ...

Reva Winkler: OK.

Naomi Schapiro: ... Is there a particular person I should contact offline about that?

Reva Winkler: Yes.

Female: Yes.

Reva Winkler: Yes, Suzanne, Nadine.

Suzanne Theberge: Yes, if anybody who's having trouble could send an e-mail to the perinatal@qualityforum.org e-mail address, and we'll get our text folks to sort out any issues that you're having, and they're pretty quick, so we should be able to sort it out, you know, by midday tomorrow at the latest. So, just let us know by e-mail.

Female: Thank you.

(Crosstalk)

Female: Yes, I mean …

Female: That way, we can forward …

Female: I mean, was there a measure on cardiology on this? Because when I opened up the link, it was a cardiology measure. Was that …

Reva Winkler: That was our example for the …

Female: OK.

Reva Winkler: That was an example that we used during the Q&A session last week.

Female: I see. OK, all right.

Reva Winkler: Yes. You aren't – no, we don't – I'm expecting you to do cardiology measures.

OK, any other last minute questions? If you do have questions, don't hesitate to send us an e-mail, get in touch in any way that works for you because we do want to answer and address any of your questions.

But if there's nothing further today, I think we're finished. Thank you for a good couple of hours of thoughtful discussion. We really appreciate the time you have contributed to this. And like I say, I really look forward to meeting all of you in person.

And we will be having workgroup calls again tomorrow and on Friday. Every member of the work – of the committee is invited to attend, just as you see some of the others from other workgroups were with us today.

So with that, have a very pleasant evening and thank you very much.

Suzanne Theberge: Thanks, everyone.

Female: Thanks. Goodbye.

Female: Thank you.

Male: Thank you.

Female: Thanks.

Male: Thank you. Bye.

END