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NATIONAL QUALITY FORUM

Moderator: Perinatal -
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OPERATOR: This is Conference #: 66719711.

Operator: Welcome everyone. The webcast is about to begin. Please note, today's call is being recorded. Please stand by.

Suzanne Theberge: Good afternoon everyone and welcome to the Third Workgroup Call for the Perinatal and Reproductive Health Standing Committee. Thank you very much for joining us today.

This is Suzanne Theberge, the Senior Project Manager on the NQF team. And I'm joined with my colleagues, Reva Winkler, Nadine Allen and Kaitlynn Robinson-Ector.

Before we begin, I would just like to do a couple of quick housekeeping notes. For those of you who have been on our calls before, this will be familiar. But we do like to remind everyone that you need to be dialed into the phone line to speak. The Webinar is audio only. But if you are both listening on the phone and the web, please make sure you turn your computer speakers off so we don't get the feedback and interference. We also do request that if you're not talking, that you put yourself on mute to reduce the background noise. And to not put us on hold so we don't hear your hold music.

I would now like to just do a quick roll call and find out which of your workgroup members is on the call today.

Greg Goyert: Greg Goyert, are you on the line?

Greg Goyert: I am. Good afternoon.

Suzanne Theberge: Hi. OK, Kimberly Gregory, are you here? Mambarambath Jaleel?

Mambarambath Jaleel: Yes, I am. Good afternoon.

Suzanne Theberge: Hi. Diana Jolles?

Diana Jolles: I'm here.

Suzanne Theberge: Good afternoon. Florencia Pereyra Segal? Karen Shea?

Karen Shea: Present.

Suzanne Theberge: Thank you. And Janet Young?

Janet Young: I'm here.

Suzanne Theberge: Hi. OK, and do we have any other committee members on the phone who are not a part of this workgroup?

Sheila Owens-Collins: Sheila Owens-Collins, I'm in Workgroup Four.

Suzanne Theberge: Great.

(Crosstalk)

Amy Bell: This is Amy Bell from Workgroup Four as well.

Suzanne Theberge: Hi.

Carol Sakala: And Carol Sakala from Workgroup Four.

Suzanne Theberge: Great. Well, thank you for joining us Workgroup Four.

And I think we can go ahead and get started. We do have several of our developer colleagues on the line, so if you have questions as we begin the

measure discussion, then they should be able to assist you or make some notes and get that information to the committee after the call.

So with that, I will turn it over to Nadine, who is going to take us through the measures today. Nadine?

Nadine Allen: Hi everyone. Thank you for joining us today. The first measure that we will be reviewing is measure number 0480, PC-05 Elective Breast Milk Feeding.

PC-05 assesses the number of newborns exclusively fed breast milk during the newborn's entire hospitalization. This measure is a part of the set of five nationally implemented measures that address perinatal care. This is a process measure and the level of analysis is facility population national. This measure was originally endorsed on October 24th, 2008 and most recently endorsed was March 30th, 2012.

So again, this is an NQF-endorsed measure undergoing maintenance evaluation and it is a process measure. So for process measure, we are looking evidence that requirements for a process measure is that it is based on a systematic review and grading up the body of empirical evidence, where the specific focus of the evidence matches what is being measured. So, the developers have said, there have been no changes in the evidence since the measure was last evaluated.

Diane, can you please provide a brief description of the evidence and offer your opinion on whether the evidence needs to be re-discussed and re-voted on?

Diana Jolles: I'd be happy to do so. The evidences certainly supports and exceeds the burden to prove evidence. There have been multiple systematic reviews, over 27,000 articles between 1980 and 2012, with over 900 studies examining these outcomes. So, I believe that everyone was in agreement that the level of evidence passed.

Greg Goyert: This is Greg Goyert. I just have one question. I don't understand why this is called a process measure when we're not measuring the process. People are

getting held accountable for the outcome of exclusive breastfeeding, not the process of education, not the process of support, not the process of all the things that go into it. But this is an outcome measure, so I don't understand why it's classified as such. Thanks.

(Crosstalk)

Diana Jolles: We have – this is – oh, go ahead.

Nadine Allen: We also have the developer on the line, Joint Commission, who is open to answer some of these questions that you may have at this time.

Diana Jolles: This is Diana. I would just comment that I can certainly how it could be considered either a process or an outcome measure. And both is true for several of these quality measures that we're looking at. However, fundamentally, I do stand behind this being a process measure because if you look, for example, at the racial disparities reported, I can speak personally to the systems level processes which lead to racial disparities, just in the selection of – and how women are choosing their preferences.

So, as there are preference sensitive variations with this measure, it truly is your systems process and performance on the process level that's leading to the outcome. I think only considering it as an outcome measure, you lose the piece of preference sensitive variations. But embracing it as a process measure, there shouldn't be that many preference sensitive variations if your system is functioning with the proper processes.

Greg Goyert: Fair enough. I understand that point. All I can do is speak from the perspective of doing this day after day after day and seeing what our particular system, the enormous investment in this particular measure in terms of having an incorporated and/or EMR, the education, as out an outpatient education, as an inpatient, the change in practices that on the postpartum unit and things like that, none of that's reflected in this measure. It's a binary thing, exclusive breastfeeding or not, so I think we're going to agree to disagree on that. Thanks.

(Elliot Maine): This is Dr. (Elliot Maine). I'm one of the developers of the measure, working with the Joint Commission. And I think it was stated clearly earlier that a number of these measures are kind of straddling between outcome and process measures. We generally think of an outcome measures though as a morbidity or mortality. And this isn't necessarily a morbidity, if you would, if you do.

You know, breastfeeding reflects on your development of morbidities potentially down the line or the lack of morbidity, therefore it's more of a process, though many process measures have underlying processes that drives the overall process. You know, we see that a lot when you drill down and they process measure, that there were many things that go into making it happen. As you clearly said, to do this well, you have a lot of things that happen that are processes to roll up into this one. So, it could go either way but I think it probably belongs where it is right now.

Sheila Owens-Collins: This is Sheila Owens-Collins. I'm sorry. Hello?

Nadine Allen: Go ahead, Sheila. Sorry.

Sheila Owens-Collins: Yes, OK. OK. So, I'm a Neonatologist and I work at a community hospital. And yes, and I'm totally just looking at this for the first time. But I know pragmatically some of the issues with this measure, even though people are working very hard to see 100 percent. But I'm wondering if there can be any allowance given for women who may not get the first feeding. I think if there's going to be a missed feeding, it would be the first feeding but there – because of mom had a C-section and I don't know if that's eliminated, or a brief transition problem with the baby that even though the mother is committed to exclusive breastfeeding, something may happen in the first – in the transition period that would make a bottle feeding necessary.

Diana Jolles: This is Diana. I can speak to that. The performance goal for this measure is 70 percent, so I think that the belief …

Sheila Owens-Collins: OK.

Diana Jolles: … is that it performs well to incorporate that type of variance.

Sheila Owens-Collins: OK, that's excellent. Thank you.

Nadine Allen: So also, so based on this discussion, Diane, do you – can you provide some information about the algorithm and how you think this measure should be rated?

Diana Jolles: Towards the initial – as far as level of evidence that it passes, so I support the initial review that systematic review has been conducted and that high quality evidence exist.

Nadine Allen: Do the other workgroup members agree with this assessment?

Greg Goyert: Yes.

Female: Yes, I do.

Karen Shea: Yes. And hi, this is Karen Shea. I agree as well. The only comment I would make is though I appreciate this measure and I think it's an important measure, it's one in which we cannot access outcomes by looking – or access process by looking at a claim. It's nothing we can derive in an administrative way to look at this measure outcome. It all has to be self reporting. And if we were ever do look at this measure again, it would be nice if we could generate some kind of a code even if it were a Category II CPT code that would reflect this activity.

Greg Goyert: The other factor with PC-05 that needs to be acknowledged, that there's nothing to do about it because this trains so far down the tracks and it's well intended. But when you stop and think about it, providers, institutions, plants are being held accountable for things over which they have nominal control, in this case, exclusive breastfeeding.

And again, on a day to day basis, when this measure is discussed at governance levels, for our systems administrative levels, that that is the complaint that always comes up. That despite what we do, patients are going to make decisions based on their own priorities, and yet we have this high stakes score card that comes out and the implications is it reflects poorly on the system.

Diana Jolles: This is Diane and I would respectfully like to disagree with that comment because I'm a nurse-midwife. I run a service in Washington, D.C. We maintain the highest rate of exclusive breastfeeding among African-American women across the city, higher than Hispanics, higher than white. And the way we did it was completely revamping the way we provided prenatal care to complete 100 percent group prenatal care and peer counselors.

So, I believe that's why this is a process measure. And I do believe that we as a system should be accountable, and that this is one of the most important measures that access – that addresses the 4 million births in our county. Whereas when you look at the panel of quality measures, many of our measures relate to NICU pathologies, morbidities, and preterm infants. But the majority of their population fit into this measure.

Greg Goyert: Fair enough.

Sheila Owens-Collins: And I'll support that comment.

Mambarambath Jaleel: This is Jaleel here from U.T. Southwestern. I support that comment as well. There are a lot of processes that can be done to improve the rate of breastfeeding in the hospitals. We, in our hospital, trying to change a lot of the workflows to accommodate mothers who want to breastfeed to encourage them to breastfeed and that has made a difference. So, I think it is still useful to have that.

The other comment that I had or question that I had was I was still intrigued by this difference between an outcome measure and a process measure. I still feel that it is an outcome measure. But what is the impact of calling it is an outcome measure or a process measure? Is there an impact for the hospitals, different institutions? What is the impact, if at all, to call it process versus as an outcome measure?

Reva Winkler: This is Reva. I think you've asked an intriguing question. There are times when it matters such as if measure is used in federal programs where there's a requirement for certain number of outcome measures to be reported. So, if

you're in sort of a programmatic situation like that, it becomes important and we have these conversations all the time.

Otherwise, I think, really, it's a way of tagging that is imprecise. In this particular case, I think there is argument to see it both ways. And, perhaps, looking at it more an intermediate outcome, very much closely related to the processes, the more traditional outcomes will be the lack of various conditions and morbidities associated with breastfeeding. And so from NQF's perspective, in your evaluation, the requirements for evidence and the rest of the criteria would be the same for a process or an intermediate outcome. So in that case, it probably doesn't make a whole lot of difference, if so – but there may be individual circumstances and programs where that may become an issue. So – but from NQF's perspective, it isn't a critical one.

Mambarambath Jaleel: Thanks, Reva.

Nadine Allen: So, thank you all for your comments. I would like to go ahead and move to the next criteria. If no objections, I would like to go ahead and move on.

Hearing none, I'll move on to the opportunity for improvement section. And for the maintenance measure, we really want to discuss this section in more detail. And so Diane, I'm going to – Diane, I'm going to go ahead and ask you to briefly describe any data presented on current performance used in this measure. Is there opportunity for improvement? Are there differences in any particular (cell) population?

Diana Jolles: Actually, so I think that the measure developer did a very good job of demonstrating a continued and significant performance gap that, again, as I said earlier, it truly affects all child bearing women. And that one of the largest, this measure affects more women annually than many other measures. So as far as opportunity for improvement, all of the national toolkits have been demonstrated to be effective. There are known ways to improve on these gaps. And it's honestly sad to see how many gaps we still have, so these demonstrated that raised for exclusive breast milk feeding remain below 50 percent for over half of the hospitals that are in this reported data. And they are looking at hospitals with over 1,110 births. There were over 1,386

hospitals included. It's over 728,000 patients. And so the baseline currently is 40.9 percent.

I will comment that this is much improved now. That the Joint Commission has required this measure be included in the reporting. We have seen significant gains with that, so at least there's more public transparency with regard to this measure. And our performance seems to be lagging with the best performance being in 2013, at 53.6 percent, and then we saw a drop in 2014, 49.4 percent. So, there are significant disparities demonstrated in the literature and also in the measure developer's report, the CDC reports on this. And I believe that the measure developer has demonstrated a high of opportunity for improvement continuing.

Nadine Allen: So, I will go ahead and ask the other members of the workgroup if they agree with your assessment of the measure, Diane – Diana, sorry.

Greg Goyert: I agree.

Karen Shea: I agree.

Nadine Allen: Do you have any further comments for the measure developer?

OK, hearing none – oh, go ahead, sorry.

Diana Jolles: Well, I mean I would echo the comments that were stated earlier that I think that we've come a long way as far as reporting and transparency. And I am thankful the measure developer for making this mandatory. I do think that it's low lying fruit to figure out a way to do this electronically. That we shouldn't come to the next measure review and not be able to report more robust racial disparity data and performance data. And I want to retire this ultimately because we can achieve the goals, but I think we're far away from that. And electronic reporting is required for that.

Reva Winkler: Yes, this is Reva. Hold that thought for one more measure.

Nadine Allen: Thank you. So, we can go ahead and move forward to reliability specifications. And so here, Diane, if you could report a little bit about the

numerator statement and the denominator statement, as well as the exclusions for the measure and the data source that is specified and tested, and report any issues or concerns you may have with the specifications definition or coding.

Diana Jolles: Sure. I think that the measure passes, it traded as a moderate for reliability testing. It does demonstrate the ability to be reproduced. The inter-rater reliability was 97.5 percent. The testing occurred using data element testing. And so as far as the reliability algorithm, it went though precise specifications, which are easily definable and fit into the workflow. And they were empirically tested using appropriate methods. Inter-rater reliability was demonstrated with high and moderate confidence that the reliability of numerator data is proven at the highest rating possible.

I'm sorry. Did you say you wanted me to get into the exclusion criteria?

Nadine Allen: Yes, please.

Diana Jolles: OK. So, as far as the specifications go, all of the codes were converted from ICD-9 to ICD-10. The submeasure 5A was reduced due to multiple stakeholder feedback and to the data burden, lack of feasibility and the negative effects on the performance of this measure. There was an issue while using this measure with late preterm newborns not being excluded from the denominator, and that has since been fixed by including codes related to being over 37 weeks gestation term newborn.

So, exclusion criteria regarding the data element, any baby admitted to the NICU, any diagnosis of galactosemia, any type of parenteral infusion, any death that occurred during the hospital stay, any stay of over 120 days, no clinical trials are included. Patient is transferred to another hospital and any premature infants, so the exclusion criteria are appropriate and inclusive.

Nadine Allen: The other workgroup members, do you agree with this assessment of the measure?

Greg Goyert: I agree.

Sheila Owens-Collins: I agree.

Karen Shea: Yes, I agree.

Nadine Allen: Any feedback for the developer at this time in preparation for the in-person meeting?

OK. Hearing none, we can move. Probably, Diana, if you could share a little bit about the algorithm for this and how we would go about rating this measure?

Diana Jolles: Will do, one second.

Kimberly Gregory: Hi, hello. It's Kim Gregory.

Diana Jolles: So, using the reliability algorithm there per site specification, there's empirical reliability testing, that data elements have been tested using appropriate methods and including inter-rater reliability. There's high and moderate confidence of reliability of the numerator and of the exclusion criteria. Moderate can be the highest rating possible for this level since it's rated at the data elements. I agree with that.

Kimberly Gregory: This is Kim Gregory. I'm sorry I'm late. And I'm sorry you can't hear me because I'm hoarse. Did you hear me?

Nadine Allen: Yes …

(Crosstalk)

Kimberly Gregory: So, I just wanted to comment on one thing about the algorithm that I thought was a little confusing. And that with the way you followed the exclusion criteria, I think they actually said if it's a term newborn, then you've got to exclude it, and I think that's just a mistake.

Diana Jolles: Apologize if I said that. Term newborns are included …

Kimberly Gregory: No, I know. That's what you said.

Diana Jolles: OK.

Kimberly Gregory: But that's not what the algorithm. If you actually click and go to that site and follow their logic, it looked like there's a typo there. OK …

(Off-Mic)

Kimberly Gregory: But otherwise, what their intent is, is correct and fine.

Reva Winkler: Thanks, Kim. We'll check on it.

Kimberly Gregory: OK.

Nadine Allen: Thanks, Kim. Any additional comments before we move on to the validity section?

Hearing none, we can continue on to validity. Diana, would you like to go ahead and take it, first discussing the specifications for the validity, and also the validity testing, providing a description of that, and walk us through the algorithm and the decision.

Diana Jolles: Sure, sure. So, the validity of the measure determines if the measure specifications are consistent with the evidence which the preliminary rating suggested yes, and all of the reviewers agreed with this.

Validity testing, the function of it is to demonstrate that the measure elements are correct and that they're correctly reflecting the quality of care provided and adequately identifying differences in quality. The prior measure, when it was endorsed was face validity only, and now there's new empirical validity testing and the measure score is provided.

So, there is no risk adjustment method. When tests of meaningful – am I almost – no, sorry. So validity testing, 1,352 hospitals submitted, again, over 700,000 inpatient records. The measure of convergent validity testing was performed using patient level data, Spearman Rank-Order Correlation on parametric test.

So, you can click and see the scatter plots in the correlation table. The correlation between different measures, so the breastfeeding and the caesarean section quality measure is moderate and statistically significant. The other P.C. measures were weak and not significant. And again, I believe this is because this particular measure is testing the majority of people accessing the perinatal continuum of care rather than the minority of patients who are put into high risk settings, meaning preterm and NICU admissions. So the performance hospital measures on that is very widely, so the range is between 23 and 75 percent, meaning, again, demonstrating that there's much room for improvement, supporting the idea that this is a valid measure of quality.

Threats to validity, there's a table that goes through looking at the overall percentages of particular pieces of the exclusion criteria. And so, on to risk adjustment, there was no risk adjustment. There is meaningful difference that can statistically, clinically and practically demonstrate meaningful differences in performance using this measure. They go through the performance percentile with 10 percent, 25th percentile. Demonstrating that the bottom10 percent hospitals achieve 23 percent, and the top 90th percentile hospitals are to 75 percent. This supports the idea that this measure is capturing supply sensitive variations, preference sensitive variations, and is a valid quality measure.

Nadine Allen: Thanks, Diane.

Diana Jolles: Yes.

Nadine Allen: OK. Thank you.

Diana Jolles: So again, the preliminary reading for validity is moderate, and this is because as you move through the algorithm, there is empirical testing, testing of measure score, appropriate methods, and testing – are moderate.

Nadine Allen: So, I have some questions here for the workgroup based on Diane's great overview of the measure on the validity specification, the validity testing. Does the workgroup expect strong correlation in performance among the five

perinatal measures? And is the test and sample adequate to generalize for a widespread implementation?

Kimberly Gregory: So, this is Kim again. I thought that was an interesting hypothesis, but I don't think that necessarily what happens on labor and delivery guarantees what happens in the nursery as reflected by the fact that it didn't hold up across all the measure.

Diana Jolles: This is Diana. Again, I believe that it doesn't hold up to the other measures because the other measures are very population specific and focused on morbid populations, very high risk, and this is one of the few measures like the caesarian measure that address the largest population of child bearing women. So, I'm not surprised not to see that correlation and I am happy to see it demonstrated regarding the caesarian measure. And I believe that's appropriate and that this is – that, you know, there's further evidence that it's a high performance measure.

Kimberly Gregory: I like it as a measure.

Greg Goyert: But I agree. I don't – I think it's fine as a measure. But I don't see any prior reason why there should be tremendous correlation between these five disparate outcomes in and of itself.

Diana Jolles: I have to echo his comments.

Nadine Allen: Are the exclusion consistent with the evidence?

Greg Goyert: Yes.

Diana Jolles: Yes.

Kimberly Gregory: I think the …

(Crosstalk)

Kimberly Gregory: I think the exclusions are consistent with the evidence and it makes the measure neat, but there's also good evidence that NICU babies benefit from breast milk too, but that's a different conversation.

Diana Jolles: Well, I think once we can fix this among the huge population, then we can have that be the next measure.

Kimberly Gregory: I agree. I agree. Hear, hear.

Nadine Allen: Any additional comments for the developer?

Kimberly Gregory: I guess the only other comment I had and I do know – I apologize for being late. But I did find that the overall incident of preterm labor was low. I mean, nationally, it's like between 10 and 12 percent, and they've got probably 70 percent of the hospital and they only reported a 5 percent incidence. And I also thought it was kind of odd that they didn't have any galactosemia cases. But, I mean, it could have just been sampling or the way it was reported. But I just want to mention that at least with regard to the preterm birth rate, it was lower than expected.

Nadine Allen: Thank you. Is it OK that we move on to feasibility at this time?

Diana Jolles: Yes.

Nadine Allen: Great. So, on the next section, we're going to be talking about feasibility. And at this point, Diana, if you could describe the data source for the measure and indicate it whether there are any feasibility concerns.

Diana Jolles: So in this particular measure, this is not the eMeasure. So, this is hospital reporting sampling. So, it was rated at a moderate feasibility level. They collect the data via manual review of a sample of records, so not all hospitals currently have the ability to extract from an Electronic Health Record. But the measure specifications are freely available making it feasible, so …

Greg Goyert: Diana, can you clarify that because I thought this was a measure, at least at our institutions, this is not a sample. This is everybody that comes through the door and then leaves.

Kimberly Gregory: In my hospital too.

Diana Jolles: I thought it should be – I think – I guess I'd ask for Dr. (Maine) to comment. I don't – this – I think that 0480 is looking at the paper submission and that the eMeasure is the next measure, 2830, that's not a sampling. Can someone clarify?

(Celeste): Hi. This is (Celeste) from the Joint Commission. You're correct. Sampling has always been optional for the paper based measure which we're reviewing right now. So, if your hospital likes to do all of the cases, that's your right to do that, but we do offer sampling options. Whereas the electronic clinical quality measure, once they select that, that's 100 percent. It will automatically pull all cases.

Greg Goyert: Got it. Thank you.

Diana Jolles: So, adding to the table of comments would be that the question about sampling and the fact that, well, at least in my opinion, we should require more and require mandatory reporting on all cases that it is feasible, but that's my opinion.

So, is it a burden for hospitals to collect data? I would say when you look that it's very possible to put the required data elements into the electronic forms of electronic health records, and that if we care about this measure, it's feasible. It's only infeasible when there are system barriers to coming around the measure.

Nadine Allen: Any additional concerns?

Greg Goyert: Well, we've all adopted that because it's there. And so I think those – if there were hurdles and challenges, and there were, to the extent possible, they have been overcome and it’s part of the workflow now.

Kimberly Gregory: I would agree.

Nadine Allen: OK. Thank you. So, we're going to go ahead and move on to usability and use because we have at least five other measures that we need to review on this workgroup call.

So Diana, could you go ahead and provide a brief overview about the usability and use, indicating whether the measure is currently being used. Again, this is an NQF-endorsed measure and it isn't being used. But indicate – you know, provide information to your workgroup members about that being publicly reported, and describe any experience you have had with the measure.

Diana Jolles: So, with regard to the fourth criteria, this is a measure that is publicly reported. Though the public reporting has …

Operator: Welcome to Verizon Wireless. The wireless customer you called is not available …

Diana Jolles: … has limitations. If a woman in my community wants to go online and sign the current rates of exclusive breast feeding discharge that is – we haven't achieved that yet. But there is qualitycheck.org. The Joint Commission reports the annual report in perinatal care certification through the Joint Commission. So, there's some level of public reporting have led to transparency and improvement in performance on this measure. Notably, these mandatory requirements out of the Joint Commission began in 2014, so we're just beginning to enjoy the benefits of that.

So, with regard to usability and use, the unintended findings, both positive and negative, that were noted by the developer are this issue of data obstruction related to the submeasure which is now being retired so we don't need to discuss that. But it was tested and was not feasible and did not make for usable measure.

Also, this importance of using the denominator element term newborn so that it's more usable and captures newborns that are over 37 weeks gestation. So, it's noted that as far as usability, that medical record extraction is the limitation to the usability of this measure. But as electronic reporting becomes more feasible, the usability will increase.

So, as far as comments from the committee and reviewer, this is – has been rated as a highly usable measure. And without concern over unintended consequences of re-endorsing it and continuing to publicly report.

Nadine Allen: Any comments from the workgroup members about this – the use and usability of this measure? Any unintended consequences that you are aware of?

If none, we can go ahead, if it's OK to move to related and competing measure. And just to let you know, there's no related or competing measure. So with that said, we ask that the workgroup members review the pre-meeting and public comments that we received before the in-person meeting because we would need to go through that in detail at the in-person meeting before making our decision.

So with that said, do you have any last minute comments for the measure developer before we move on to the next measure?

Hearing none, we can go ahead and move on to the eMeasure for this paper measure that we just reviewed and this is measure 0480, 2830. This is the eMeasure for the PC-05 Elective Breast Milk Feeding. It's measuring – PC-05 accesses the number of newborns – exclusively fed breast milk during the newborn's entire hospitalization. It's a process measure again and it's level of analysis facility population national.

We're not going to go through the evidence again because with eMeasures, the evidence would apply to the same evidence that was given for the – the paper measure would be the same evidence that's given for the eMeasure. And the score, the voting results will remain the same for both, so.

Reva Winkler: Nadine, this is Reva. Let me just make a couple of comments about eMeasures. NQF really supports the development of eMeasures and we are seeing more and more eMeasures coming about, as someone mentioned earlier, the desirability of having more electronic measures. And so, we are seeing this as the electronic – the eMeasure version of the measure you just discussed. And so, I think there's a lot of carry over and a lot of similarity.

And the question is maybe we should just focus in on any specific questions about the eMeasure version that any of the workgroup members would like to bring up just in the interest of time.

Kimberly Gregory: So, this is Kim and I totally support it. And I think as they go forward, especially with ICD-10, I don't know that hospitals are as consistently and reliably coding with ICD-10, especially this term newborn, the way we have found that they have been coding with ICD-9. And I'm just going to throw it out there. It's nothing to stop it from going forward. It's just to say that we may find a drop in the – either at the denominator or in the success rate for the first year or so as people really get better at the ICD-10 coding.

Greg Goyert: And the other factor that plays into that in a very way is the more explicit it can be with respect to – from I've already heard from our analytics team and our epic team making – you know, being able to easily document was already being done as opposed to having to reinvent the will. That said, when the eMeasure is introduced, I agree, there's going to be a drop off. But it's probably going to be artifactual until folks around the country figure out with whatever EMR they're using, how to check the right box and make sure the – that activity is accurately reflected.

Reva Winkler: This is Reva. One question I would ask our developers is, to what extent is the eMeasure version of this measure being used by hospitals right now to report this measure?

(Michelle): This is (Michelle) from the Joint Commission. Can you hear me?

Reva Winkler: Yes. Hi, (Michelle).

(Michelle): Hi. That's actually a great question. And we can get back to the committee with the number of hospitals that are submitting this measure to us. But this year is the first year that CMS is actually requiring electronics submission. In 2016, hospitals will have to report one quarter of data on – for eCQMs. So, we don't actually have – we actually have not received data to date. To date, hospitals have attested to CMS that they're able to collect this data. And they report the numerator and denominator but don't actually send the electronic

data. So, we're very early in the process and we can get back to you with our submission numbers if that's of interest.

Nadine Allen: OK. Are there any other points that committee members would like to raise about the eMeasure version? Again, I'm just – I'm looking at the time. And, perhaps, you can look at the documents because so much of it is going to be the same as it was for the original measure. And, perhaps, if there are no comments or questions on the eMeasure specifically, we could move on to the next measure.

Diana Jolles: This is Diana. I believe that the committee reviewed this document and found the eMeasure specifications to be aligned with the chart review, and that all of the HQMS components, QDM components, value sets and feasibility testing passed. So, all of the pieces looking at this eMeasure, they're – we're intending comments against this and moving forward with this.

Reva Winkler: Thanks, Diana. OK. Nadine, I think we can move on.

Nadine Allen: OK, great. So, we're moving on to measure number 1731, PC-04 Health Care-Associated Bloodstream Infections in Newborns. I will turn it over to Janet Young, who is one of our discussants, to provide a brief overview of the – a brief description of the measure, including the measure type and level of analysis and the endorsement maintenance information.

Janet Young: OK. And I'm also going to share some of this responsibility with Greg Goyert as well since this is …

Nadine Allen: Correct. Yes.

Janet Young: So this is measure 1731, Health Care-Associated Bloodstream Infections in Newborns, which measure septicemia or bacteremia rates. In ICD-10 codes for newborn septicemia and bacteremia defined by very large appendix based.

Greg Goyert: Right.

Janet Young: That's the numerator statement. The denominator statement is the target population of live born newborns with birth weight between 500 and 1,490

grams or birth weights between blah, blah, blah, sorry. For birth weights greater than 1,500 grams is defined in appendix A. There are many, many additional appendices for the denominator statement.

Greg Goyert: Right, and that boils down to (dies) or head surgery and things like that.

Janet Young: The exclusion listed were – sorry. Exclusion codes were diagnosis codes for septicemia or bacteremia with bloodstream infections present on admission, or those birth weights that's outside those tables. And then any length of day, say, greater than – sorry, less than two days or any enrollment in clinical trial was also exclusion.

Nadine Allen: OK. Thanks. So, this is the outcome measure and its level of analysis to this facility, population national. It was originally endorsed in April 2012 and the most recent endorsement was March of 2012.

Greg, if you could provide a brief description of the evidence of the measure. And since this is outcome measure, if you could put report whether there are processes or care that can influence the outcome.

Greg Goyert: Sure.

Nadine Allen: And then share your ratings for the algorithm as well.

Greg Goyert: Sure. But before we do that, what I want, all the other committee members that may not have gone line by line through this as well as 0478, just keep all of this in mind because the subsequent differences between 1731 and 0478 are chart level obstruction versus administrative data. And that's really the – in round numbers, that's the only difference.

The evidence for this is very strong. It's a big problem particularly and that is bloodstream infection in this particular patient population for the obvious reasons. And as we'll talk about later, there's a significant gap in performance. So, I don't think there's, in my mind, anything but that this would pass on the basis of the evidence rating. It's an important metric.

Janet Young: Agreed. This is Janet Young.

Nadine Allen: So, do the committee agree that the evidence based for the measure has not change and there is no need for a repeat discussion or voting on the evidence?

Greg Goyert: Correct.

Janet Young: I agree.

Nadine Allen: OK.

Diana Jolles: I agree.

Nadine Allen: Great. Moving on to gaps and care, Janet, could you provide a brief overview about the gaps and care, as well as letting us know if there is a gap in care that warrant a national performance measure, and any information that the developer provided about disparities.

Janet Young: I'm sorry. Did you ask for me to do it?

Nadine Allen: Yes, please.

Greg Goyert: Or we can just say there's a gap that needs to be closed.

Janet Young: There is a gap in care and there were no mentions of disparities, race or socioeconomic status – sorry, provided with this particular measure.

Nadine Allen: OK. Great, thank you. So, we can move forward to reliability, both the reliability specification and testing.

Greg Goyert: You know, when you look at the …

Nadine Allen: Greg?

Greg Goyert: Yes, right. When you look at the reliability testing, it was tested by the vendors and the – it has a very high reliability in the range of – as far as point of origin, admission type, admission date, things like that in excess of 99 percent, and for birth weight, 94 percent. So, at a minimum, I think the

reliability is moderate. I guess I'm a little bit curious as why it wasn't rated as high, but.

Janet Young: That's because moderate – according the …

(Crosstalk)

Greg Goyert: Through the box, the algorithm.

Janet Young: … flow sheets that were given on the algorithm, that's the highest possible rating.

Greg Goyert: Got it. I see.

Janet Young: I agree with Greg. This is – should be the highest possible that we could possibly rate it.

Greg Goyert: Yes.

Reva Winkler: Right, yes. This is Reva. I mean, we make a difference between testing for reliability of the data elements versus reliability of the measure score. And if you haven't tested the measure score either instead are also then the highest rating possible is moderate.

Janet Young: Right, right.

Nadine Allen: Any comments for the measure developer?

Greg Goyert: I don't.

Nadine Allen: Fair enough.

Greg Goyert: Yes. I think it makes sense that they moved the length of stay down from three days to two days and things like that. And I think they removed the greater than 100 day – 120 day exclusion, so I think it's just an improved measure.

Nadine Allen: Great. So now we can move on to validity, specification and validity testing. The developer did – so, the question – so, if you could provide a brief overview about that, Janet or Greg? And then, you know, are the specification consistent with the evidence? And the developer did mention that they provide some additional validity testing of the measure score, so if you could provide some information about that?

Greg Goyert: Right. Well, like we talked about before, I don't see any (prima facie) evidence why this should be related to the other Joint Commission measures, because they're just different things, but I think that the remainder of it is fine.

Janet Young: I happen to agree. There's not a ton evidence there, but I don't see any influx of reason why there's a concern for validity testing.

Nadine Allen: The length of days – for this measure, there is five exclusions. Are the exclusions consistent with the evidence, do you think?

Greg Goyert: Yes.

Janet Young: Yes, I do.

Nadine Allen: OK.

Greg Goyert: I mean, there are kids coming in septic already and things like that, kids less than 500 grams, length of stay less than two days, those are all appropriate.

Nadine Allen: OK, great. And then, you know, this – since this is a outcome measure, we have to take into account the SDS. So, if you can provide a brief overview about what is the sociodemographic status – factors that they're accounting in this measure.

Greg Goyert: There's just two. It's race and ethnicity.

Female: Do you agree?

Greg Goyert: Yes, and I think that's appropriate. Janet, what do you think?

Janet Young: Oh yes, I agree. And also, after they tested for race and – sorry, race and ethnicity, it was important that these specifics, probably one the strongest we're going to discuss today, 2.7.

Greg Goyert: Exactly, exactly.

Nadine Allen: OK. We can – so for meaningful differences, does the measure identify meaningful differences about quality?

Greg Goyert: It certainly requires – it identifies meaningful differences and outcome, so as an indirect surrogate for that.

Nadine Allen: OK. And missing data?

Janet Young: And so the missing data for this particular measure is there was no data, the category E was assigned, which means it was a failed measure, but not rejected. So, they didn't state a number of times or percentages in which there was missing data. They just assigned it as an E and that was a failure.

Nadine Allen: Any additional comments from the other workgroup members about the validity of the measure?

Female: No. This is a strong measure.

Nadine Allen: OK. I think, now, we can move on to feasibility.

Janet Young: So, from a feasibility perspective, we rated this high because currently, it's being used. It's available from the paper record evaluation, as well as the EMR. It's currently collected. And apparently, it's going to be retooled from electronic source for 2016.

Greg Goyert: I think the final – the committee said moderate, but …

Janet Young: Sorry, I apologized, moderate.

Greg Goyert: Yes, but it …

Janet Young: Yes.

Greg Goyert: Yes. It's hardwired in. It's in the workflow so it's – that's not an issue.

Nadine Allen: Any additional comments about feasibility? Hearing none, we can move on to usability and use.

Greg Goyert: And I think that was fine. If you scroll through it, they talk about for unintended consequences that were fixed, in terms of it, one of them was widening the sources for data. Second was extending it beyond 120 days. One we already talked about was, you know, the kids that were bacteremic on admission. So, I think that's appropriate.

Nadine Allen: Do any committee members on the call have any personal experience with using this measure and can provide any feedback about it?

OK. Hearing none, we can move on to related and competing measure. The developer identified two measures that is competing with this measures, 0304, Late Sepsis or Meningitis in Very Low Birth Weight Neonates, and 0478, Neonatal Blood Stream Infection Rate. The developer state that this measure has been harmonized to the extent possible with 0478. However, there are intrinsic differences which are addressed in a comparison table in the appendix.

Janet Young: And I think Greg alluded to what he was going to talk about in terms of how they are not harmonious in that sense.

Greg Goyert: Well no. I mean 0304 is a different – really a different measure altogether and it's getting a different patient population. But the comparison with 0478, I mean, 0478, like the one we're discussing is already endorsed. The question, it's a more philosophical question like a lot of these things, do we need two measures that are assessing the same thing will all be it coming through two different doors at the same house, one with administrative data, one with patient level data and (chart obstruction). So, that may boil down to a (taste grade), less filling conversation.

Nadine Allen: Any additional comments for the measure developer before we move on to the next measure?

Greg Goyert: I'm sort of curious about what other committee members think about the – having two measures addressing the same – very same outcome?

Diana Jolles: This is Diana Jolles. I echo your concerns, and would also point out that it's not even just measuring the same measure from two different angles, but that you're measuring the same – similar population, not the same. I agree with that difference, but I feel …

Greg Goyert: No, no, no. When you look at – when you're talking about NQI 3, that is the same population. The other one, the 0304 is a slightly different population. Right. No, the …

Diana Jolles: Great, then absolutely no.

Greg Goyert: The 0478 that we're going to talk about next is …

Diana Jolles: Is different, correct.

Greg Goyert: No, it's personally identical population.

Janet Young: The same population, correct.

Mambarambath Jaleel: And there is – Hi, this is Jaleel. I am actually assigned the 0478 …

Greg Goyert: Good.

Mambarambath Jaleel: … one, so I agree. And I was there for the previous NQF committee as well and this was discussed and that, I mean, three years ago or four years ago now. The same thing was discussed for that too, that there are three measures that which are very similar. There are nuances. There are difference – slight differences. But all in all, they're almost the same.

So, do we need three measures? And so that questions will, again, come up this time. And I agree with that. I mean, there is a slight difference that in 0478 that I am doing, it's only babies who are less than 1,500 gram and none of the others are included. And this measures by the Joint Commission, there

are babies who are more than 1,500 grams but were ventilated or require other procedures that …

Greg Goyert: Correct.

Mambarambath Jaleel: … I don't think (inaudible). Now, the Vermont Oxford Network measure which is the other one which is the third one. I can't remember the number of that now.

Greg Goyert: 0304.

Mambarambath Jaleel: Yes, 0304 includes meningitis as well.

Greg Goyert: Right.

Mambarambath Jaleel: But the population is the same. It's very low birth weight infant which is less than 1,500 grams. So, they're all almost the same. The source of data is different as we mentioned. What we hear in 0478, the source of administrative claim, and your measure, looking at this because, I mean, right now, it's manual review which is probably much more accurate than just administrative claims.

Greg Goyert: Right.

Diana Jolles: Correct.

Greg Goyert: But let's go back to something you said, because when you look at – and I don't mean to jump ahead, but we already have. On 0478, the kids greater than 1,500 grams are still included in that measure with – if they die or if they have a procedure or if they're ventilated. So, those patient populations are really almost, right, they are identical. I think the only distinction in terms of the patient population is that it's less than two days versus less than three days length of stay.

Mambarambath Jaleel: Well yes, I'm not sure because we discussed this last time. I think …

Greg Goyert: I'm looking at it and you pull it up. I'm looking …

(Crosstalk)

Mambarambath Jaleel: I think there was harmonization between that. And one of the measures changed the – I think that was 0478 that changed the data. And well, I'm going to look back again and …

Greg Goyert: Sure.

Mambarambath Jaleel: … confirm that. But I think one of them, either one of them changed is what I remember.

Diana Jolles: This is Diana. If you want to ask the question, you brought up the question about what is our role in narrowing down the number of measures. Are we to look at each of these individually as a valid measure and not look at the big picture? Or, when do we discuss the fact that eight of these measures on the table related to intensive care, high intensity care to the minority of child bearing women and babies?

Reva Winkler: Diana, you asked several questions there. In terms of these three measures that are directly related around infection, we want you to be sure that each measure individually meets the criteria and would be recommended for endorsement. That's sort of the first step because if it fails, then you don't have the subsequent question. So, we have to be sure all of those meet, and that's the first step.

Then we will very specifically ask you on these measures of infection to compare them and have this conversation very deliberately with the purpose of answering the question and giving us your best input and your best recommendation of whether there are, you know, there's good enough reason to have multiple measures or whether you should pick with just one and which one is it.

The one question I would ask you all prior to the in-person meeting is, is there any additional information about these three infection measures that you would want to have to help you with that conversation – that we could pull together before the in-person meeting? Some – you know, we have an

opportunity with a little bit of time that if there's something you think would be helpful that, perhaps, we could provide to foster that conversation, but you will be expected to have that conversation.

Now, Diana's other question which was, how about all these measures around the premature or high risk population versus all the normal – the babies, is the conversation will be around the portfolio of measures that we have for perinatal care. And as the standing committee, your – one of your responsibilities is to oversee that portfolio. And your conversation about what's in the portfolio, where the gaps in the portfolio, and how – and the kinds of issues Diana has raised is pertinent to that conversation. So – and you will be having that both, sort of, at the beginning of your meeting and at the end of your meeting. So, I hope that answers your question a little bit.

Greg Goyert: So with that said, specifically, if we go back to 1731 and 0478. If somebody, somewhere can tell us, "Oh, the reason we need two as mentioned in, you know, the fine print is that some states, some agencies don't have access to the – or the capability to access the chart level information, and that's why they need to rely upon the administrative data. If somebody can demonstrate this, "Well, if we don't use administrative data, we can't get any of these outcomes." I think that'd be a valuable piece of information for the committee to have in terms of when they make their decision.

Kimberly Gregory: And this – this is Kim. Excuse me. I'm sorry. What I have called too about that last time was that one of those was specifically a VON measure, and their requirement for reporting was different, and that everyone felt like if they were going to have to report it anyway, they might as well keep.

Mambarambath Jaleel: Yes, I remember that discussion. The 0304 is a VON measure. And any member of VON, which is about 1,100 or 1,200 NICUs in the country, they will be reporting this data to VON on a regular basis. So, they have it reported, but not all the NICUs within the country are VON members, even though majority are. There are – some of the centers which are still not members of the Vermont Oxford Network.

(Karen Shea): And can I also say from the perspective of payer, having access to the administrative data is a real advantage because we don't always have access to electronic medical record or to the chart. And, you know, that process of doing a chart audit is becomes extremely costly. And so to have a measure that we can pull from a claim using administrative data is really a major advantage to developing pay-for-performance program and, you know, providing facilities with information about their outcomes in relationship to, you know, peers and other regions.

Mambarambath Jaleel: But it sort of begs for an eMeasure doesn't it?

(Karen Shea): Well, it does but I guess we're not there yet, are we?

Kimberly Gregory: And then to some extent, we would want to know who the two measures compare, right? Because if administrative data gives you reasonably close information to the chart audit data, then that's helpful to the insurers and easier for everybody. But if the char audit data is actually giving better data and different, then it raises the point of wanting to push to it to the eMeasure quicker, and that the one – if we were going to choose one, it would probably be, you know, the one that may be more burdensome but more accurate. I don't know (inaudible). But I'm just saying, if there's any head to head comparison data, that would be helpful.

Reva Winkler: Yes. This is Reva. I would just ask the measure developers if they are aware of any comparison data that exists, that might exist.

Nadine Allen: Is (Celeste) or (Michelle) from the Joint Commission on the line still?

(Celeste): Yes, (Celeste) is here. You're asking if we have comparison data between the AHRQ measure and our measure, correct?

Nadine Allen: Yes, either a face validity or reliability.

(Celeste): We would have to look at what they've submitted but we actually – the only thing that we've done with AHRQ is try to harmonize the specifications which you got that comparison table. But as far as how our rates compare, we haven't done that.

Nadine Allen: Reva …

(Steve Schwartz): This is (Steve Schwartz) from the Joint Commission. We do get administrative data from – as part of our database, so that is something in theory that we could look at, we just haven't done that yet.

Mambarambath Jaleel: That would be fantastic if we …

Nadine Allen: I think that this committee would like to at least see some evidence of some inter-rater reliability or at least comparison accuracy rates between the two, perhaps, sometime before we discuss this in-person.

(Steve Schwartz): OK.

Nadine Allen: We spent a very long amounts of time in our 2012 meeting on specifically this issue. And I'd like to, you know, perhaps have some new data to discuss by the time we re-meet again.

(Steve Schwartz): We are looking to the amount of ICD-9 codes we get, but I think AHRQ has the same limitation. So, I think it should be pretty much a good comparison to do it both ways.

Female: OK.

Greg Goyert: But part and parcel of this entire conversation is not in the weeds of Appendix 3C but rather at 10,000 feet is to a certain extent, though we have the function as stewards of scarce health care resources, there are only so many hours in the day that folks can gather data. There's only so many analytics people and so on and so forth. And so, I think there is a certain priority to making – to prioritizing these needs and desires.

Reva Winkler: OK.

Nadine Allen: OK. Thank you all for your feedback.

Reva Winkler: All righty. Yes, it's Reva. I'm just looking at the time, Nadine. In terms of measure 478, we haven't gone through the details. And I'm just wondering if

Jaleel or Greg have just anything to add about that specific measure? Any concerns about the testing with it, which is really going to be the one thing, I think, you probably haven't talked about. Otherwise, I think we …

(Crosstalk)

Greg Goyert: I can go. I think, you know, going through all the details and things like that, I think the measure is fine. The question is do we need it? That's my take on it.

Mambarambath Jaleel: Yes, I agree with that for 0478 too. The measure is fine. The feasibility and reliability and all that is fine. My question was also the same.

Reva Winkler: OK, already. Well, that's going to be a big question at our in-person meeting. So, given that we do have some time constraints today, perhaps, we can all look forward to that conversation and move on to our next measure, which is a new measure. So, we do want to have time to talk about that. Nadine?

Nadine Allen: OK. So, the key discussants for this new measure is – which is 2893, Neonatal Intensive Care All-Condition Readmissions. Key discussants are Janet Young, Jaleel – Mambarambath Jaleel and Karen Shea. So with that said, Karen, would you like to go ahead and give a brief overview of the measure?

Karen Shea: I …

Nadine Allen: Before we go into evidence?

Karen Shea: I would be happy to do that, but as these things do happen, my computer screen has frozen on me about five minutes ago. I'm sorry.

Janet Young: This is Janet. Jaleel and I will bail you out. We're good.

Karen Shea: All right, thank you so much.

Janet Young: So, I'll start. And Jaleel, please feel free interrupt.

Mambarambath Jaleel: Sure.

Janet Young: So, this is a new measure and it took me – I spent hours on this evaluation. This is about a neonatal intensive care all-condition readmission. And it's essentially looking at graduates of the NICU and their 30-day readmit rate. And to look at whether or not there are factors that are influencing it, for lack of a better term. That's a brief overview.

Do you want me to go into more detail?

Nadine Allen: No, that's fine. We can move on to evidence. And Jaleel, if you could just provide, this is an outcome measure so we want to hear more about whether there's processes of care that can influence the outcome, and that's it.

Mambarambath Jaleel: Yes. I think the major concern that I have with this measure is the, how do we capture this information because the – many of the NICU are maternity hospitals and they do not readmit these babies. And many of these maternity hospitals do not have a pediatric floor or a pediatric ICU, so they do not readmit these patients into their own hospital. So, they are admitted to another children's hospital, and so getting that data on readmission would be difficult. That was my short synopsis on this.

Janet Young: I have to wholeheartedly agree that the – reporting a neonatal admission rate or even to a pediatric ICU at an institution, by calling this NICU quality care, essentially using this measure as an evaluation of the quality of care, of discharge planning, and the quality of care from the NICU at time of discharge, which then is going to be readmitted to another institution doesn't reflect upon the quality of care or the discharge care from a different institution and insurer rate. Does that make sense?

Greg Goyert: It does. And not only that, when you look at what the developers talk about, they're talking – the quote that I wrote down was process of discharge that we would like to measure, well, that's all well and good. But again, this measure does not asses the process of discharge. This measure says, "Did the kid bounced or not?" So, this is not a process measure. This is an outcome measure, if the kid comes back or not.

The other point that comes up is that there are so – I mean, it's a multifactorial math. But then there's factors. Once that kid goes home, who's taking care of the kid at home, and I mean by other providers and yet, that kid may bounce back to the NICU, having nothing to do with the care that that child received prior to discharge.

Mambarambath Jaleel: Yes, yes. Go ahead, sorry. The developers did …

Karen Shea: Hi, this is Karen. I agree. I looked at this measure and it was the first one I tackled and I thought, "Oh my god, if they're all like this, I'll never make it through this committee."

Janet Young: Amen to that.

Karen Shea: So, I ended up doing quite a bit of research just on unplanned readmission rates just to ground myself to review the measure. And then, you know, when I was going through it, I thought well, you know, I actually didn't even think of that issue. That was just mentioned as that if you are discharged from one facility and then readmitted to another, how is facility A going to assess their own readmission rate.

Mambarambath Jaleel: Right.

Karen Shea: But, you know, from a payer perspective where you have, you know, the member receiving their care and, you know, I can look at all of the different claims of over the period of the first, you know, four to six months and determine if there was a readmission within that window. So, it's a measure I think that a payer could use but I would think if we wanted to make this universally applicable to facilities, it would be very, very difficult. And I've got a couple of comments there, but off the top of my …

Mambarambath Jaleel: Yes, the developers do mentioned the first comment about difference factors affecting that you mentioned about patient factors affecting readmission, inpatient quality of care, the different care processes involved with the such, education and transition of care and all of those things. So yes, they do – I think they do understand that this is not only about transition of care and discharge education but also has multiple other factors.

The second comment I have is about the, how do we capture this information at this (space), baby is admitted to a different hospital. They do mentioned about insurance records will contain this information, or population based data will have this information, of which I am not sure how much it is feasible in all the states.

Now, I can give you the example of our own institution over here. We take care of about 20,000 deliveries in three different hospitals. And we have tertiary care children in NICU too. None of the 20,000 deliveries that happened in these three other hospitals, they're all maternity hospitals, and none of those babies are readmitted to the maternity unit as they are all admitted to the children's hospital. And there are three different children hospitals around the community, so you don't know which hospital they're going to admit, hopefully get admitted to based on their demographics. So, it is really very difficult unless you have a robust insurance record and population based record.

Janet Young: I agree, and I happen to work in a very disparate environment. I'm in a very large rural particular area, we have a six-hospital system which readmissions are done to tertiary care, NICU or PICU, and so the delivering hospitals may or may not. Obviously, they generally don't readmit those patients. And certainly, we receive patients from three other states.

Mambarambath Jaleel: Yes.

Karen Shea: The other aspect about this particular measure that I found interesting is they chose to close the window of the numerator to 23 to 34 weekers, and I wondered why they didn't include 35 and 36 weekers since, you know, some of the literature suggest that the late preterm group is really the group that sees most of these readmissions.

Mambarambath Jaleel: Yes, I had the same question too. One of the reasons could be that many of these babies who are 35 and above are not admitted to a NICU. So, they are mostly taken care of in the newborn nursery and they go home from this. So, they might not have the patient record for those.

Karen Shea: Right.

(Crosstalk)

Reva Winkler: This is Reva. Just some of these questions, perhaps, do we have someone from the developer with us who could respond to that question?

Karen Shea: Very good. It's Philadelphia Children's Hospital. Do we have anyone on from that group?

(Shawn): Yes, this is (Shawn). I am from the Children's Hospital, but I would have to actually speak with Dr. (Scott Lorge) who is the actual person for the measure. I'm just here to take notes. I'm sorry.

Karen Shea: OK, all right.

Greg Goyert: You know, along the same lines, it did go to the summary of the evidence, what the developers described their conceptual logic model. They say on the hospital level, readmissions represent either poor quality of care during the hospitalization or poor discharge planning and transition from inpatient to outpatient providers. So, this is – I mean the whole tenure of this measure is we're getting out the red pencil again and saying, "You're bad. You're bad. You're bad." Without any thought of, well, these kids come back, some need it, some don't, are there issues there? I think it sort of gets off on the wrong foot all together.

Janet Young: I agree. The other take home message was you're asking an institution to be held accountable for essentially a 3 or 5 percent error rate – I mean effective rate, and about 93 to 95 percent of what happens to that infants in the discharge arena is parental care or parental ability, environment primary care ability, specialist availability and those are things that that NICU, that institution has absolutely zero control over a specialty in my area of the country.

Mambarambath Jaleel: That would – I'm not sure but there might be ways to tackle that. Say for example, risk adjustment, say, it's an inner city hospital who has

higher, you know, extremely premature babies delivering over there, or high risk babies delivering over there, there might be risk adjustment that can be done for all those kind of issues.

Janet Young: And he attempted to that risk adjustment in this particular measure, but it was risk adjustment for only I think retinopathy of prematurity bronchopulmonary dysplasia, the typical things that we know that are weight adjusted or the risk adjusted …

Karen Shea: Right.

Janet Young: … admission rates for just as – for particular condition. It doesn't …

Karen Shea: It's major co-morbidity.

Janet Young: … outpatient setting, it doesn't address the lack of specialty pediatrician.

Karen Shea: Right.

Greg Goyert: Or SDS and things like that. And, you know, particularly this week, the CMS and the grown ups did not seem particularly fond of risk adjustments, see the hospital star rating so I don't think we can rely on that.

Janet Young: Correct.

Karen Shea: And one of the other areas I saw that wasn't included is planned transfers. So, you who have a child whose in hospital A and then discharged to a higher level of acuity. Sometimes this is going to come through whether as a readmission and …

Karen Shea: Correct and, you know …

Mambarambath Jaleel: Also that …

Karen Shea: … would this affect their data. The other area was planned readmission.

Mambarambath Jaleel: Readmission, yes.

Karen Shea: Children who are admitted for hernia repair or some kind of surgical procedure that it wasn't available child, then go home safely and come back in a week. I didn't see any of that in the data logic.

Janet Young: I believe that was the numerator and denominator statements, I think. I know at some point in time, in the literature that provided for us, there was a discussion about planned readmissions and these were unplanned readmission, and I don't know how he planned on capturing that data.

Karen Shea: The difference between the two.

Janet Young: Correct.

Karen Shea: And then the major reason that they had stated for readmission is this whole concept of parental confidence. And I wondered how one would measure parental confidence.

Janet Young: License to have children. I'm kidding, kidding.

Karen Shea: Right. But, you know, clearly I like the concept of this measure. I do think that it's an area that we need to do more work on. I struggle with trying to measure this from, you know, a claims perspective. But, you know, we've looked at all these different issues of planned readmissions and things like children who go home and get pneumonia, who, you know, we wish we could but evidently, you know, these things do happen. How do we really at this in such a way that we can measure it and then come up with what are really mitigating factors that can also be measured.

Mambarambath Jaleel: Yes, I struggle with this as a Neonatologist as well. The patients who are discharged from my NICU, I would like to know, well, if they are getting readmitted to a different hospital. And if so, how can we review those readmissions. So, it's an important measure that if we can capture accurately, would be a good one.

Karen Shea: And I also saw some of the downside of measuring this or, perhaps, setting a benchmark and holding facilities accountable to a certain percentage is an increase in a necessary length of stay.

Mambarambath Jaleel: Yes, I agree.

Nadine Allen: OK.

Reva Winkler: It's Reva. It's Reva. It sounds like you guys have kind of hit a bunch of the different criteria without going through it in order. Were there anything specific about the current performance data that was provided or the testing data that was provided about this measure, so that for feedback to the developer in preparing for the in-person meeting?

Janet Young: I made multiple comments in my pink boxes on the survey tool about the – gosh, I made so many and I'm sorry, about – at least on the adult side, we look at – so we look at, in the adult side, we look at readmission rates for a very particular population, specifically (CHF). And one of the issues for (CHF) readmissions in adult is that we thought very tightly maintained and integrated discharge planning would reduce 30-day readmission rates for these particular adults who have a very narrow set of diagnosis unlike NICU graduates. And what we found was that in at least two cases, that integrated system actually increased the rate of readmission, not decreased it.

So, if you're taking a measure like this and you're trying to measure or evaluate how good you're discharge planning services are for that NICU or the readiness for patient to be discharge which is, again, the key of the developer, are we, in fact, not going to be measuring what we think we are? And I actually made multiple comments in the pink for those issues.

Reva Winkler: We'll be sharing those with the developers as well.

Mambarambath Jaleel: One other comment I had was about the measure title itself. It says, Neonatal Intensive Care, All-Condition Readmission. Not sure whether it is appropriate or not because we are measuring only those babies who are between 23 and 34 weeks. So, this is not all-condition. This is not on the NICU. This is only a small – major group within the NICU, but it certainly does not include the full NICU and all-conditions.

(Crosstalk)

(Shona): Hi, this is (Shona) from the (CHOP). To clarify, all-condition refers to the reason for which somebody was readmitted, you know, rather than you have to be readmitted for the same diagnosis or DRG code. You can get readmitted for any reason. So, that's what that refers to.

Mambarambath Jaleel: OK.

Karen Shea: Right.

Sheila Owens-Collins: This is Sheila Owens-Collins. I'm a Neonatologist. I'm sorry, I missed the first part of this conversation. But being on the managed care side, we find that a lot of readmissions are a function of the availability of the PCP. And I'm not sure if that is included in any of the variables of this measure. When the PCP is available, many times, the E.R. and patient admissions can be avoided.

Mambarambath Jaleel: The developers …

Sheila Owens-Collins: Especially for the complex kids.

Mambarambath Jaleel: Yes. The developers do mention that as a part of the package that hey having good outpatient who are cared for …

Karen Shea: Right.

Mambarambath Jaleel: … is important, but I'm not sure how they tease it out as to what is due to poor discharge planning and what is due to the high acuity for high risk patients, and what is – how much is that due to outpatients care quality?

Greg Goyert: And so if we're not careful, part of this is going to become a commentary on the quality of social work services within a given NICU as we all know. But if you go specifically to the data collection strategy, what the developers highlight in their own words are test of the measure show a high degree of variation across hospitals, blah, blah, blah, and does accurate implementation of this metric will require new data collection linkage with birth certificates or more widespread and standardized use of the EHR for publicly reported

measures, which sort of begs the whole question that this is not quite ready for prime time.

Mambarambath Jaleel: Ready for prime time.

Karen Shea: Yes, I agree. I think that it would – it would blend itself to electronic health record reporting. But we don't have access to – they're not linked. Different facilities, EHRs are not linked in order to pull this data.

Janet Young: Yes. This would require an entirely new set of either electronic reporting codes or electronic measure. Or, in the case of a smaller institution or a community, like a large community hospital, this would require essentially paper chart reporting, which is not feasible at this point.

Reva Winkler: OK, anything else from anybody on this measure? You've had a pretty robust discussion.

Diana Jolles: This is Diana. I just would ask that we get back to the developer to ask about the issue of attribution specifically, because I'm sure that Children's Hospital of Philadelphia is the recipient of many babies born outside of their facility has been readmitted to their facility. So, I would value their opinion on attribution.

Nadine Allen: Anything else for this measure? All right, are you ready to move on to the last one?

Karen Shea: Sure. That one's easier.

Nadine Allen: OK.

Greg Goyert: A lot easier.

Reva Winkler: All right, Nadine go ahead.

Nadine Allen: OK. Thank you. So the next measure is 0475, Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge. The key discussants for this measure is Karen Shea, Diana Jolles and Kimberly Gregory. So, Karen, I'm not sure if your computer is back up

working, but if it is, if you can go ahead and provide a brief overview of the measure.

Karen Shea: I'm sorry. I'm still dead in the water here. I apologize. And I promise to make it up to the group on another occasion. Basically, I think that this is …

(Crosstalk)

Karen Shea: … let's say, a reevaluation of an existing measure for the number of babies who received Hepatitis B vaccine prior to discharge. And if a child is – has a prolonged hospital stay, that they received that dose, you know, within 30 days, you know, of birth. So, it's an existing measure. And, you know, basically, it's a worthwhile measure and I had no problem with it.

Nadine Allen: OK. Thank you for that. So, this is a process measure and the level of analysis is facility. So, the evidence we're looking for is to describe the relationship to patient outcome presented by the developer. And it is a systematic review and QQC presented, which is QQC stands for quality, quantity and consistency.

So with that said, Diana, would you like to provide a brief overview of the evidence? The developer did say that he – they provided updated evidence for this measure.

Kimberly Gregory: They updated it with four systematic reviews and just added further strength to the argument.

Nadine Allen: Any additional information to add for the evidence? If not, we can move on to gaps and care.

OK, moving on to gaps and care. Is there a gap and care presented by the developer? And does this measure provide information to understand disparities in the area of health care? Kimberly? Diana?

Diana Jolles: This is Diana. Gap was significant. I was actually surprised …

(Crosstalk)

Diana Jolles: … and I think with the – the evidence report about the gap and care was supportive of endorsement.

Kimberly Gregory: Right. They should be at 100 percent and there are still pretty significant variation between 67 and one hospital was low. It was in Texas, as low as 21 percent.

Nadine Allen: Any additional comment? OK. So, we can move on reliability, specification and testing. We can report on the numerator, denominator exclusions, and the type of testing that was done. I know the developer presented new testing for the measure score using signal to noise. So, you know, I'll – if you guys – one of you just take that away between Kimberly and Diana?

Kimberly Gregory: I'm sorry. You wanted to talk about the signal to noise. OK, let me look at that just a second.

Greg Goyert: It was very high.

Kimberly Gregory: Yes.

Greg Goyert: I mean it was 90 percent. Above 90 …

Diana Jolles: 90.

Greg Goyert: … it wasn't very high.

Diana Jolles: … percent high of – yes.

Kimberly Gregory: So (.99) – yes, yes, yes.

Greg Goyert: It was 98 to 1, so.

Kimberly Gregory: So they felt that that is a reflection of the actual performance. They're not a reflection of measurement error.

Diana Jolles: Correct.

Nadine Allen: OK, great. And do you agree with the ratings based on the guidance from the algorithm?

Kimberly Gregory: Yes.

Nadine Allen: OK, any further comments on reliability and testing before we move on to validity specification and validity testing?

Karen Shea: No.

Nadine Allen: Hearing none, we can move on, validity specification. The specification is consistent with the evidence. And for validity testing, the validity tested level is the measure score and the developer used the face validity only. So, any comments on that?

Diana Jolles: No.

Kimberly Gregory: No. Yes. I mean basically, they did a survey and everyone thought it was important.

Nadine Allen: One of the question for exclusion that we would like you to provide more information on is the refusal of treatment, is that valid reasons for exclusion from the denominator?

Kimberly Gregory: That's a good question.

Karen Shea: No.

(Sarah Shelley): This is (Sarah Shelley) from the CDC. We're the measure steward and I don't if this is the appropriate place to bring this up. But we would love it if caregiver refusals were not excluded for the denominator. We definitely feel like it would be made more robust that way. And I don't know if there's anyway to consider that.

Janet Young: Well speaking anecdotally – this is Janet Young. Speaking anecdotally, I think that there are many reasons why an educated parent may choose to have a Hepatitis B vaccine given at a day or two of life at their repeat PCP visits.

So, hospital refusal doesn't necessarily mean it's a failure of the – of Hepatitis B being given to a neonate.

Nadine Allen: Any additional comments before we move on to risk adjustment and meaningful differences? So, there's no risk adjustment for this measure and there were some meaningful differences presented by the developer. Does the measure – so the question for the discussants is does the measure identify meaningful differences about quality?

Kimberly Gregory: This is Kim. I think the perceived changes don't change that much. I guess the question is that – and this was asked to the developer. The reason why you want to not exclude the people who refuse and so that you can keep any denominator, all those people, which will make your quality measure, the absolute number lower, but when you look at this, it's only fractionally lower.

(Diana Jolles): I mean, we just feel that, you know, the hospitals and the hospital providers are in a unique position to educate the mothers about the importance of vaccine. And certainly, vaccination in the hospital is the safety net as opposed to waiting a couple of weeks of life and getting vaccinated at the PCP's office. There are infants who fall to the cracks or don't return for follow up. I mean, so we – you know, that's our basis for that.

Nadine Allen: Any further comments for the developer around validity specification and validity testing? Hearing none, we can move on to feasibility.

(Crosstalk)

Kimberly Gregory: This is Kim. Can I ask a question? So, can the developer decide to change the denominator on their own before we vote or, it stays the way it's written because that's way it's written?

Reva Winkler: This is Reva. I mean, the developers in – is the owner of their specifications, and so they do have the ultimate decision making on what the specs will be. I think that any guidance that the committee might want to give them, I think, is more what they're looking for. But it truly would be up to the committee – up to the developer to actually make any changes to the specifications. They are the owner of them.

Karen Shea: But ultimately, it would be up to the committee to decide to endorse it.

Kimberly Gregory: Right. So if it's stay the same. That we were just re-endorsing. If they change it, is that new or it's a re-endorsement?

Reva Winkler: No, it's still a re-endorsement of the existing measure with revisions and updating. We see that with measures all the time.

Kimberly Gregory: Perfect. OK, all right. Thank you.

Nadine Allen: OK. So for feasibility, can we describe the data source for the measure and indicate whether there are any feasibility concerns? Discussants?

Kimberly Gregory: I have no concern. I think that will be a great eMeasure eventually.

Mambarambath Jaleel: Do we have a sense of what percentage of hospitals gives this data an (eFormat)?

Nadine Allen: Thank you for your comments, moving on to usability and use.

Reva Winkler: I think Jaleel just asked a question correct?

Mambarambath Jaleel: Yes.

Janet Young: You asked – OK. So, is anybody from the CDC online? How many of us – how many of these institutions are here reporting this in electronic format?

Female: I don't have that data and I know we did. I did take this to my division about pursuing the electronic measure, but we just couldn't devote the resources to the measure testing for the electronic version of it.

Janet Young: It might be helpful for us to have just some idea about that before the in-person meeting.

Female: OK. Thank you.

Janet Young: Thank you.

Nadine Allen: OK, moving on to usability and use. So, the measure is currently publicly reported and it's currently used in an accountability program. Has anyone on the committee familiar with this measure, have any personal experience with using this measure?

Do you guys have any feedback for the measure developer around the usability and use of this measure?

Greg Goyert: Well, are we sort of indirectly asking the developer to (gen) up a new metric by the in-person meeting that takes out the exclusion of parental choice because I can – I sense we sort of left it out there in the middle of the field.

Kimberly Gregory: Yes, we did.

Diana Jolles: I would like to comment on that. I think this is – this is Diana. This is similar to the 5A exclusion in the decision not to make those types of exceptions. Meaning, you're …

Greg Goyert: Yes, you're right. You're right.

Diana Jolles: … making it less feasible. And yes, and I think that that's a great example of that would support the idea that facilities report their rate and that this is not an acceptable exclusion.

Greg Goyert: Well, I agree. And the other thing is if you look on page nine, the potential harm that the developer knows is that if the unintended consequence of having that exclusion is that there's a loss of information about hospitals with an unusually high refusal rate. Now, you can have different reasons for an unusually high refusal rate, i.e., you don't want your kid to get the shot, do you, you know, to more legitimate things.

Female: Correct.

Kimberly Gregory: Plus, I guess, to some extent, and I apologize for missing the discussion on the breast feeding exclusion. But this is a little more – have a little more population-based implication. If you decide not to breast feed your kids, not

like they won't to eat. But if you decide not to vaccinate your kids, not only is your kid at risk but (inaudible) potential threat to others.

Greg Goyert: Yes. So, are we asking the developers to tweak their metrics?

Janet Young: I think it seems like consensus from the five of us that are on the phone. That thinks to be the case.

(Karen Shea): So, tweak it to exclude parental …

(Crosstalk)

Greg Goyert: Refusal.

(Karen Shea): Yes, I agree.

Female: Oh, right now, parental refusals are excluded. So you mean tweak it to not exclude …

(Crosstalk)

Female: Correct.

Female: … parental refusal.

Female: Not exclude parental refusal. (Inaudible).

(Crosstalk)

Female: So, exclude the exclusion.

Greg Goyert: Right.

Reva Winkler: Yes. In terms of just process, if the developers could just look at the aspects of the measure on how – where that tweaking would take place, and be able to kind of bring a comparison so we could get a sense of what the tweak measure might look like against all the criteria versus the one you've submitted. I think

that's really what will we be needed to help the entire committee continue this conversation.

Female: Sure thing. Got it.

Kimberly Gregory: Just out of curiosity too. Is there any data on the proportion of babies who get their first vaccine in the hospital who then ultimately get their complete vaccine series?

Female: It is correlated. Having the first dose before hospital discharge has been shown to be correlated with timely completion of the series.

Kimberly Gregory: So, I think that's another argument in favor of doing it.

Female: Agreed.

Nadine Allen: Thank you everyone for your feedback on the measure. Thanks for hanging out with us for the discussion of the measures. I'm going to go ahead and turn it over to Suzanne who will be providing next steps.

Reva Winkler: Maybe go to public comment first.

Nadine Allen: Oh yes, public comment first, and then we'll do next steps.

Can you open the lines, operator?

Reva Winkler: If anybody has any comments?

Operator: Certainly, to ask a public comment, please press star one.

And there are no public comments.

Suzanne Theberge: Great, OK. Well, thank you very much for time this afternoon. We very much appreciate it.

So as we mentioned, this is workgroup three. We have one more workgroup call next week on Wednesday. You are welcome to join and listen in on that conversation if you'd like, but you're certainly not obligated to be there.

We do ask that at this time, you start reviewing the rest of the measures that we'll be discussing at the in-person on May 2nd and 3rd, and just come ready that to have this discussion – these discussions on all the measures and vote on the criteria and the recommendations.

We'll be sending along some additional information next week to help you prepare for your role as a lead discussant at the meeting, as well as some other information about – around the meeting. If you have not already registered and made your travel plans, please do so, and so we can get all that that squared away.

And we also do ask that our committee members bring their laptops to the meeting, rather than printing out the thousands of pages of information that we provided with you on the SharePoint site. We do have wireless available in the conference room, and so you will be able to download any files that you need.

If you have any questions over the next couple of weeks as you are looking at the measures, don't hesitate to call us or e-mail us, and I think that's everything. So, I'll just pause real quick and see if there any questions before we end the call.

All right. Well, hearing none, thanks everyone and have a great weekend.

Greg Goyert: Thank you.

Female: Thank you.

Greg Goyert: You too. Thank you.

Female: Thank you.

END