

NATIONAL QUALITY FORUM

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PERINATAL AND REPRODUCTIVE HEALTH
STANDING COMMITTEE

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TUESDAY
MAY 3, 2016

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The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:00 a.m., Kimberly Gregory and Carol Sakala, Co-Chairs, presiding.

PRESENT:

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CAROL SAKALA, PhD, MSPH, Director of Childbirth Connection Programs, National Partnership for Women & Families, Co-Chair

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NQF STAFF:

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NADINE ALLEN, Project Manager

KAITLYNN ROBINSON-ECTOR, Project Analyst

SUZANNE THEBERGE, MPH, Senior Project Manager

REVA WINKLER, MD, MPH, Senior Director

ALSO PRESENT:

ERIKA EDWARDS, PhD, MPH, Vermont Oxford Network

CORINNA HABERLAND, MD, Stanford University *

SCOTT A. LORCH, MD, MSCE, The Children's

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ELLIOTT MAIN, MD, The Joint Commission

CELESTE MILTON, MPH, BSN, RN, The Joint

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PAMELA OWENS, PhD, Agency for Healthcare Research

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ANNE SANTA-DONATO, MSN, RNC, Association of

Women's Health, Obstetric and Neonatal

Nurses

STEPHEN P. SCHMALTZ, MPH, PhD, The Joint

Commission *

ANN WATT, MBA, The Joint Commission

* present by teleconference

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1 P-R-O-C-E-E-D-I-N-G-S

2 8:08 a.m.

3 CO-CHAIR SAKALA: Good morning,
4 everyone. Good to see you again.

5 I would like to give a little recap of
6 yesterday. We were very hard-working -- I heard
7 people say they were very tired at the end of the
8 day -- thoughtful, and efficient, I think, in
9 what we did.

10 We covered 15 measures. Ten of them
11 were maintenance measures and five are new. Of
12 the new measures, we recommended three for
13 endorsement, including a significant addition of
14 robust, new contraceptive measures to the corpus
15 of NQF-endorsed measures, pending approval down
16 the line.

17 One was considered consensus not
18 reached. That is the thermal condition in low-
19 birthweight babies, and one of the new measures
20 was not recommended for endorsement, structural
21 attributes of facilities with high-risk women.

22 We did 10 maintenance measures. One

1 was not recommended, frequency of ongoing
2 prenatal care. One consensus was not reached,
3 prenatal and postpartum care. Eight passed, and
4 five 100-percent support, the remaining with 88
5 to 96 percent. So, I think that was a good day's
6 work. And today we have eight more measures, two
7 that are new and six that are maintenance.

8 Okay. So, let us begin. Today we
9 will include The Joint Commission core set. We
10 have developers here, Celeste and Elliott.

11 The first measure will be a third
12 measure related to the last two we considered
13 yesterday. That is 1731, PC-04, Health
14 Care-Associated Bloodstream Infections in
15 Newborns.

16 So, we will ask you to give a little
17 intro to that. Thank you.

18 And then -- excuse me -- no one is
19 recused, and Janet, Greg, and Florencia, but is
20 she here today? Okay. And Jennifer Moore is
21 recused on this. So, this will be Janet and Greg
22 as discussants.

1 MS. MILTON: Okay. Good morning.

2 Yes, the measure that we are going to
3 discuss is PC-04, Health Care-Associated
4 Bloodstream Infections in Newborns. The
5 denominator is comprised of live newborns with
6 two included populations, newborns that are 500
7 to 1499 grams, newborns that are greater than
8 1500 grams that had one of the following: they
9 would have had to have experienced death, major
10 surgical procedure, on a mechanical ventilator,
11 or received them as they transferred to the
12 hospital. These are the babies that we would
13 consider more at high risk. And then, if they
14 were in the numerator population, it would mean
15 that they had a newborn bacteremia or septicemia.
16 And that is what would be evaluated in this
17 measure.

18 It is an outcome measure. So, we do
19 have a risk-adjustment model. The goal is to
20 have a lower rate as noted improvement for this
21 measure.

22 CO-CHAIR SAKALA: Okay. Thank you.

1 So, can we have our discussants lead
2 off, starting with the evidence?

3 MEMBER GOYERT: Sure. As far as the
4 evidence, the developers provided no new
5 evidence, and I don't think there is a need to
6 repeat the discussion or to vote on the evidence.

7 CO-CHAIR SAKALA: Okay. If there are
8 no objections, that will be the case. Great.

9 So, next is the importance to measure
10 gap issues.

11 MEMBER GOYERT: Great. So, the
12 developers have presented data from 2011 through
13 2014 that continue to demonstrate significant
14 opportunity for improvement.

15 CO-CHAIR SAKALA: Okay. I think we
16 don't need to vote on that. Is that your
17 recommendation? Okay. That's right, we do
18 because we are closer to where we want to be than
19 we were before. Okay.

20 Any other comments on that portion?

21 (No response.)

22 Okay. So, can we open it up for

1 voting then?

2 MS. ROBINSON-ECTOR: Voting is now
3 open for performance gap for Measure 1731.
4 Option 1 is high; 2 is moderate; 3 is low, and 4
5 is insufficient.

6 (Voting.)

7 It looks like we are still missing
8 four votes.

9 CO-CHAIR SAKALA: Are you counting one
10 recusal that was added this morning?

11 MS. ROBINSON-ECTOR: Yes, I am.

12 CO-CHAIR SAKALA: Okay.

13 (Voting.)

14 MS. ROBINSON-ECTOR: Great. We've got
15 23 votes. All the votes are in.

16 Okay. So, 74 percent put it high; 22
17 percent put it moderate; 4 percent put it low,
18 and zero put it insufficient. So, for the
19 performance gap of the Measure 1731, the measure
20 passes.

21 CO-CHAIR SAKALA: Okay. Do we have
22 any new -- oh, Carolyn?

1 MEMBER WESTHOFF: Thank you.

2 Looking at the graph, I am just
3 confused as to the change since 2011, and maybe
4 somebody could explain that to me?

5 CO-CHAIR SAKALA: Not the voting, but
6 the data.

7 (Laughter.)

8 MEMBER WESTHOFF: Great. It is just
9 the data. It is not the voting. It is a
10 question about the data.

11 MS. MILTON: It's too early in the
12 morning. I'm still on Midwestern time.

13 I believe the reason that we are
14 seeing a higher gap than what we did see is that
15 there are more hospitals reporting, as a result
16 of the fact that in 2014 we made it mandatory for
17 hospitals with 1100 births or more annually to
18 start reporting on the measure. So, I think that
19 there weren't hospitals that were really
20 monitoring this as closely. So, with a larger
21 number reporting --

22 MEMBER WESTHOFF: Okay.

1 MS. MILTON: -- we are seeing more
2 infections that we weren't before. Because we
3 had less than 200 hospitals reporting when we
4 went through this the last endorsement cycle.

5 MEMBER WESTHOFF: So, people are just
6 paying attention now?

7 MS. MILTON: Correct, yes.

8 MEMBER WESTHOFF: Good. That's a good
9 thing.

10 MS. MILTON: We're about 1200
11 hospitals now versus 200.

12 MEMBER WESTHOFF: Well, that's
13 excellent, yes.

14 CO-CHAIR SAKALA: Okay. Thank you.

15 Do we have any new -- oh, Cindy?

16 MEMBER PELLEGRINI: Just a question.
17 Can anyone explain why over 1,000 hospitals were
18 added to this from 2013 to 2014? I'm sorry, I
19 missed that.

20 MS. MILTON: We made it mandatory, if
21 you had 1100 births or more annually and you are
22 Joint Commission accredited, this is a

1 requirement that you had to report on the
2 perinatal care set, all of the measures.

3 CO-CHAIR SAKALA: And beginning
4 January of this year, it has gone to 300 or more.

5 So, do we have any new reliability
6 data?

7 MEMBER GOYERT: The specifications
8 have been updated to ICD-10. The numerator was
9 changed a little bit to exclude babies that came
10 septic the first 48 hours. The denominator was
11 changed to remove the exclusion of greater than
12 120 days and bloodstream infection present on
13 admission.

14 Developers reported an inter-rater
15 reliability of 94-plus to 99 percent.

16 CO-CHAIR SAKALA: Thank you.

17 Is that a card up next to Janet?
18 Karen? Okay, down.

19 Any other comments on the reliability
20 issues?

21 (No response.)

22 So, let's have a vote on that because

1 of the changes, if there are no comments.

2 MS. ROBINSON-ECTOR: Voting is now
3 open for reliability of Measure 1731. Option 1
4 is moderate; option 2 is low, and option 3 is
5 insufficient.

6 (Voting.)

7 It looks like we are missing two
8 votes. So, if everyone could re-vote, please?
9 Thank you.

10 (Voting.)

11 So, 96 percent put it moderate; 4
12 percent voted low; zero voted insufficient. So,
13 for reliability of Measure 1731, the measure
14 passes.

15 CO-CHAIR SAKALA: Thank you.

16 Okay. Comments on validity, please?

17 MEMBER GOYERT: A priori, I don't
18 think you would expect a correlation with the
19 other perinatal core measure set, measures in the
20 set. I think they the conclusions about quality
21 can be made and that it is an indicator of
22 quality.

1 CO-CHAIR SAKALA: Other comments on
2 that?

3 (No response.)

4 Okay. Let's open the voting, then,
5 for the validity.

6 MS. ROBINSON-ECTOR: Voting is now
7 open for validity of Measure 1731. Option 1 is
8 high; 2 is moderate; 3 is low, and 4 is
9 insufficient.

10 (Voting.)

11 All the votes are in and voting is now
12 closed.

13 Sixty-one percent voted high; 39
14 percent voted moderate; zero voted low, and zero
15 voted insufficient. So, for validity of Measure
16 1731, the measure passes.

17 CO-CHAIR SAKALA: Thank you.

18 So now, feasibility, please.

19 MEMBER GOYERT: I don't think there's
20 any issues with feasibility. Folks are doing it.

21 CO-CHAIR SAKALA: Other comments?

22 Yes, Sarah?

1 MEMBER McNEIL: Sorry, this is
2 delayed, but has there been talk about parsing it
3 out by race as well for feasibility. If it is a
4 required measure, is it possible to also add
5 that?

6 Sorry. I was wondering -- this is
7 late in the game -- but I was wondering if there
8 is any way, also, if it is a very feasible
9 measure, if we could also add something about
10 race, because my understanding from the data is
11 that race is not parsed out.

12 MS. MILTON: Yes, that could be done.
13 I believe we did that for the SDS part, if I
14 remember right. Yes.

15 MEMBER YOUNG: You actually did parse
16 that out, and it showed that there was no
17 meaningful gap in race.

18 MS. MILTON: Right.

19 MEMBER YOUNG: Which is different than
20 many other measures we have considered where
21 there is definitely a racial disparity.

22 CO-CHAIR SAKALA: Okay. If there are

1 no other comments, we can vote on feasibility.

2 MS. ROBINSON-ECTOR: Voting is now
3 open for feasibility of Measure 1731. Option 1
4 is high; 2 is moderate; 3 is low, and 4 is
5 insufficient.

6 (Voting.)

7 All the votes are in and voting is now
8 closed.

9 Sixty-five percent voted high; 35
10 percent voted moderate; zero voted low, and zero
11 voted insufficient. So, for feasibility of
12 Measure 1731, the measure passes.

13 CO-CHAIR SAKALA: And finally,
14 usability and use.

15 MEMBER GOYERT: I think it's fine.
16 The measure has been improved with expanded data
17 sources being available for use, removed the
18 length of stay greater than 120 days, removed the
19 bloodstream infection present on admission, and
20 removed bloodstream infections that were not
21 healthcare-related per se.

22 CO-CHAIR SAKALA: Do we have any other

1 comments on that?

2 DR. WINKLER: I have a question. I am
3 just wondering, the changes to the
4 specifications, what kind of impact is it having
5 on the actual measure results, such to be able to
6 monitor trends? You know, if you made the change
7 this year, how are you looking at this year's
8 data compared to last year's or two years' ago
9 data? Is it making that a big of a difference in
10 the measure results?

11 MS. MILTON: It should be more
12 accurate. We made these changes based on
13 feedback from the field. We were hearing from
14 the field about -- the first part as far as
15 bloodstream infections present upon admission has
16 always been there, but when we took this measure
17 and respecified it, we added this as a chart-
18 abstracted data element because the present on
19 admission indicator is not always there. So, we
20 couldn't rely on just administrative data.

21 We allowed the hospitals to actually
22 do the cases for babies that were born with

1 infections or were received in as transfers, and
2 we did this by use of ICD codes, ICD-10 now, and
3 looking to see if there were signs and symptoms,
4 if they were on a longer course of IV
5 antibiotics, to confirm that they were infected.

6 I am not exactly sure about a change
7 in the numbers, though. The second data element
8 hasn't been in use long enough for us to really
9 look at any trends with the confirmed-after-48-
10 hour data element.

11 CO-CHAIR SAKALA: Okay. Other
12 comments about usability and use?

13 (No response.)

14 Okay. I think we can vote on this
15 item.

16 MS. ROBINSON-ECTOR: Voting is now
17 open for usability and use for Measure 1731.
18 Option 1 is high; 2 is moderate; 3 is low, and 4
19 is insufficient.

20 (Voting.)

21 It looks like we are missing one vote
22 to reach 23.

1 CO-CHAIR SAKALA: Do you want re-
2 voting?

3 MS. ROBINSON-ECTOR: Yes, please.

4 CO-CHAIR SAKALA: Okay. Thank you.

5 (Voting.)

6 MS. ROBINSON-ECTOR: Great. We now
7 have 23 votes and voting is now closed.

8 Sixty-five percent voted high; 35
9 percent voted moderate; zero voted low, and zero
10 voted insufficient. So, for usability and use of
11 Measure 1731, the measure passes.

12 CO-CHAIR SAKALA: Okay. So, we have
13 determined that this measure again meets all the
14 criteria that NQF has, and the final vote will be
15 to decide whether we recommend it for continued
16 endorsement.

17 Before we do have that vote, are there
18 any other questions or comments?

19 (No response.)

20 Okay. Let's open it up for voting,
21 then, for endorsement.

22 MS. ROBINSON-ECTOR: Voting is now

1 open.

2 CO-CHAIR SAKALA: Oh, sorry. John?

3 MEMBER KEATS: I'm sorry, I had a
4 quick question which is kind of general. And it
5 is probably because I am new. But I am looking
6 at this. That improvement results in the bullet,
7 it says, "In 2014, hospitals in the median lower
8 quartile and 10th percentile recorded no
9 infection," which is what you are looking for,
10 right? What we are looking for is no infections.

11 So, shouldn't that be the 90th
12 percentile, upper quarter, upper quartile? I
13 mean, it seems like it is flipped. I mean, to
14 me, 90th percentile means you are doing better
15 than 90 percent of the hospitals out there. So,
16 I am just wondering on the terminology. Is this
17 typically how it is reported or should it be the
18 other way around, or is it a distinction without
19 a difference?

20 Okay. I am just used to seeing it the
21 other way around. Then, I will shut up. Thank
22 you.

1 CO-CHAIR SAKALA: Okay. Okay. So,
2 let's open it up for voting if there are no other
3 comments.

4 MS. ROBINSON-ECTOR: Voting is now
5 open for recommendation for overall suitability
6 of endorsement for Measure 1731. Option 1 is yes
7 and option 2 is no.

8 (Voting.)

9 All the votes are in and voting is now
10 closed.

11 A hundred percent voted yes and zero
12 voted no. So, for recommendation for continued
13 endorsement for Measure 1731, the measure passes.

14 CO-CHAIR SAKALA: Okay. So, there is
15 another 100-percenter. That's great.

16 We have now to deal to deal with NQF's
17 policy about related and competing measures,
18 which is that we should have a thoughtful
19 discussion about whether all three of the related
20 measures are, indeed, needed; what the rationale
21 would be; how we would turn around and justify
22 this to the people out there in the field who are

1 feeling burdened by this, and how we would also
2 justify our decisions to consumers and
3 purchasers, payers, who are looking for changes
4 in performance.

5 So, I think that we welcome anyone's
6 comments, but the people who have taken the lead
7 on these measures probably will have more
8 detailed comments to make.

9 And there is a table that was provided
10 by the NQF staff that puts all three measures
11 side by side, and it is in the SharePoint. So,
12 you can look at the comparisons.

13 MEMBER GOYERT: Could I ask the
14 developers to go through the new document just
15 briefly, comparing 0478 and 1731, that you
16 provided just recently? I think that might help
17 a little bit.

18 MS. MILTON: Our statistician did a
19 comparison. He took data from The Joint
20 Commission warehouse, and this would have been
21 from the fourth quarter of 2014 to the third
22 quarter of 2015.

1 Of that data, we looked at up to 30
2 ICD-9 diagnosis codes and 30 of the procedure
3 codes. This is from administrative data, and
4 comparing The Joint Commission measure to the
5 other measure, which uses strictly administrative
6 data. We tried to do sort of what we called an
7 inter-rater reliability to see does the
8 administrative data get the same results as if
9 you do partial chart review, in addition to the
10 administrative data.

11 The Joint Commission doesn't look at
12 the present on admission flag. That is not
13 something that we receive in the data, and that
14 is something that the other measure, the NQI
15 measure relies on in order to determine if those
16 bloodstream infections were present upon
17 admission.

18 So, what happened was we had 178,027
19 cases that were in the warehouse. Of these, 71
20 percent were missing principal diagnosis code,
21 which the NQI 3 needs in order to exclude
22 patients from the denominator population. So, we

1 knew that the coding wasn't always taking place
2 as it should to get that initial patient
3 population.

4 As a result of that, only about a
5 third of the measure population was able to be
6 identified using administrative data only. The
7 fact that we were doing it in a little different
8 manner allowed us to actually identify more cases
9 that could be evaluated against the measure.

10 Then, the other thing that was a
11 little bit different that might have attributed
12 to part of the disagreement had to do with the
13 fact that the NQI measure was allowing to exclude
14 cases with seven days or less; whereas, The Joint
15 Commission measure was looking at only two days
16 or less for exclusions.

17 So, our statistician felt that it was
18 about 10 percent of the discrepancy, right, as
19 far as an exclusion. I understand that they have
20 since changed that, I believe, to three days now
21 versus the amount of time that we were looking at
22 at that time.

1 Then, he ran a cross-table here and,
2 of that, we determined that were 723 cases that
3 did not appear in the numerator for the NQI
4 measure, and approximately 94 percent of those
5 had the secondary diagnosis code for the
6 septicemia or bacteremia, but they didn't have
7 the accompanying code for the staphylococcal or
8 the gram-negative bacterial infection, which is
9 required. In other words, if one is present, the
10 other has to be present, in the NQI measure in
11 order to be counted; whereas, we don't count both
12 of those. So, we were able to identify more
13 cases that way.

14 And the remaining 6 percent had to do
15 with the fact that there was a diagnosis code for
16 the staphylococcal or the gram-negative bacterial
17 infection, but, then, they didn't have the
18 newborn septicemia or bacteremia codes that would
19 be present for your neonates 28 days of age and
20 under.

21 Then, in addition, there were over
22 1100 numerator cases that were identified where

1 PC-04 identified those as being in the numerator,
2 but the NQI 3 measure did not.

3 So, these were the significant
4 differences, and it seems that administrative
5 data doesn't always get everything because, with
6 newborns, they don't always code as much as you
7 would for an adult. So, that was where we felt
8 this might have been part of the problem, is that
9 the codes were not being uniformly assigned.
10 Therefore, they are not able to identify cases
11 just by relying on administrative data.

12 CO-CHAIR SAKALA: Thank you.

13 MEMBER YOUNG: Just a question or
14 comment. Was this using ICD-10 codes or was this
15 ICD-9 at 2014?

16 MS. MILTON: No, this was '09, yes.

17 MEMBER YOUNG: Okay.

18 MS. MILTON: We haven't gotten down
19 that road yet, yes.

20 MEMBER YOUNG: So, these issues,
21 obviously, will change as of this year with
22 everyone using ICD-10 codes as a mandatory

1 reporting. So, I am curious to see what is going
2 to happen in the next 12 months.

3 MS. MILTON: So are we.

4 (Laughter.)

5 DR. MAIN: For better or for worse.

6 MEMBER YOUNG: So, I think the side-
7 by-side comparison or analysis is valid only for
8 the 2013-2014 cycle, but I think, as of today,
9 this analysis probably isn't going to hold true.
10 It may, but with ICD-10 being very, very
11 specific, I think that that is going to fall out,
12 and I think you will see less discrepancy or less
13 loss on the NQI 03, the 0478 measure we talked
14 about yesterday and the measure we just
15 discussed.

16 CO-CHAIR SAKALA: Thank you.

17 Before we get into our discussion, I
18 would like to see if there is someone from AHRQ
19 on the line who would like to comment on that
20 analysis.

21 DR. OWENS: Thank you again very much.

22 This is Pam Owens. I am the

1 Scientific Lead of the AHRQ Quality Indicators.

2 Just a couple of points broadly, and
3 then, I would like Corinna Haberland, who is the
4 clinician on the Pediatric Quality Indicators, to
5 discuss some of the differences because they are
6 the ones that did all of the collaborative work
7 with The Joint Commission and know the
8 intricacies both of The Joint Commission's
9 analysis as well as what AHRQ does.

10 I do want to point out that the
11 version that was used here is not the version
12 that is being released this summer. We, as a
13 function of collaboration, changed things, and it
14 was alluded to. The length of stay, for example,
15 we have some additional qualifying codes, for
16 example. But there is a version difference, that
17 there would be more alignment that what is
18 currently shown in the memo.

19 Corinna, are you on the line?

20 DR. HABERLAND: I am. Can you hear
21 me?

22 CO-CHAIR SAKALA: Yes, we can hear

1 you.

2 DR. OWENS: Would you like to
3 introduce yourself?

4 CO-CHAIR SAKALA: Can you speak up
5 just a bit?

6 DR. OWENS: And if you could introduce
7 yourself, that would give them some context.

8 DR. HABERLAND: Sure. I'm Corinna
9 Haberland. I'm from Stanford, a pediatrician by
10 training and one of the clinical leads on the
11 AHRQ --

12 CO-CHAIR SAKALA: Could you speak up
13 just a bit, please, Corinna?

14 DR. HABERLAND: Sure. Is that a
15 little bit better?

16 CO-CHAIR SAKALA: Yes. Thank you.

17 DR. HABERLAND: Okay. Sorry.

18 So, my background is in pediatrics, if
19 that is helpful to hear.

20 Just to speak a little bit about the
21 harmonization that we tried to take care of, you
22 know, the major difference between our two

1 measures seems to be or is obviously that The
2 Joint Commission measure has the ability or
3 allows the hospitals to go and do a chart review.
4 Since our measure is based on administrative
5 data, we do our best to be very clear about the
6 infections that would be most likely to be
7 perinatally-acquired, which is how we determined
8 which codes to keep in the measure, and tried to
9 also look at those that were more likely to be
10 hospital-acquired.

11 I believe as Pam mentioned yesterday,
12 obviously, we look at all causes of sepsis or all
13 cases of sepsis as opposed to just those that are
14 perhaps due to central lines, as The Joint
15 Commission measure is focusing on.

16 CO-CHAIR SAKALA: Okay. Thank you.

17 Anything else from AHRQ right now?

18 DR. OWENS: The only other thing I
19 would like to say is that we saw the memo
20 yesterday. So, we haven't been able to do our
21 own in-depth analysis about compare and assess in
22 terms of numerator and denominator counts and

1 work with The Joint Commission specifically on
2 this particular analysis. We have some hunches
3 about the differences in the numbers, but without
4 going through each one, that would be a little
5 more difficult to do on the phone.

6 CO-CHAIR SAKALA: Right, and we also
7 face the challenge that in both cases data are
8 now different how they were before. So, that is
9 a little bit of a challenge for us.

10 DR. OWENS: Exactly, yes.

11 CO-CHAIR SAKALA: I would like to
12 share a little bit of the history of this. The
13 originally-endorsed measure was the AHRQ measure.
14 That was brought into The Joint Commission's core
15 set. They turned it into a clinical data
16 measure.

17 Last time around we did look at this
18 same question of related and competing measures.
19 There were Medicaid programs represented in the
20 room who strongly said, "We cannot collect this
21 unless it comes out of administrative data." So,
22 that was the basis. That is why we have two

1 currently-endorsed, very similar measures.

2 And now, we will need to have a
3 discussion today to decide how we want to handle
4 that. And let's not forget about the third
5 measure as well for -- what is it, lower
6 birthweight babies? Very low birthweight babies.
7 Okay, yes.

8 So, open it up for discussion,
9 beginning with Tracy.

10 MEMBER FLANAGAN: You know, I think it
11 is in the spirit of the users to want to do as
12 much administratively as possible. So, my
13 question is to The Joint Commission developers.
14 With the advent of ICD-10 codes, will this be
15 able to be primarily, with very little chart
16 review burden, done administratively?

17 MS. MILTON: I think it is too soon to
18 tell. It is really going depend on coding
19 practices. And I can tell you we get a lot of
20 questions about coding. Just even identifying
21 the initial patient population for our maternity
22 measures, we determined that hospitals weren't

1 coding for normal manually-assisted vaginal
2 deliveries, which is a big thing that should be
3 done, and it is not being done. So, it is really
4 hard to say how this is going to translate into
5 the infection measure until we have got some
6 experience.

7 Coding guidelines and the coding
8 clinics are trying to update the field, but it
9 doesn't always get to the users. So, I think
10 everybody is in a big learning curve right now.

11 MEMBER FLANAGAN: Let me ask a follow-
12 up question. At present, what is the chart
13 review burden on this measure? I mean just
14 approximately. Is it like every case needs to be
15 reviewed?

16 MS. MILTON: No. No.

17 MEMBER FLANAGAN: Just for those of us
18 who may not be doing that primarily, does anybody
19 in the room, can anybody comment on that? I know
20 the maternity measures and what that burden is on
21 chart review. I just don't know on the pediatric
22 ones.

1 CO-CHAIR SAKALA: This is one, of
2 course, of the maternity measure.

3 MEMBER FLANAGAN: I understand that,
4 but I am an obstetrician/gynecologist. So, I
5 actually review fallouts, and I know what happens
6 at a very granular level. I'm asking the
7 question from the standpoint of a system that
8 adopts; what is the actual chart review burden of
9 a clinician, a person, as opposed to
10 administrative pull?

11 MS. MILTON: Our review would be those
12 that have infection codes. So, the majority
13 don't. It is pretty much an open-and-shut thing,
14 especially if you are coding your birthweight, or
15 you can pull a report up that can get
16 birthweights. Then, there is really no reason to
17 do a chart review.

18 But, if you do have one of the
19 infection codes, that is what triggers the
20 review. So, because the rate is about 3 percent,
21 give or take -- depending on the hospital, it
22 could be even less -- if there is an infection

1 code, though, then you do have to look at the
2 record.

3 And I have talked to some of the
4 larger systems, and it might be maybe 15 cases a
5 quarter. It just depends on your volume of
6 deliveries.

7 MEMBER FLANAGAN: Thank you.

8 DR. MAIN: I think the challenge here
9 is that coding for neonatal sepsis is very
10 complicated. Multiple layers of codes need to be
11 put in to have it meet the AHRQ measure; whereas,
12 this is really relying on using the codes for
13 case identification and, then, chart review to
14 make it more accurate.

15 MEMBER FLANAGAN: Thank you.

16 MS. MILTON: The other thing we
17 learned, too, is that coders are coding if there
18 is a lot of language in there about "suspected,"
19 "suspicious," and then, it never really gets
20 confirmed. That was the other reason we were
21 allowing hospitals to look at the record. Is
22 this just because they pulled this code in

1 because it looked like they were septic or were
2 they truly septic?

3 We are allowing them to look at blood
4 culture results, how long they were on
5 antibiotics, documentation of signs and symptoms.
6 So, it becomes a little bit more objective,
7 rather than we are just looking at a code that
8 said they had an infection, when, indeed, they
9 didn't.

10 CO-CHAIR SAKALA: Thank you.

11 Sindhu?

12 MEMBER SRINIVAS: So, is the purpose
13 of the chart review, then, to sort of eliminate
14 false-positive cases, and so, to make it more
15 accurate? Or is it to get people to think about
16 sort of the -- like I guess it is sort of a
17 combination of viewing the cases and trying to
18 get at what could be improved to reduce sepsis
19 personally.

20 But, from a like data perspective,
21 what is the percentage of like false-positive
22 identifications? So, the idea that in order to

1 do chart review, people want to look better, so
2 that they can actually eliminate some of the
3 cases that seem to have been identified, but,
4 then, are misidentified. But it sounds like the
5 volume of that is actually pretty low. And has
6 it been worth the chart review to eliminate a
7 couple of pieces? Or do you just take a little
8 bit of noise to make the measure a lot easier
9 from a system perspective?

10 MS. MILTON: Well, we have a lot of
11 type A hospitals. They would prefer not to have
12 an infection, if it truly wasn't, you know, show
13 up on their record. So, this is why we made that
14 part of the measure, a chart-extracted, to
15 identify for sure were they infected or not.

16 So, like again, we are only looking at
17 cases -- they could have a thousand discharges,
18 and there might be, like I say, 15 that have
19 infection codes. And then, they are incumbent to
20 look at the record to determine was it, indeed,
21 an infection or just that it was a suspected
22 infection that got coded. That seems to happen

1 more than not.

2 DR. MAIN: Sindhu, on the other side,
3 though, I think there was a pretty high rate of
4 false-negatives. There was 33 percent of the
5 cases weren't identified with the AHRQ measure.
6 That was picked up this way by using what are the
7 codes and, then, doing the chart review to
8 confirm.

9 CO-CHAIR SAKALA: Greg?

10 MEMBER GOYERT: Maybe somebody can
11 help me. I just don't understand, if all the
12 hospitals are collecting the measure for The
13 Joint Commission, where does the disconnect come
14 in with Medicaid? They are doing the work. They
15 are collecting the data. Why can't Medicaid see
16 the results? Am I being slow?

17 CO-CHAIR SAKALA: Can someone comment
18 on that in the room?

19 MEMBER SHEA: I think the only
20 distinction is that, from a Medicaid perspective,
21 when you are looking at claims, you can have a
22 three-month lag data showing you what your rates

1 are; whereas, with The Joint Commission rates, we
2 really have to wait perhaps until the end of the
3 year, a little bit longer, before the results are
4 published.

5 DR. MAIN: The bigger issue is
6 identification of Medicaid enrollees. Medicaid
7 wants their numbers based on their enrollees, as
8 opposed to The Joint Commission that does it for
9 all the patients in the hospital.

10 MEMBER SHEA: I'm sorry, I didn't
11 really catch onto that, but it is true. So, we
12 would receive all-payer data from The Joint
13 Commission; whereas, I could look at Anthem's
14 rates for the facilities where our patients are
15 receiving care.

16 CO-CHAIR SAKALA: Okay. Raj?

17 MEMBER WADHAWAN: While the chart here
18 seemed like an inordinate amount of burden, the
19 reality is that almost every institution gets a
20 trigger off records, considers those. And all
21 those cases are reviewed. Because all infection
22 teams that I know of, almost every hospital

1 reviews all those cases because it is important
2 for them internally.

3 So, this data exists. It has already
4 been done. They have gone through the charts. I
5 don't think it is that much of an inordinate
6 burden that these additions have to be. It is
7 more accurate.

8 CO-CHAIR SAKALA: Thank you.

9 Jaleel?

10 MEMBER MAMBARAMBATH: Yes, I agree
11 with Raj; it is not an inordinate burden. We do
12 this on a regular, routine basis at our
13 institution.

14 As you mentioned, the incidence of
15 bloodstream infections is very low. And so,
16 every month when you review this, there is either
17 zero or one case, even though we have about
18 1,000-1200 admissions a year. So, yes, the
19 burden is not inordinate; I would agree with
20 that.

21 One of the things I would like to
22 comment is, with the AHRQ measure, this is blood

1 culture positive, all-comers. So, even if they
2 are receiving antibiotics for necrotizing
3 enterocolitis as urosepsis pneumonia, but if they
4 have a blood culture positive, then they are
5 included in the group.

6 But The Joint Commission measure does
7 not have that. That excludes all the other
8 patients. It is only strictly bloodstream
9 infection. And if they have another diagnosis,
10 they are excluded from the group. Is that
11 correct?

12 MS. MILTON: That's correct. And
13 that, again, was based on feedback from the
14 field.

15 MEMBER MAMBARAMBATH: Yes. This kind
16 of leads to gaming of the system a little bit
17 because none of the other things, necrotizing
18 enterocolitis, for example, or pneumonia, are
19 public-reportable issues. And the diagnosis of
20 necrotizing enterocolitis, stage 1, or pneumonia
21 is very debatable sometimes and it is very
22 subjective. So, people can add in the diagnosis

1 of necrotizing enterocolitis for a suspect
2 necrotizing enterocolitis or pneumonia to reduce
3 their number of bloodstream infections.

4 MEMBER YOUNG: Jaleel, on the new
5 ICD-10 codes, you can't put "suspect" anymore.
6 It is actually falling out in the nomenclature,
7 at least from coding at least in the emergency
8 department. We don't have the ability to have
9 "suspect" or "probable" anymore. That is gone.
10 You either have it or you don't. You can put a
11 comment; there is no way to code for it.

12 MEMBER MAMBARAMBATH: Yes, but
13 necrotizing enterocolitis is different because --
14 yes, it is on. It is on? Is it okay now? Yes.

15 So, with necrotizing enterocolitis,
16 the situation is different because stage 1
17 necrotizing enterocolitis is suspected
18 necrotizing enterocolitis.

19 CO-CHAIR SAKALA: Tracy, did you want
20 to make a comment?

21 Okay. Sindhu?

22 MEMBER SRINIVAS: I guess I am asking

1 a question about sort of how do we -- like what
2 is the goal of sort of the discussion in the
3 sense that -- I mean, it seems like the
4 fundamental is here, but the chart burden is not
5 too difficult, and people are doing it anyway,
6 which is what you would expect if there is
7 bloodstream infection.

8 It seems like we are more like
9 debating sort of the coding itself and the
10 exclusions and the inclusions. But it seems like
11 there shouldn't be two different measures that
12 are essentially measuring the same thing.

13 As people move forward with quality,
14 I feel like one of the problematic things is that
15 there are sometimes too many definitions for the
16 same thing, and then, everybody ends up using a
17 different definition. And then, you can't
18 compare the apples and oranges. And so, kind of
19 having a consensus on a single way to measure
20 certain things seems very important. But I guess
21 I don't know how what we are sort of charged
22 with.

1 DR. WINKLER: Actually, you are
2 charged with grappling with that question, which
3 is not an easy one, absolutely. And so, you
4 could call this the fifth criteria. All right?

5 So, we have looked at the measures
6 fundamentally. If they had failed on any of the
7 others, they wouldn't be on the side-by-side.
8 So, the question on the table is the one you
9 raise. You know, what are the issues around
10 having multiple measures? These three measures
11 come from different data sources. Their history
12 and how they got here are different and have
13 various reasons for doing so. But, on the other
14 hand, as you say, there is a lot of feedback and
15 pushback about like, why do we have so many? Why
16 don't we focus on one?

17 And that is really the question on the
18 table, is: do you want to make a recommendation
19 around that? You know, can you justify saying,
20 "Okay, well, three is fine because...." or maybe
21 having three isn't so fine and we would recommend
22 going with one, two, whatever. And so, that is

1 what your conversation is about. It absolutely
2 is a difficult one to have, but that is exactly
3 your charge at the moment.

4 CO-CHAIR SAKALA: Yes?

5 MEMBER YOUNG: Sorry. Is there anyone
6 from CMS or Medicare/Medicaid here to discuss?
7 Because, apparently, they were the largest
8 stewards of NQI 3.

9 MEMBER JOLLES: In response to several
10 of the previous comments, beginning with Dr.
11 Keats' comment about the performance improvement
12 opportunities, at some point we have to talk
13 about when it is time to retire this. So,
14 strategically, the function of NQF is to really
15 push the needle and improve quality, and it is
16 not in our best interest to continue to endorse
17 measures where we have achieved the goals.

18 So, with that in mind with regard to
19 this debate we are having, I would say that the
20 next step in strategy in data measurement is to
21 adopt this proposed measure that includes chart
22 review, because what you need to do now is

1 hardwire. So, if we have figured out how to fix
2 it, we have almost got it down to zero harm, now
3 hardwiring process is where people are routinely
4 auditing their codes and manually reviewing the
5 charts and having meaningful meetings and
6 processes to improve, to maintain and spread the
7 practices.

8 But, at some point, we need to have a
9 bigger discussion about the entire profile of
10 what we are endorsing and the fact that we have
11 an emphasis on acute care. From a population
12 standpoint, we need to be looking at population
13 health when we put forth a panel related to
14 perinatal and gynecologic care. I know that is
15 outside of this.

16 CO-CHAIR SAKALA: Okay. Thank you.

17 Matt?

18 MEMBER AUSTIN: Yes, just to reflect,
19 I think, what others have maybe referenced
20 earlier, to me, I think one of the big wildcards
21 here is ICD-10 and us not really knowing or
22 understanding how well ICD-10 will capture some

1 of the maybe deficiencies in the AHRQ measure.

2 So, I guess, to me, one option would
3 be, are we allowed to sort of kick the can down
4 the road another two or three years to see how
5 ICD-10 plays out and maybe have more information
6 to make a better decision?

7 I mean, in my mind, the big concern
8 with chart obstruction is burden, and where we
9 can reduce burden or eliminate burden, those
10 should be opportunities that we take advantage
11 of. But I think ICD-10 is sort of why we put it
12 here, yes.

13 DR. WINKLER: The answer to your
14 question simply is, yes, you can.

15 CO-CHAIR SAKALA: Amy?

16 MEMBER BELL: I like your point about
17 making sure that we don't just keep endorsing
18 things just to endorse them. And I also like
19 Matt's point about ICD-10. But I think we need
20 to bring about, as we bring in the facilities
21 that have 300 deliveries or more, there is a
22 whole gap of hospitals that we truly don't know

1 their performance yet, and we really need to make
2 sure those processes are onboard and we see the
3 results of that before we just stop endorsing
4 this one.

5 CO-CHAIR SAKALA: Thank you.

6 Other comments?

7 MEMBER NEVINS: I have just a
8 question. Does anyone have any statistical data
9 or some idea of the extent of the use of
10 electronic medical record in the nation? Because
11 I think at some point, you know, the burden of
12 data extraction will be not an issue, right?
13 Now, yes, electronic medical records also means
14 that you get 300 pages, right, that someone has
15 to look through, but I just wanted to sort of
16 introduce that as something that we should
17 consider when we are thinking in terms of burden.

18 CO-CHAIR SAKALA: Do you want to
19 comment on your plans for eMeasures or anything
20 else?

21 MS. WATT: Hi. I'm Ann Watt from The
22 Joint Commission.

1 CO-CHAIR SAKALA: Can you come a
2 little closer?

3 MS. WATT: Sorry. Sorry, Elliott.

4 (Laughter.)

5 I don't have specific numbers. I can
6 tell you, though, as we all know, the uptake of
7 electronic health records is becoming significant
8 in acute care hospitals. And we are quite active
9 in the development of electronic clinical quality
10 measures which are extracted directly from the
11 electronic health record. Of course, that is
12 everybody's goal, that there will no longer be a
13 burden of data collection. I think we are a way
14 away from there, to be perfectly honest with you,
15 but we are getting there.

16 The challenge is that, even with the
17 electronic health record, the data element that
18 we are looking for needs to be in a structured
19 field. Nobody is going to be reviewing an
20 electronic health record to pick out that nugget
21 of information that we need. That is the
22 challenge.

1 But, you know, measure developers, not
2 just The Joint Commission, all of us have been
3 working very hard to develop that capacity and,
4 also, to work with the EHR vendors, so that it is
5 easier to do.

6 CO-CHAIR SAKALA: Raj?

7 MEMBER WADHAWAN: I just wanted to add
8 to that, I think it is about 80 percent, that
9 option of acute care hospitals today from the EHR
10 perspective. I just read it a few days ago; 78.5
11 percent was the number that I came across.

12 While it seems like it should be a
13 very achievable goal of pulling data out of the
14 EMR, those of us who have been working in that
15 space for the last many years, the databases, we
16 have been utterly unsuccessful, for a variety of
17 reasons.

18 You know, Virginia and I both
19 participate several databases for neonatology, it
20 still is all manual extraction. I don't think it
21 will be achievable in our time on the Committee
22 for sure; I am hoping it will be achievable in

1 our lifetimes.

2 CO-CHAIR SAKALA: Greg?

3 MEMBER GOYERT: So, I guess I am
4 wondering, what are the choices before us? We
5 are not going to un-endorse a measure that we
6 endorsed yesterday or what, I guess, for the
7 Committee? Door A, Door B, Door C?

8 DR. WINKLER: Because you feel all
9 three of them do meet the criteria, those
10 recommendations stand. This is the next step.
11 It is, of those, do you feel that you want to
12 say, because we don't want to have three doing
13 the same thing, we want to go with one, or two,
14 or whatever? If there is enough reason to say it
15 is okay to have three continuing, that is an
16 option as well.

17 And so, that is why having this
18 conversation that we have been having is
19 important to factor in all those considerations.
20 At this point, we probably want to hear from you,
21 what would be your proposal among all those
22 options?

1 CO-CHAIR SAKALA: Kim?

2 CO-CHAIR GREGORY: I wanted to follow
3 up on that EMR issue, just to say it is hard to
4 get the data out. You almost have to have a
5 full-time person who works for both the IT
6 Department and your department because they don't
7 always talk to each other, and you are really a
8 low man on the totem pole if you are not in the
9 IT Department.

10 And the other issue is that a coder
11 can only code what a doctor writes as a
12 diagnosis, not a nurse, not anybody else. And
13 so, what we are finding is that the doctors
14 aren't writing enough diagnoses. And so, even
15 though with ICD-10 we have the capability to be
16 very specific, you know, you just get tired of
17 clicking and you just put down two diagnoses and
18 you move on to the next patient. So, I am
19 concerned that the diagnoses won't be in the
20 chart. I think that we just need to put that out
21 there.

22 And then, just sort of as a

1 consideration for these three measures, I think
2 probably the discussants and the clinicians who
3 are most involved in it, if they wanted to
4 propose something, we would certainly be
5 interested in what you thought. And then, maybe
6 another idea might be if we want to prioritize or
7 rank them in some way.

8 CO-CHAIR SAKALA: Sheila?

9 MEMBER OWENS-COLLINS: Okay. So, I am
10 also just trying to make sure I understand what
11 we are looking at.

12 All right. I just wanted to make sure
13 I understand what we are looking at. It looks
14 like the emphasis is primarily on low birthweight
15 infants, and I understand that, and only the
16 PC-04 could potentially look at low birthweight
17 as well as the larger babies, the term babies,
18 with any incidence of infection. Is that
19 correct?

20 DR. WINKLER: Yes.

21 MEMBER OWENS-COLLINS: Okay. So, I
22 mean, I think if we are going to look at

1 infection in newborns, we should look at all of
2 them. So, that is my vote. Then, that would
3 mean we would have to look at least two out of
4 the three.

5 DR. HABERLAND: Corinna Haberland
6 again from Stanford.

7 I just wanted to add the AHRQ measure
8 also looked at larger babies, if they had a major
9 surgery or were ventilated.

10 CO-CHAIR SAKALA: Could you turn your
11 microphone on and say that, please, Jaleel?

12 MEMBER MAMBARAMBATH: Yes. So does
13 The Joint Commission measure, too. So, if they
14 have more than 1500 grams, but they are
15 mechanically ventilated or have a procedure or
16 die, The Joint Commission measure includes those
17 patients as well.

18 CO-CHAIR SAKALA: All right. Did you
19 have something else to say, Jaleel?

20 MEMBER MAMBARAMBATH: Yes.

21 CO-CHAIR SAKALA: Yes.

22 MEMBER MAMBARAMBATH: So, we have

1 discussed these two measures at length, but we
2 have not talked about the Vermont Oxford Network
3 measure. I wanted to consider that as well.

4 One of the things which the Vermont
5 Oxford Network measure does not include is those
6 babies who are more than 1500 grams. Also, it
7 includes meningitis in its mix. Now early-onset
8 sepsis, the incidence of meningitis is very low,
9 but with late-onset sepsis, the incidence of
10 meningitis is slightly higher.

11 But most of these cases of meningitis
12 are secondary to hematogenous spread from the
13 blood culture. So, the blood culture is
14 positive. There is a small, little group of
15 babies wherein the blood culture will be
16 negative, but the CSF culture can be positive.

17 CO-CHAIR SAKALA: Small like 1 percent
18 or 10 percent?

19 MEMBER MAMBARAMBATH: So, that is the
20 question I had for the Vermont Oxford Network
21 measure yesterday, whether we have an idea of how
22 small is this group of meningitis babies. I am

1 not sure whether we are capturing a significant
2 number of babies in that group of meningitis and,
3 if not, then is there a reason to continue with
4 that measure while we are capturing this
5 information with The Joint Commission measure or
6 the AHRQ measure?

7 CO-CHAIR SAKALA: Is anyone from VON
8 here to comment on that?

9 DR. WINKLER: She is right behind us
10 here. She is here, I think.

11 DR. EDWARDS: So, as I explained
12 yesterday, there is no way to tease out the
13 meningitis in the definition.

14 MEMBER WADHAWAN: Why can't you do
15 that with that data? Based on my knowledge of
16 VON, which is a lot more limited than yours, if
17 you have babies coded as sepsis and you have got
18 babies coded as meningitis, you can look at the
19 two together and see where they don't disagree.
20 Where you have got meningitis that is CSF-
21 positive and you don't have sepsis, that is your
22 category.

1 Now, if you go back and look at the
2 published data from NICHD, it is about 10 to 20
3 percent of ELBW, not VLBW, extremely low
4 birthweight infants, who would have CSF
5 positivity without blood culture positivity.

6 But Jaleel's question is very
7 interesting and relevant, I think, to more sort
8 of to this Committee, as to what is the
9 incidence. And you have a database that can
10 answer that question.

11 DR. EDWARDS: But the definition that
12 we give is that you can have a positive culture
13 from blood or CSF. So, it is not two
14 definitions; you have a positive blood culture;
15 you have a positive CSF culture. It is blood or
16 CSF. And then, it is combined with coagulase-
17 negative staph.

18 MEMBER WADHAWAN: You don't collect it
19 separately?

20 DR. EDWARDS: No. No, but, I mean,
21 this is a fantastic question. In a perfect world
22 we would ask our members to separate those out

1 and report them to us, and maybe we should, as a
2 result of this conversation, because it certainly
3 sounds like it would add to the information that
4 we have.

5 MEMBER WADHAWAN: Can I just add one
6 more thing, since we talked about the VON
7 measure? I think the one thing that is different
8 about this measure is that it has a risk
9 adjustment, and that is kind of relevant if you
10 are, as a consumer, looking at information.

11 Because, you know, if you have a
12 nursery with a small Level 2 and you have got no
13 healthcare-associated infection because you know
14 you have to put in a central line and you
15 transferred all those kids, versus a large Level
16 4 NICU in the city that is taking care of the
17 sickest patients, the numbers can be very
18 different and it could be misinterpreted in a
19 wrong way in a hospital that takes care of the
20 sickest of the sick kids. And I am sitting in a
21 Level 1 nursery; I have got zero AHIA and he has
22 got 1.2 percent. It doesn't necessarily mean he

1 is bad.

2 What VON data does is that it allows
3 you to make that comparison because you have
4 other factors. As imperfect as the model is, at
5 least it is an attempt at answering that
6 question.

7 CO-CHAIR SAKALA: Thank you.

8 Yes, Janet?

9 MEMBER YOUNG: I want to just frame
10 the discussion slightly differently, looking at
11 it as these very small or smaller hospitals, the
12 300 deliveries, are just now coming online for
13 The Joint Commission's measure. Many of those
14 hospitals don't have access to electronic health
15 records, and they are not even automated in any
16 way, shape, or form. They are still back in
17 progress notes and handwriting and hand-signing
18 everything.

19 So, I would like us to at least
20 consider those small hospitals who now have a
21 huge burden to report out this data to The Joint
22 Commission and perhaps give them a learning

1 curve. At least if not for a year or two years,
2 when we next discuss this measure, to look at the
3 differences in those much smaller hospitals than
4 what we currently have reported right now.

5 DR. MAIN: Although it should be
6 pointed out that those hospitals aren't going to
7 be caring for VLBWs or babies on ventilators.
8 They will be transferred to other settings.

9 MEMBER YOUNG: Oh, that is a good
10 point.

11 CO-CHAIR SAKALA: So, Nancy and
12 Jennifer, I don't know who was up first with your
13 card.

14 MEMBER LOWE: Yes, as a non-neo, non-
15 peds person in this group, I am struggling with
16 -- I need some help from the experts on the
17 Committee to know which of these measures moves
18 us more consistently toward quality care, which
19 is what this is about. So, I would really like
20 some clear opinion from the peds/neo people about
21 which one, as you look at them now, you think
22 helps us accomplish that goal better.

1 MEMBER BAILIT: Can I just make mine
2 before you answer that, because I think it
3 dovetails onto that?

4 CO-CHAIR SAKALA: Great.

5 MEMBER BAILIT: I absolutely agree
6 with your point. I was going to make something
7 very similar. The question is, you said a
8 keyword. What is your opinion about which one
9 is? We don't know, right?

10 In the ideal world, you would collect
11 both for two years. You would compare which one
12 is directionally better. Are they going in the
13 same direction? If so, it doesn't matter; let
14 people pick.

15 So, to the extent that this is an
16 opinion, let's be clear, it is an expert opinion.
17 If we can convince our users of these kinds of
18 measures to collect both and get some empirical
19 data about which is directional more helpful,
20 that to me sounds like a good solution.

21 CO-CHAIR SAKALA: Great.

22 MEMBER WADHAWAN: Can I take that

1 also?

2 CO-CHAIR SAKALA: Thank you.

3 MEMBER WADHAWAN: It depends on what
4 patient group you care about more. There's about
5 40,000 very low birthweight infants born in the
6 country every year. If that is the group that we
7 cared about, which we should because that is
8 where the bloodstream infections are most
9 prevalent, then, of course, the VLBW measure
10 makes more sense because it is more specific, it
11 is more accurate. But, then, there's also those
12 other newborns that have low sepsis, but there's
13 a lot of them. You get either a postnatal onset
14 of a disease that would cause you to be in a NICU
15 or you have congenital malformation. Those are
16 bigger kids that are not captured if you just
17 look at the one, one specific measure. So, that
18 is the problem. They answer different questions.

19 I think if you just focus on the
20 bread-and-butter neonatology, which is VLBW care,
21 what moves the needle is, in my opinion, the one
22 measure. But, then, there the whole stuff, but

1 most NICUs don't care for those patients. It is
2 about a fourth of the NICUs in the country that
3 care for a lot of those patients. Three-fourths
4 of them don't. Three-fourths of NICUs just care
5 for regular prematurity and VLBW infants.

6 CO-CHAIR SAKALA: Thank you.

7 Are your cards up? Yes?

8 MEMBER MAMBARAMBATH: So, I agree with
9 Raj's comments, but I think one of the other
10 issues is that what Vermont Oxford Network will
11 measure is not publicly-reported. It needs a
12 registration fee, while the other two measures
13 are publicly-reported.

14 CO-CHAIR SAKALA: Thank you.

15 Sindhu?

16 MEMBER SRINIVAS: I guess I am
17 struggling a little bit with the sort of focus on
18 the population, just because, one, as you said,
19 limiting something to a population or a network
20 that not everyone belongs to might not be the
21 right solution. But, separately, bloodstream
22 infection prevention is like process metric,

1 right? I mean, it is an outcome that we are
2 preventing, but with a known process to prevent
3 it.

4 And so, when you focus on certain
5 small babies, even though they have a higher
6 prevalence, you are missing the opportunity to
7 engage other hospitals in a process improvement
8 structure or having a standard process, because
9 we know standard processes, when they are
10 implemented, can reduce central line infections.

11 And so, it seems like, while smaller
12 babies have a higher prevalence, that focusing on
13 all babies and just trying to prevent all
14 bloodstream-associated infections in general, at
15 least from my perspective, would be where we
16 should focus.

17 CO-CHAIR SAKALA: Yes, Sheila?

18 MEMBER OWENS-COLLINS: Okay. I agree
19 with what everybody is saying. I think that we
20 should have a more comprehensive approach, and
21 bloodstream infections are a very serious issue.
22 Also, if we concentrate on all newborns, it will

1 dovetail to the efforts in the adult world,
2 preventing infection, you know, most nosocomial
3 infections.

4 And to the point of the community
5 hospitals, I think that, even though the numbers
6 are small, they would have a significant
7 contribution in terms of looking at infections in
8 the larger babies, because, as someone said,
9 there are more of them and they can have serious
10 morbidity from those infection.

11 CO-CHAIR SAKALA: Thank you.

12 So, that really raises the question
13 of, if we do both parts, what about the two
14 measures that are quite similar as well?

15 We need to tie this up. Maybe the
16 answer is that we can't do better than we did
17 before last time around.

18 Also, I think that the points about
19 the ICD-10 and the changes in the AHRQ measure
20 and the broader pickup and ongoing look from The
21 Joint Commission are all good reasons to say
22 let's take a look again, if we can't make a

1 decision now.

2 So, I would love a proposal from
3 anyone about how we should move forward.

4 MEMBER BAILIT: So, I guess what I
5 would say is we have approved all three. People
6 who are using these measures are going to use
7 them for different things. But, to the extent
8 that we ask our users, if you will, to collect
9 data or, if possible, to collect both sets of
10 data, so we can have a comparison for next time,
11 but I think they are being used for different
12 things.

13 You know, the NICUs who are the
14 Parklands and the other high-elite taking care of
15 very small babies, most of them are Vermont
16 Oxford anyway. The general hospitals are going
17 to use The Joint Commission measures. So, to the
18 extent that those are being collected in both
19 places and lots of hospitals, let's see if we can
20 get that data from them.

21 CO-CHAIR SAKALA: Thank you.

22 Karen?

1 MEMBER SHEA: I agree. Practically
2 thinking about someone who is sitting in maybe a
3 general hospital with the burden of collecting
4 information for The Joint Commission measure and,
5 then, a separate data collection that would,
6 then, be sent off to VON, and then, maybe an
7 insurer coming in behind both of these and
8 saying, "Geez, I really want you to collect
9 information on the AHRQ measure because this is
10 what we can collect in terms of administrative
11 data," it can be a burden on those health
12 facilities if they have to collect data on these
13 three measures from a practical standpoint.

14 But I do see that there is merit in
15 each one of these different measures. And I
16 guess I won't repeat what the group has already
17 said, that it might be worthwhile to see what are
18 the distinctions between the three.

19 But I guess, in summing up, I would
20 say to those facilities who are being asked to
21 collect data on all these three measures, if they
22 can push back on that request and select the one

1 that seems most suitable for their institution.

2 MEMBER BAILIT: Having said that, we
3 know that some hospitals are already collecting
4 all three. So, rather than asking them to do it
5 de novo, we can just say, "Hey, if you happen to
6 be doing more than one of these, let us know."

7 DR. EDWARDS: So, that is actually a
8 great point, and we do a member survey every
9 year. I'm sure The Joint Commission does as
10 well. I will add that to the member survey -- I
11 am meeting about that tomorrow -- to find out
12 what other hospitals are reporting on these
13 measures and how they are using them.

14 And I would also like to say that I
15 would love to work with The Joint Commission to
16 compare data as well in aggregate, if possible.
17 So, that might be something that we work on
18 between now and then.

19 CO-CHAIR SAKALA: Naomi?

20 MEMBER SCHAPIRO: Yes, this is just a
21 question about unintended consequences, since I
22 am new to this process. Which is, if we sort of

1 continue to endorse all three, then we don't
2 necessarily have control over who requires people
3 to collect them. And I am just kind of wondering
4 if we have any idea of what that burden might be,
5 especially for the new hospitals coming online
6 that have fewer resources.

7 You're shaking your head. So, we
8 don't have any idea?

9 DR. WINKLER: I mean, you all are out
10 in the field and can give us a much better idea
11 of what is going on in the real world.

12 MEMBER YOUNG: What was the question?
13 Who was reporting to whom?

14 MEMBER SCHAPIRO: No, the question
15 was, if we continue to endorse all three and say
16 this new round of hospitals that are coming into
17 reporting, are they going to have to report all
18 three? Or they don't report the VON because they
19 are not in the VON?

20 MEMBER YOUNG: So, the subspecialty,
21 the high-level NICUs are reporting to VON. They
22 are all part of the VON network. Almost everyone

1 has to report to The Joint Commission, again, if
2 you have 300 deliveries or over. So, that is
3 essentially every community hospital and higher.

4 And I'm not really sure who is
5 reporting to the Agency for Healthcare, or AHRQ.
6 I don't have a sense of that.

7 DR. OWENS: On the AHRQ measure, just
8 so you know, there is no reporting burden from a
9 hospital perspective. It is coming directly out
10 of billing data. The hospitals collect the
11 discharge data. And then, for what we use it,
12 each is sent to their state data organization,
13 rolled up and collected into a graphic state.

14 For claim status or if it goes to
15 Medicaid, for instance, the state Medicaid
16 offices get the data, but the hospitals don't
17 have to do anything to subset it. I mean, it is
18 sent as part of the bill.

19 And by the way, AHRQ does not do
20 hospital-level reporting.

21 CO-CHAIR SAKALA: We have many more
22 comments, and we really need to wrap this up in

1 the next five or so minutes.

2 So, the comments that driving us
3 toward a decision --

4 MEMBER KILDAY: I just have one
5 clarifying question. How many hospitals in the
6 country are Joint Commission versus D&B? D&B.
7 There are two different accreditation agencies
8 out there, and we can't make the assumption that
9 all hospitals are reported to The Joint
10 Commission because that is not true.

11 MS. WATT: Ninety-some percent of the
12 hospitals are Joint Commission, though, 90-some
13 percent.

14 CO-CHAIR SAKALA: And about 80
15 percent, a little over I think, are now included
16 in the 300 or more births.

17 Sindhu?

18 MEMBER SRINIVAS: I guess I would like
19 to -- and maybe this is just sort of striving for
20 the future -- I mean, it just seems like the only
21 sort of thing that I heard about the AHRQ measure
22 was the payer issue of payers getting, I know it

1 is like direct data feeds to HCUP and payers are
2 being able -- like you can do a payer-related
3 evaluation instead of getting all payer data.

4 But it seems like fundamentally the
5 difference is really in the codes and the
6 exclusion. Because you could take The Joint
7 Commission measure and the codes and make it
8 payer-specific. So, that doesn't seem to be the
9 limitation.

10 It is seems to be fundamentally in
11 terms of what is actually being included and
12 excluded. And I may be misunderstanding that,
13 but it just seems like I would caution us, for
14 the reasons that Naomi mentioned, too, of having
15 so many measures that are really trying to get at
16 the same thing and trying to push us towards
17 harmonization.

18 I mean, to the public, we are all the
19 experts in these areas and we can tell like,
20 well, in this measure, these couple of people are
21 excluded because of these codes, and in this
22 other measure they are not. But when you put

1 them side by side and the numbers are so
2 different, from a public perspective, that is
3 like incredibly confusing. And it seems like we
4 should be striving towards a single harmonized
5 way to measure things to really drive quality.

6 I feel like it is very difficult to
7 have different ways to measure the same exact
8 thing that are marginally different. And I think
9 we should be trying to get to a place where we
10 are actually limiting it from three to at least
11 two, and even getting towards one eventually.

12 CO-CHAIR SAKALA: Ann?

13 MS. WATT: Thanks.

14 One thing I want to emphasize is that
15 Joint Commission staff and AHRQ staff have worked
16 very closely together to harmonize all of the
17 data elements that are possible to harmonize and
18 all of the specifications in these two measures.

19 I think what you are seeing as the
20 fundamental difference between The Joint
21 Commission measure and the AHRQ measure is the
22 dependence solely on coded data used for the bill

1 in the AHRQ measure. There is no reliability
2 evaluation of the coding, of the appropriateness
3 of it. There is for The Joint Commission chart-
4 abstracted measures. It is one of our
5 requirements, is that inter-rater reliability be
6 done, so that we have a fairly -- and we do
7 extensive quality testing of the data. I think
8 that is one of the things that sets our measure
9 apart.

10 Having said that, though, I think that
11 The Joint Commission measure -- I think that what
12 our analysis that Celeste discussed at the
13 beginning of this discussion showed was that the
14 biggest differences is in the coding. And so, I
15 think that is a big difference. It is just sort
16 of a fundamental thing.

17 We haven't done a comparison with the
18 VON data. We would be happy to work with VON, so
19 that we can do that type of harmonization as
20 well.

21 I don't think that we are talking
22 about so much as apples and oranges. We are

1 talking about different data collection systems,
2 basically.

3 CO-CHAIR SAKALA: Sheila?

4 MEMBER OWENS-COLLINS: I just wanted
5 to just make another quick plea for comprehensive
6 data collection and looking at the late preterm
7 and the bigger babies, because, as I was noticing
8 the criteria for infection, I noticed that GBS,
9 unless I missed it, is not up there, which is a
10 real significant marker for infection for bigger
11 babies. And it is a very prevalent, probably
12 still the most common infection in newborns.

13 CO-CHAIR SAKALA: Jaleel?

14 MEMBER MAMBARAMBATH: So, it appears
15 that we are moving forward endorsing all these
16 three measures. I was on the Committee three
17 years or four years ago discussing the same
18 thing. It was a robust discussion, but ended up
19 kicking the can three or four years forward.

20 (Laughter.)

21 And now, we are kicking the can again
22 for another three or four years. So, I am kind

1 of feeling disappointment at that and trying to
2 see if there is a way to try to hone-in on this
3 and try to fix this problem before the next time
4 the Committee meets.

5 I think it was really helpful to see
6 the comparison between the AHRQ measure and The
7 Joint Commission measure. Thanks a lot for that.

8 But I think it would be worthwhile
9 trying to see if we can have this comparison in
10 more detail, looking at meningitis, and giving a
11 chance for AHRQ to come up with their opinion on
12 this comparison, and all that.

13 I am trying to see if we can have this
14 as one of the items even for the Committee to
15 start off with, and even before we reach this
16 level, get a better understanding of the lay of
17 the land.

18 CO-CHAIR SAKALA: Thank you.

19 So, that is a good way for us to turn
20 to the developers and say, "Help us next time
21 around with better working together around moving
22 toward a better place."

1 So, Diana and Nancy.

2 You know, Jaleel is saying we are
3 moving toward continuing with all three.

4 MEMBER JOLLES: Could we vote, because
5 I don't support that? And I don't know; maybe I
6 am an outlier.

7 CO-CHAIR SAKALA: Do we have to vote
8 on, first of all, all three and, then, if we
9 don't support all three --

10 DR. WINKLER: Vote on the proposal.

11 CO-CHAIR SAKALA: The proposal is?

12 DR. WINKLER: The proposal is to keep
13 all three.

14 CO-CHAIR SAKALA: To keep all three?

15 MEMBER MAMBARAMBATH: If we say we
16 vote for the proposal and the answer is no, then
17 what do we do?

18 MEMBER JOLLES: Then, we call on the
19 neonatologists to help us.

20 (Laughter.)

21 CO-CHAIR SAKALA: Nancy, while we are
22 waiting.

1 MEMBER JOLLES: Well, I mean, I am
2 half-tempted to begin like a lecture on what NQF
3 is and what we are being called to do. We can't
4 kick this down the road.

5 MEMBER LOWE: I agree with that.

6 DR. WINKLER: Let me offer one other
7 potential, because I think a great many of you
8 have suggested that there is a need for better
9 data on which to make your decisions.

10 As to opposed to waiting, say, three
11 years or so, this is a standing Committee. We
12 could perhaps consider something in the interim
13 before three years to bring the data back, if our
14 developers are willing to work with us on that.
15 So, we could have this discussion with a little
16 bit more data to help us understand what is going
17 on. So, that is potentially, again, one of the
18 benefits of the standing Committee, sort of an
19 outstanding issue that we might be able to deal
20 with on an off-cycle basis.

21 MEMBER LOWE: Carol, actually, Reva
22 just said I was going to say, because that is a

1 difference now that we are a standing Committee,
2 that we are here for a period of time. And why
3 can't we ask them to come back to us in a year
4 with more information about the pros and the
5 cons, what the data look like, using the two
6 different measures?

7 I totally agree with Diana. I think
8 we are not helping the industry from the
9 perspective of what NQF is about, I don't think,
10 by kicking the can one more time.

11 MEMBER FLANAGAN: I just want to make
12 one additional comment that was said earlier, but
13 to emphasize. What I heard the table say is that
14 the AHRQ measure is being used by Medicaid,
15 primarily because it has almost no -- it is
16 derived administratively.

17 To the extent that PC-04 can be made
18 more administrative, I think it would satisfy
19 Medicaid. And I think we need to ask Medicaid
20 whether they would consider changing. Because,
21 you know, they, then, accept PC-04 with very
22 little chart review burden. This whole

1 discussion goes away.

2 CO-CHAIR SAKALA: So, are you okay,
3 Jaleel, with a proposal to stand with the three
4 measures until next year, until a year from now,
5 when we get more information from the three
6 developers, including regarding the changes that
7 have been made?

8 What is the proposal that we are
9 talking about here?

10 MEMBER MAMBARAMBATH: I agree, but why
11 is it only me?

12 (Laughter.)

13 CO-CHAIR SAKALA: Well, you were the
14 person who opened up saying maybe we accept all
15 three. So, there we have it.

16 Nancy?

17 MEMBER LOWE: Yes, can we ask the
18 three developers, charge them with coming up with
19 a true single measure? Why can't we charge them
20 with that? Why do we have to figure that out
21 when they are the people that work with this data
22 all the time?

1 CO-CHAIR SAKALA: Well, I think VON
2 has its own limitations around the population-
3 wide measure.

4 MEMBER LOWE: Well, that's their
5 problem, not ours. I'm sorry, but it is.
6 Because if we are all interested in quality care,
7 then it seems to me that we should be able to
8 negotiate a single measure that provides useful
9 data for this issue of infection in the high-risk
10 neonate. I'm sorry if I'm too simplistic, but --

11 CO-CHAIR SAKALA: Matt?

12 MEMBER AUSTIN: Yes. So, my
13 understanding is the VON measure is actually
14 looking at a subset of the babies that the other
15 two measures are looking at. The VON measure is
16 looking at the really small babies.

17 So, from my perspective, it feels like
18 I could understand why a hospital might want to
19 have specific data on those. To me, the real
20 conflict is between The Joint Commission measure
21 and the AHRQ, as they really are looking at the
22 same population and trying to get to the same

1 outcome.

2 I do feel like we need additional data
3 with the change of ICD-10 to really make a
4 distinction on which we think is the better
5 measure. So, my proposal would be we reconvene
6 in 18 months to evaluate those two measures and,
7 for now, we stand with the three measures.

8 MEMBER YOUNG: I would like to second
9 that proposal, so we can move on.

10 CO-CHAIR SAKALA: Raj?

11 MEMBER WADHAWAN: I just wanted to add
12 to that comment. I think the only measure, if we
13 had to choose one of the two, it cannot be the
14 VON measure because it is not all-encompassing
15 and it doesn't answer the questions for other
16 babies. So, it has to be one of the two,
17 although VON, certainly being a subset, with some
18 work could be incorporated into that.

19 CO-CHAIR SAKALA: So, a stratified
20 measure that VON would be able to use a part of?

21 MEMBER OWENS-COLLINS: Yes. And
22 again, I mean, if we are going to come back, I

1 will make the plea again that we look at the
2 bigger babies and not just concentrate all of our
3 efforts on the smaller babies, as important as
4 they are.

5 MEMBER BAILIT: I think the other
6 thing here, though, is that VON is voluntary.
7 Nobody is going to force you to do VON, right?
8 So, you are really just talking about, if you are
9 worried about data burden, it is just the other
10 two.

11 DR. EDWARDS: It is, and from VON's
12 perspective, we are going to collect it anyway,
13 and we are going to collect it for the expanded
14 centers on all infants admitted to a NICU, which
15 in hindsight maybe I should have proposed that
16 measure as a new measure.

17 I mean, I would sort of agree with
18 Matt, but our measure is different in that way,
19 in that it is the very low birthweight infants
20 risk adjusted, SMR or 0 minus e, but including
21 meningitis. So, it is kind of fundamentally
22 different from the other two.

1 But, as I said, I am very happy to
2 work with AHRQ and The Joint Commission on
3 harmonizing.

4 CO-CHAIR SAKALA: We need to move on.
5 So, can we take a vote on a proposal?

6 Matt, would you like to clarify? Yes.

7 MEMBER AUSTIN: So, the proposal is
8 that we reconvene in 18 months to evaluate the
9 AHRQ measure and The Joint Commission measure
10 based on updated data. Yes, the VON contribution
11 as well. So, I guess the proposal is in 18
12 months to reconvene with better data to continue
13 this conversation.

14 CO-CHAIR SAKALA: And put some
15 pressure on the developers to help us move toward
16 a single measure.

17 CO-CHAIR GREGORY: So, to clarify
18 that, on the VON piece, though, since that is
19 chart audit, it would be worthwhile to know the
20 overlap of their chart audit with administrative
21 codes. How many of those babies would you get?
22 That is what we are asking.

1 CO-CHAIR SAKALA: Okay.

2 MEMBER WADHAWAN: Just a quick
3 clarification. Why are we saying it in months
4 and not 12 months or less? I mean, there is a
5 lot of data.

6 CO-CHAIR SAKALA: By the time we get
7 the data in --

8 MEMBER AUSTIN: Yes. If we were just
9 filling out --

10 CO-CHAIR SAKALA: Eighteen is not
11 enough time.

12 MEMBER BELL: You need a full year's
13 worth of ICD-10 data.

14 CO-CHAIR SAKALA: Okay. All right.
15 So, let's vote.

16 MS. ROBINSON-ECTOR: Voting is open on
17 the proposal. Option 1 is yes; option 2 is no.

18 (Voting.)

19 Yes is to agree with Matt's proposal.

20 Okay. All the votes are in and voting
21 is now closed.

22 A hundred percent voted yes and zero

1 voted no. So, that motion passes.

2 (Applause.)

3 CO-CHAIR SAKALA: Last comment.

4 MEMBER WESTHOFF: Well, this is a more
5 generalizing question, being new to the
6 Committee. Has the Committee done anything like
7 this before? And given the larger national need
8 to harmonize and reduce the number of measures,
9 is this new? It seems like a good idea.

10 And then, second, either having done
11 it in the past or thinking ahead to doing it
12 right now, who is it at NQF who is now tasked
13 with -- you know, there is the burden on the NQF
14 side.

15 DR. WINKLER: Yes, you're looking at
16 us.

17 (Laughter.)

18 We will be staffing this Committee as
19 long as it's in existence and as long as we are.
20 So, this goes on our to-do list to keep everybody
21 reminded. And again, it will become one of the
22 off-cycle activities.

1 Because we moved to standing
2 committees two to three years ago, we have begun
3 having some of these, "Hey, you know, we couldn't
4 resolve everything today," but we need more data;
5 something is going to change in three months,
6 blah, blah, blah. We want to revisit sometime
7 down the road. So, it is becoming something we
8 see.

9 The issue around related and competing
10 is huge across all measures, across all topic
11 areas, in terms of really understanding burden
12 and the use of measures. So, this is not unique.

13 CO-CHAIR SAKALA: Okay. Thank you.

14 So now, we move on to 0471, which is
15 PC-02 in The Joint Commission's core set,
16 Cesarean -- it says "Section" here -- but it is
17 "Birth" now.

18 And no one is recused, I believe.
19 Jennifer Moore and I are discussants. And we
20 will begin with an introduction from the
21 developers.

22 MS. MILTON: Thank you. This is

1 Celeste again from The Joint Commission.

2 PC-02, Cesarean Birth, the denominator
3 population is comprised of patients that are
4 having their first live birth and it is a
5 singleton in vertex position, and they have
6 reached term, which means at least 37 weeks f
7 completed gestation or more. Of those patients,
8 then, in the numerator would be those that ended
9 up having a Cesarean delivery.

10 The goal of this measure is to reduce
11 the number, but not to zero. There's always
12 going to be a Cesarean rate. This is a variation
13 of a primary Cesarean birthrate that hospitals
14 have looked at for years.

15 So, this is just focusing-in on an
16 area where ACOG especially has made a
17 recommendation that we focus our efforts to make
18 sure that we take a look at variation in
19 practice. The goal is to get this rate close to
20 the Healthy People 2020 of 23.9 percent. We are
21 still above that nationally.

22 CO-CHAIR SAKALA: Thank you.

1 MEMBER MOORE: There was only one
2 comment that came out of our Workgroup meeting
3 they think is worth mentioning. During the
4 discussion, we questioned whether it should be
5 classified as an intermediary measure instead of
6 an outcome measure, but that really was the only
7 thing that came out of our discussion to pass
8 along.

9 DR. WINKLER: Again, I think there is
10 a certain level of philosophy around here. I
11 have thought about this one for years. I can
12 even argue it is a process measure.

13 So, fundamentally, we let the
14 developer give its assignment. It doesn't have a
15 great deal of impact. There is a huge interest
16 in outcome measures, priority over process
17 measures. So, I do think it qualifies in that
18 kind of dichotomy, but I am not sure it is hugely
19 different, whether it is intermediate outcome and
20 the final outcome is healthy mom and healthy baby
21 or it is a pure outcome itself.

22 MEMBER MOORE: Okay. Thank you.

1 CO-CHAIR SAKALA: So, on the evidence,
2 the documentation says no new evidence. We would
3 say that there is continuing affirmation of the
4 same conclusions that were made, that eliminating
5 avoidable, safely avoidable, Cesareans has
6 important benefits for moms and babies, and there
7 are supported ways of doing so. So, if there is
8 no objection, I would take the position that we
9 don't need to re-vote on that one.

10 And then, on the performance gap, as
11 Celeste mentioned, the Healthy People target is
12 23.9 percent, and the 2014 data with 1388
13 hospitals reporting is 26.8 percent. But the
14 variation for this measure is really quite large.
15 So, the performance was 14th percent at the 90th
16 percentile -- wait -- at the 10th percentile, 14
17 percent, and 40 percent at the 90th percentile.
18 So, there is quite a bit of practice variation
19 out there and, also, just disparities for various
20 kinds of socioeconomic variables.

21 So, I think we need to vote again on
22 the performance gap, just to see where changes

1 are and have been. And I would say that we,
2 after a steady rise, we have been plateauing.
3 So, that is kind of the change right now, is
4 stopping that rise. We can talk later that the
5 environment is such that we should be expecting
6 to see this actually turn around. But, right
7 now, I think that is a good beginning, is to stop
8 the rise.

9 So, any other comments on performance
10 gap?

11 (No response.)

12 Okay. So, let's vote on that.

13 MS. ROBINSON-ECTOR: Voting is now
14 open for performance gap of Measure 0471. Option
15 1 is high; 2 is moderate; 3 is low, and 4 is
16 insufficient.

17 (Voting.)

18 All the votes are in.

19 Eighty-eight percent voted high; 12
20 percent voted moderate; zero voted low, and zero
21 voted insufficient. So, for performance gap of
22 Measure 0471, the measure passes.

1 CO-CHAIR SAKALA: Great.

2 So, on reliability, I think we do need
3 to take a quick vote. This measure was aligned
4 with the ACOG-led reVITALize Project. So, thus,
5 the new name, for example.

6 And also, they report an improved
7 ability to identify cases. So, there is a little
8 bit of change there.

9 Can we pass on this if it is even
10 better than before?

11 (Laughter.)

12 DR. WINKLER: Please go ahead and
13 vote.

14 CO-CHAIR SAKALA: Yes. Okay.

15 Yes, Jaleel?

16 MEMBER MAMBARAMBATH: So, I have a
17 comment, a question about the denominator
18 exclusions. One of the exclusions is enrolled in
19 a clinical trial. Now I'm talking in terms of
20 the bigger hospitals. If I can look at my own
21 institution, there are, at least with neonates,
22 in my own hospital there are, at any given time,

1 there are about 15 to 18 clinical trials going
2 on. So, almost all of the babies will be
3 included in clinical trials. So is the case with
4 many of the NICHD Neonatal Research Network
5 Centers. And I would assume that the MFM Network
6 would also have similar numbers. So, are pulling
7 out a lot of these moms away from the
8 denominator.

9 CO-CHAIR SAKALA: Celeste, did you
10 have a comment on that?

11 MS. MILTON: We're actually removing
12 clinical trials in our next version of the
13 manual. So, we were just reporting on the data
14 as it had been collected for this submission.
15 Because we found that the numbers weren't really
16 that large as you looked across the board, when
17 we looked at a 12-month exclusion report. And
18 you have to look at why are they in a clinical
19 trial. Is it really directly related to what we
20 are measuring? So, that was part of it, that we
21 weren't really seeing that there was a lot of
22 variation as a result.

1 MEMBER MAMBARAMBATH: So, you leave
2 out --

3 MS. MILTON: Clinical trial, yes.

4 DR. WINKLER: Okay. I need to ask,
5 Celeste, when does that go into effect?

6 MS. MILTON: July 1st, 2016
7 discharges.

8 DR. WINKLER: But is that reflected in
9 the specs that you submitted to us?

10 MS. MILTON: For the previous
11 specifications, because they had to be in before
12 we finalized the specifications.

13 DR. WINKLER: Right. So, if the
14 Committee's okay with that, I am going to ask her
15 to make that update on these specs for where we
16 are now.

17 MS. MILTON: We can do that.

18 DR. WINKLER: Thanks.

19 CO-CHAIR SAKALA: Great. Okay. So,
20 can we have a vote, please, on reliability?

21 MS. ROBINSON-ECTOR: Voting is now
22 open for reliability of Measure 0471. Option 1

1 is moderate; 2 is low, and 3 is insufficient.

2 (Voting.)

3 All the votes are in and voting is now
4 closed.

5 Eighty-eight percent voted moderate;
6 12 percent voted low; zero votes insufficient.
7 So, for reliability of Measure 0471, the measure
8 passes.

9 CO-CHAIR SAKALA: Thank you.

10 So, on validity, the developer reports
11 previous and continuing face validity for measure
12 users as well as a website that picks up
13 questions and issues from the field and tries to
14 deal with them in a continuous process of
15 clarification and refinement.

16 I feel that the exclusions seem
17 appropriate, but, as was just discussed, many of
18 them, so few cases are eliminated, that this
19 seemed to me to be an area where we could look at
20 reducing the burden of collection by really
21 taking out the ones that aren't materially
22 impacting the results.

1 It was switched to ICD-10 codes using
2 a careful process with checks and verification.

3 And then, we got some comments, pretty
4 extensive, in the pre-meeting period regarding
5 adjustment for various demographic variables. I
6 don't know if we can bring those data up, but we
7 were provided with some PowerPoints from Elliott
8 with data from 231 California hospitals showing
9 that hospitals with a higher concentration of
10 older moms -- and that is over 35 years -- and
11 higher concentration of moms who had a BMI 30 or
12 higher just before being pregnant were
13 distributed across higher, medium, and lower
14 range NTSV hospitals.

15 So, what that is suggesting is that
16 there is not a pure risk among women, but it
17 depends on clinical practice. Just to give an
18 example, a woman comes with a BMI of 33. Do you
19 say this woman is at elevated risk if she has a
20 Cesarean and I'm going to work really hard to
21 help her not have one or do you say this woman is
22 headed that way and I'm going to lower my

1 threshold for going there?

2 So, that is an example. I believe you
3 are, on July 1st, also eliminating the age bans,
4 is that correct?

5 MS. MILTON: Yes. That will be
6 effective, again, with July 1st discharges of
7 this year.

8 CO-CHAIR SAKALA: Okay. And any other
9 comments on that?

10 DR. MAIN: This gets to really the
11 fundamental issue of what is driving the
12 variation among the hospitals, which is different
13 than among patients. So, when you look at
14 hospitals, what this graph shows, the green dots
15 are hospitals that have low NTSV C-section rates
16 and the red dots are hospitals that have high
17 rates of NTSV C-sections, 35 percent or more.

18 And you can see on the x-axis is the
19 proportion with high BMIs, and the y-axis is the
20 proportion with high rates of maternal age.
21 There is a general trend that the older the
22 population of nullips, first births, the thinner

1 the population, and vice versa; you are going to
2 be heavier in your first birth. So that they do
3 have a tendency toward balancing each other out.

4 But anywhere along the line here, for
5 every red dot, you see green dots next to it.
6 So, a hospital that has the same distribution of
7 high BMIs or high maternal age can have very
8 different rates, which strongly indicates that
9 this is related to practice patterns. It is
10 likely some effect of those are, but you
11 certainly don't want to bake-in the population
12 rates of high BMIs or high maternal age if you
13 have hospitals that can be very well at one end
14 or the other.

15 And that is really the struggle here,
16 is to tease out what is related to the practice
17 pattern and what is related to the patient. And
18 it is really not the individual patient we are
19 talking about here, and I think that is a super-
20 important point. It is really the practice
21 pattern of the hospital taking care of all the
22 patients that come to that hospital.

1 CO-CHAIR SAKALA: And I would just
2 like to say that I think baking-in practice
3 patterns where there is significant room for
4 improvement is a problem that we should try to
5 avoid.

6 Cindy?

7 MEMBER PELLEGRINI: Can the OBs in the
8 room enlighten me? Are there strong, clear
9 consensus practice guidelines for how to deal
10 with these two populations? In other words, are
11 some of these hospitals adhering to guidelines,
12 whether their rates are high or low, and others
13 are not?

14 DR. MAIN: No.

15 MEMBER GOYERT: No. If the question
16 is, are there guidelines for particular labor
17 management, no.

18 CO-CHAIR SAKALA: Microphone on.

19 MEMBER JOLLES: All right. Okay.
20 Sorry.

21 I mean, well, if we broaden your
22 question, is it a guideline specifically on the

1 elderly nullip or is it a guideline on the obese
2 patient? But the standard guideline that is the
3 root of the CMQCC work and the SMFM, yes, it is
4 all about stopping the overdiagnosis of labor
5 dystocia, and that is what this is all about, are
6 the elderly nullips and the BMI. Okay. Correct?
7 So, yes.

8 MEMBER PELLEGRINI: We prefer a word
9 other than "elderly". Thank you.

10 (Laughter.)

11 CO-CHAIR SAKALA: There are guidelines
12 in terms of obviously -- oh, Sindhu?

13 MEMBER SRINIVAS: Also to answer that,
14 I mean, I agree there are things that are
15 published as risk factors for having a C-section
16 and how individual clinicians utilize that
17 information to make decisions.

18 I think Carol pointed out the sort of
19 two versions of how somebody could take that into
20 account, but there's not like guidelines that
21 say, you know, manage labor this way for this
22 person. And I think people just use that

1 information differently.

2 I had a different comment, which is --
3 I don't know if it is appropriate to say here,
4 but just more food for thought -- you know, we
5 talked about a measure yesterday that was about
6 adverse term-birth outcomes. When we talk about
7 lowering the C-section rate, there is a
8 countermeasure to lowering the C-section rate,
9 which is not lowering it too much or
10 inappropriately in certain places where you need
11 to increase adverse neonatal outcomes. You know,
12 lots of measures have a countermeasure that could
13 have a negative consequence. I think the
14 elective delivery one is another one.

15 And I don't know if there is a
16 precedent or if The Joint Commission is
17 considering sort of kind of pulling together the
18 low-risk C-section rate with a countermeasure
19 that sort of is ensuring that, while we are
20 trying to lower the C-section rate, we are not
21 actually leading to unintended adverse
22 consequences.

1 DR. MAIN: We are certainly doing that
2 in California, in Oregon and Washington, where
3 these are all in play. I can't speak to where
4 The Joint Commission is going on this.

5 MS. MILTON: There aren't any plans at
6 this time, but, certainly, this is something we
7 could discuss with our Technical Advisory Panel.

8 CO-CHAIR SAKALA: Tracy?

9 MEMBER FLANAGAN: So, I want to echo
10 what Cindy just said about going too low can be
11 just as bad as being too high. I have seen this
12 scatter graph a couple of times.

13 We in Kaiser Permanente ran our 66,000
14 births in a one-year or a two-year time period.
15 What we found is multipliers of risk for five
16 conditions. One was age, BMI, race,
17 hypertension, and diabetes. And the biggest
18 factor was pre-pregnancy diabetes increased the
19 risk by 130 percent.

20 Within our system, while we have a
21 very low rate as a system, we have hospitals that
22 are higher, and we have a very consistent care

1 pattern because we have 24/7 staffing. I mean,
2 we really have fairly consistent care.

3 So, while I think Elliott is making
4 the point that there is variation in clinical
5 practice, there may be some real differences
6 based on medical issues that really impact
7 whether babies fit or whether babies tolerate
8 labor, and whether labor goes smoothly in a
9 timely fashion that doesn't exhaust the baby or
10 the placental reserve.

11 So, while I know that the age
12 adjustment is going away, I actually think that
13 that is okay. What troubles me is what the
14 number is. When purchasers start talking, as has
15 happened in California, that if you are below
16 23.9, we are not going to pay you, that troubles
17 me a lot.

18 And so, because that is happening, I
19 really am troubled about not risk-adjusting this.
20 What we are planning on doing is actually taking
21 our own analysis and submitting it to The Joint
22 Commission. We haven't run it by hospitals yet.

1 We do know we have these factors of risk, and we
2 will see.

3 CO-CHAIR SAKALA: Thank you.

4 Nancy?

5 MEMBER LOWE: Yes, well, I think I am
6 back to the question that was asked about
7 guidelines. I think the literature is very clear
8 -- in fact, I know it is -- that the diagnosis of
9 dystocia during labor is one of the most
10 imprecise, undefined diagnoses that there may be
11 in the whole realm of medical practice.

12 You know, you can't run a laboratory
13 test. It is in the eye of the beholder what is
14 dystocia during labor. And that is
15 extraordinarily clear in the literature, and I
16 think it is what some of us are trying to help
17 give clinicians better tools to help them with
18 the issue of what is really delayed-labor
19 progress; what is failure to progress; what is
20 failure to wait, all those kinds of issues that
21 really get into this measure of variation by
22 institution.

1 And so, I just caution us to be very
2 careful about making decisions or assumptions
3 based upon statistical risk, when statistical
4 risk can vary greatly in any one study. And I
5 think Elliott made the point very, very well that
6 there's no bottom-line risk that being older
7 gives you by itself that is reliable and that
8 statistically works across the board.

9 And so, to me, when we start to tie
10 these kinds of things to outcomes -- and I'm not
11 being very clear what I want to say -- but it is
12 scary when people want to say, "I'm not going to
13 pay you." Because, to me, for this population,
14 23.8 percent rate is way too high, way too high,
15 for healthy nulliparous women at term, one baby,
16 head down. That is one in every five women, more
17 than one, almost one in every four ends up in the
18 OR. What is wrong with that picture? I think it
19 is a public health problem, that we are doing
20 that much surgery on women to have a baby, which
21 is a physiologic process.

22 So, enough. But I just want to

1 caution us about this, not to get so far down the
2 road of tearing things apart statistically that
3 the measure becomes unmeaningful to the public or
4 unmeaningful in terms of really monitoring what
5 is going on nationally in terms of safety and
6 quality.

7 CO-CHAIR SAKALA: Thank you.

8 Juliet?

9 MEMBER NEVINS: So, I am payer, and I
10 certainly would not at anytime support a
11 situation where we paid for a certain percentage
12 of C-section rate. I am also a laborist. You
13 know, last weekend I did a C-section on a baby
14 that was five pounds.

15 We do have guidelines with respect to,
16 or new guidelines I should say, with respect to
17 what is the definition of arrest of dilation or
18 descent. So, that is available, and there is
19 significant uptake with respect to that.

20 Most of the obstetricians in obstetric
21 programs are moving towards some sort of a
22 hospitalist model where you do have in-house

1 obstetricians available. You know, the day of
2 the private OB doctor is sort of going to the
3 wayside. Certainly, in certain sections,
4 regional sections, of the country, that still
5 exists, but certainly in the larger urban centers
6 I would say that most of the hospitals do have
7 24-hour care.

8 So, I guess the point, I think that
9 these studies should be risk-adjusted because I
10 do understand the graph, but I also have to agree
11 that it is an art; it can be very subjective.
12 But I would say that there are inherent risks to
13 ending up in the operating room if you have one
14 of these five risk factors, one of them certainly
15 being your BMI. So, that is my slant on it.

16 And anecdotally -- and I don't know if
17 the other OBs in the room would agree with me --
18 but no one wants to take a heavy patient to the
19 OR. We want that lady to deliver vaginally, just
20 letting you know. It is much easier for the baby
21 to come out through the vagina.

22 CO-CHAIR SAKALA: Jaleel?

1 MEMBER MAMBARAMBATH: I want to
2 caution those comments about balancing risk,
3 because this maybe not relevant to this
4 particular case, but there is more food for
5 thought over here for NQF.

6 Whenever there is a QI project which
7 comes up for me as a medical director of an EQ, I
8 ask for what are the process measures, what are
9 the outcome measures, and, okay, do you have
10 balancing measures, too.

11 When we have measures coming up over
12 here, one of the major concerns that we have in
13 the committee is that, hey, is this going to
14 worsen some other outcome? But we don't have a
15 balancing measure included into many of these
16 measures that we have. Should we be including,
17 asking the developers to include a balancing
18 measure in there, along with this as a package?

19 CO-CHAIR SAKALA: So, and Elliott is
20 going to comment.

21 DR. MAIN: We are doing major quality
22 improvement efforts on this subject currently in

1 California. And the balancing measure for this
2 particular measure presented yesterday and that
3 was approved or re-endorsed, which is the healthy
4 term newborn. This is all term patients and the
5 question is how you manage the labor. This is
6 one outcome of the labor management. It is a C-
7 section, of course.

8 And as I said yesterday, the most
9 outcome is of the baby from birth and that is
10 what is being used around the country and in the
11 western three states and, as we heard yesterday,
12 in other parts of the country as well, as is
13 appropriate for any obstetric intervention.

14 MEMBER MAMBARAMBATH: Yes, my question
15 is more broad not only for this particular
16 measure but as any measure which comes through to
17 NQF, should we ask them to have a balancing
18 measure associated along with that and come up as
19 a package to NQF, when they come up with the
20 measure.

21 CO-CHAIR SAKALA: So, I think the
22 staff can take that under advisement.

1 So, Dianna and Amy and then let's vote
2 on validity after that.

3 MEMBER JOLLES: I just wanted to speak
4 to another side of the important points brought
5 up. I think sometimes we actually have to
6 question our assumptions and our reality to
7 really move the hockey puck where it is headed.
8 And I will just that while we await Strong Start
9 data, I can speak to the management of a
10 perinatal data registry that I am involved with,
11 where a nulliparous term vertex singleton
12 cesarean rate is race is not a predictor in
13 cesarean. So, the assumption that race has to be
14 where it is, I understand nationwide because of
15 healthcare delivery system issues. We don't have
16 to accept that assumption.

17 As for preexistent diabetes, PRAMS
18 data and birth certificate data would suggest
19 that population-wide, it is no more than three
20 percent.

21 So, if you have a system where you are
22 caring for like 20 percent of your patients are

1 preexistent diabetics, then this is, again, a
2 signal-to-noise issue, where we have got to
3 accept that and move on. But in general, with
4 the amount of unwarranted variation going on, I
5 personally believe that we have to remember that
6 NTSV is risk-adjusted. We are dealing with
7 healthy childbearing women, in general, with a
8 low chronic disease burden, at this point in
9 their lifetime, and that we are fortunate in this
10 beginning of life care group to be able to have
11 this level of equal playing field. Whereas, when
12 you get into the end of life care measures and
13 Medicare, it is a whole different thing where
14 risk adjustment becomes important. But be
15 careful about assuming we need to adjust for
16 certain things where the model of care is
17 predictive of outcome and, in this particular
18 data set I am discussing, hospital and parity
19 were the only independent predictors of cesarean
20 section.

21 CO-CHAIR SAKALA: Thank you. Amy.

22 MEMBER BELL: Just a question about

1 when looking at further development of the
2 measure, if there is any consideration for making
3 a clause in there regarding vaginal -- or C-
4 section delivery is the preferred method of
5 delivery or vaginal delivery is contraindicated.

6 So, if there is a contraindication for
7 a vaginal delivery, if those patients can be
8 excluded from that measure moving forward.

9 DR. MAIN: I have looked extensively
10 at other diagnoses what would be contraindicated
11 for vaginal delivery. There is a couple of
12 comments to be made.

13 One is that they are very rare in a
14 nulliparous population. Conditions such as
15 placenta previa, for example, nulliparous at
16 term. There is a very small number of previous
17 that we meet that. I have also looked at HIV.

18 And the trouble with both HIV and
19 placenta previa is the coding. There is only 56
20 cases in all of California that were coded as HIV
21 with the several codes for HIV in pregnancy
22 nulliparous to term, suggesting we were under

1 coded. But there is not a huge number that would
2 change anybody's rate.

3 Placenta previa, for example, we had
4 a couple of hospitals that two or three percent
5 of their patients had placenta previa. Half of
6 those were delivered vaginally. Another quarter
7 of those were induced. And the coding was
8 indicative of a placenta previa being present on
9 ultrasound in the first or second trimester that
10 got coded on the delivery chart.

11 And so as you get into other
12 diagnoses, you get into coding issues that may or
13 may not be real, which is one of the reasons we
14 wanted to keep this as simple as we could with
15 the best quality codes or the best simple
16 indicators. This can also be done using birth
17 certificate data. So, it is used by states and
18 nationally. The NCQS or the national Center for
19 Health Statistics runs this for every state every
20 year and that correlates very, very well. Part
21 of it is that it is clear-cut and simple and it
22 is I think a value to stay that way. Even

1 though, yes, there is 20-odd percent good reasons
2 to do C-sections, of which some of those fall
3 into place.

4 Patient choices often raised and that
5 is the area of some percent but it is kind of
6 interesting. It varies greatly by provider and
7 how you talk to your patient and how you discuss
8 the pros and cons. And again, that isn't one
9 that really drives the rate. It is how you treat
10 everybody else in your practice that is desirous
11 of a vaginal delivery that really drives the
12 rate.

13 CO-CHAIR SAKALA: Thank you. So,
14 let's, in the interest of time, now vote, please.

15 MEMBER NEVINS: Can I just -- I'm
16 sorry. One quick comment. I will be very, very
17 quick.

18 So, I just wanted to stress that I
19 certainly understand the dilemma and I certainly
20 appreciate the comment that you made with respect
21 to strident words more and more vaginal
22 deliveries.

1 And I will just give you an example.
2 I worked as a private practitioner in a very
3 middle class healthy community for seven years.
4 Our C-section rate was like 40 percent because
5 you had it was very subjective. We were limited
6 to the desires of the patients and doing
7 inductions when we weren't supposed to because
8 Mom wanted her baby delivered on a particular
9 day. And so in that situation, you can see where
10 leaving the data pure would tease out C-sections
11 that are being done as the fault of the provider.

12 However, I know work in a very
13 different environment, where we have 24-hour
14 staff but we have a very sick population. We
15 don't have healthy moms. If you have got ten
16 patients on the labor floor, six of them have
17 preeclampsia.

18 So, I mean I think that to be fair to
19 the hospitals that have high-risk populations, in
20 my view, I think that it should be risk-adjusted
21 and that is why I am stressing that because it is
22 regional and it depends on the cohort of the

1 patients that you are dealing with. So, I just
2 wanted to add that.

3 CO-CHAIR SAKALA: Thank you. I think
4 we need to vote and move on. I'm sorry.

5 Could we please open up the voting for
6 validity for this Cesarean Birth Measure?

7 MS. ROBINSON-ECTOR: Voting is now
8 open for validity of Measure 0471. Option 1 is
9 high, 2 is moderate, 3 is low, and 4 is
10 insufficient.

11 All the votes are in and voting is now
12 closed.

13 Eighty-eight percent voted high,
14 fifty-four percent voted moderate, eight percent
15 voted low, and zero voted insufficient.

16 So, for validity of Measure 0471, the
17 measure passes.

18 CO-CHAIR SAKALA: Thank you. Next is
19 feasibility. And in this case, it is manually
20 extracted from health records by approved vendors
21 among now all hospitals with 300 or more births
22 per year.

1 And a notable point is that they are
2 working on an eMeasure that will be tested this
3 year. That will be a good addition. And they
4 provide sampling guidelines to their hospitals
5 and have many years of implementation by an
6 increasing number of facilities.

7 So, are there any other comments on
8 feasibility, including your knowledge from the
9 field?

10 Okay, I think we have two cards up
11 that are not intended to be comments. So, thank
12 you.

13 If not, we can vote, please.

14 MS. ROBINSON-ECTOR: Voting is now
15 open for feasibility of Measure 0471. Option 1
16 is high, 2 is moderate, 3 is low, and 4 is
17 insufficient.

18 All the votes are in and voting is now
19 closed.

20 Fifty-eight percent voted high, forty-
21 two percent voted moderated, zero voted low, and
22 zero voted insufficient.

1 So, for feasibility of Measure 0471,
2 the measure passes.

3 CO-CHAIR SAKALA: Thank you. So,
4 moving on to usability and use.

5 For public reporting, I just would
6 like to ask -- in my view there is a lot of
7 confusion out there and we just saw it with the
8 Consumer Reports release is all this discussion
9 of the cesarean rate. And I feel as if we need
10 to teach all the stakeholders what we are talking
11 about and kind of coalesce around the most
12 meaningful measure among total primary and NTSV.
13 And so would be very eager to have public
14 reporting beyond voluntary circumstances and
15 wondering what the plans are for this, when we
16 could expect it. It was noted in the specs.

17 DR. OWENS: We are currently trying to
18 figure out how to do it, to be perfectly honest
19 with you. Our public reporting system is set up
20 basically for process measures. We are trying to
21 figure out how to accurately report it publicly,
22 this measure, as well as some others, so that

1 they make sense to the public. We are working on
2 it. We hear you. We know that it is necessary.

3 CO-CHAIR SAKALA: Thank you.

4 And as far as improvement, this
5 measure is used in programs internal to the Joint
6 Commission. It is a population measure. It is
7 included in the Medicaid Child Core Set.

8 I feel that the ACOG-SMFM
9 recommendations in early 2014 were a really
10 important signal to the field and since then, we
11 are seeing a lot of important work around the AIM
12 bundle and the toolkit that was released last
13 week and that these are around primary but the
14 toolkit says the best measure is the NTSV
15 measure. So, it is really -- and the new or
16 alternate payment models that are coming up and
17 are starting to be used, especially in Medicaid
18 programs for our purposes and the requirement is
19 to be collected in now over 80 percent of
20 hospitals.

21 So, this measure is really out there
22 and my view is that this issue is the heritor to

1 elective delivery, in terms of the primary QI
2 focus for our field right now. So, I think this
3 is a really big one around use and usability.

4 DR. MAIN: My only cautionary note is
5 we certainly don't want to have this be driven
6 down to a very, very low number. I would
7 certainly be supportive of, unfortunately, early
8 elective deliveries being driven to zero and
9 there probably should be three to four to five
10 percent. We don't want to see that with this
11 measure.

12 But you know there are hospitals in
13 California that are 35, 40, 45, 50, 60, 65
14 percent on this rate. That is the target.

15 CO-CHAIR SAKALA: And the other
16 question here is unintended consequences. And
17 again, my view for the next group with the Joint
18 Commission is that unexpected newborn
19 complications would be a great addition to that
20 measure set and would, I think, give a lot of
21 people good peace of mind around this question
22 because we don't know where the right rate is.

1 And people need to improve in a safe way.

2 Chances are they can really move the needle over
3 time but they need to do it safely. And so we
4 need to have ways to monitor that.

5 Tracy.

6 MEMBER FLANAGAN: There was a comment
7 from the presenters about the challenges of
8 public reporting of outcome measures. Could you
9 elaborate on that? Maybe other people at the
10 table don't know what those challenges are.

11 DR. OWENS: What the issue has to do
12 with is determining the expected rate versus the
13 actual rate and reporting that in such a way that
14 it makes sense to people. That is basically it.

15 MEMBER FLANAGAN: But why is it more
16 challenging than a process measure?

17 DR. OWENS: Because we have the system
18 set up without that piece of it and it is a
19 question of adjusting our system.

20 MEMBER FLANAGAN: Okay.

21 CO-CHAIR SAKALA: Is that Sindhu?

22 Yes.

1 MEMBER SRINIVAS: This is just a
2 general question for the Joint Commission. Is
3 there consideration that you would give to even
4 changing the title of the measure just because it
5 is called Cesarean Birth and it makes it seems
6 like it an all cesarean number versus like a low-
7 risk cesarean or whatever in the NTSV or whatever
8 we want.

9 MS. MILTON: The short name is
10 Cesarean Birth but the full measure description
11 or the full name of the measure goes into that
12 greater detail. And it only has to do with space
13 when you are putting it out there. But if you
14 look at the measure form, it is clearly
15 articulated right below the name of the measure.

16 CO-CHAIR SAKALA: Any other comments
17 about usability and use? Okay, let's open up for
18 voting, please.

19 MS. ROBINSON-ECTOR: Voting for
20 usability and use is now open for Measure 0471.
21 Option 1 is high, 2 is moderate, 3 is low, and 4
22 is insufficient.

1 All the votes are in and voting is now
2 closed.

3 Seventy-eight percent voted high,
4 twenty-two percent voted moderate, zero voted
5 low, and zero voted insufficient.

6 So, for usability and use of Measure
7 0471, the measure passes.

8 CO-CHAIR SAKALA: Okay. So, any
9 crucial comments before we turn to our overall
10 question of whether we vote to continue
11 endorsement of this message -- to recommend
12 continued endorsement?

13 Okay, so voting is now open, please
14 for whether we wish to recommend re-endorsement
15 of this measure.

16 MS. ROBINSON-ECTOR: Voting is now
17 open for 0471 for recommendation for overall
18 suitability for endorsement. Option 2 is yes --
19 Option 1 is yes, option 2 is no.

20 All the votes are in and voting is now
21 closed.

22 Ninety-six percent voted yes and four

1 percent voted no.

2 So, for recommendation for continued
3 endorsement of Measure 0471, the measure passes.

4 CO-CHAIR SAKALA: Okay, now we are
5 scheduled to take a break at 10:15 and we are
6 scheduled by 10:15 to have done one more measure.
7 So, do people have a sense of what they want to
8 do right now? It is the other measure on
9 cesarean rate.

10 CO-CHAIR GREGORY: Does anyone want to
11 take a break? How many want to keep going?

12 CO-CHAIR SAKALA: Okay, can we start
13 by 10:30, please?

14 (Whereupon, the above-entitled matter
15 went off the record at 10:18 a.m. and resumed at
16 10:29 a.m.)

17 CO-CHAIR SAKALA: Let's reconvene,
18 please.

19 CO-CHAIR GREGORY: Okay, gang, let's
20 reconvene.

21 CO-CHAIR SAKALA: Okay, so now we are
22 moving on to a new submission, which is number

1 2892, Birth Risk Cesarean Birth Measure. And no
2 one is recused. And the discussants are Jennifer
3 Moore and Nancy Lowe, and Tracy Flanagan.

4 And first of all, we will hear from
5 the developer, Dr. San Roman.

6 DR. SAN ROMAN: Good morning. My name
7 is Gustavo San Roman and I would like to thank
8 you for taking the time to review my measure.

9 If I could ask one question before I
10 start, I am little confused as to Measure 0471.
11 Did the committee endorse the measure as
12 submitted with the direct standardization age
13 adjustment or was the dropping of the age
14 adjustment what was endorsed?

15 DR. WINKLER: They dropped the age
16 endorsement for the new version.

17 DR. SAN ROMAN: Okay, thank you.

18 Good morning. The Birthrisk Cesarean
19 Birth Measure was developed, in part, as a result
20 of not being able to convince anyone six years
21 ago that the flow in the direct standardization
22 risk adjustment of Measure 0471 would become

1 problematic.

2 With that in mind, I set out to
3 develop a better measure and found that research
4 has shown that the physical characteristics of
5 the mother and the size of her baby significantly
6 affect a woman's risk that labor will result in a
7 cesarean birth. Therefore, we need more risk
8 adjustment and not less, if the goal is to assess
9 the effect of the obstetrical care provider. Or
10 in other words, every woman enters into labor
11 with an inherent risk that her labor will end in
12 a cesarean birth based on her physical
13 characteristics and the size of her baby. The
14 goal of the cesarean birth measure is to measure
15 the effect that the obstetrical care provider has
16 on this inherent risk.

17 Inherent risk is not a new concept but
18 it has had different terminology. In 2003, Dr.
19 Bailit referred to this risk as probability of
20 cesarean delivery and she referred to a
21 hospital's average expected probability as the
22 expected or risk-adjusted cesarean delivery rate.

1 I bring up Dr. Bailit's work on
2 logistic regression modeling only because the
3 method used in my measure is similar to her work
4 from 2003. Unfortunately, it seems that I do not
5 have her ability to describe my work clearly
6 enough for committee members to see the
7 similarity of my measure through logistic
8 regression modeling, as became apparent by the
9 comments during the last work group phone call.

10 I believe that a quick comparison
11 would be helpful. In logistic regression
12 modeling, an equation is used to predict the
13 number of expected cesarean deliveries based on
14 the risk factors contained in a population and
15 compares it with the populations actual cesarean
16 delivery rate. In logistic regression modeling,
17 this prediction is created by taking a fixed data
18 set and obtaining an equation from the data set
19 that reflects the effect of each risk factor on
20 prior outcomes.

21 The equation has a coefficient for
22 each risk factor, which assigns a weight to each

1 of the risk factors. The equation is then
2 applied to each birth record in the data set in
3 order to calculate the expected cesarean birth
4 rate for that woman. A provider's or hospital's
5 average expected rate for their population of
6 patients determines the expected rate for that
7 provider or hospital.

8 Once the expected rate is calculated,
9 then a simple comparison of the actual rate the
10 expected rate creates the cesarean birth measure.

11 The only difference in my measure is
12 that instead of using an equation to calculate
13 the expected rate, my measure uses the cesarean
14 birth rate of a cohort of 100 similar patients to
15 assign the expected rate. The cohort method uses
16 the same mathematical concept that is used to
17 create the equation in logistic regression
18 modeling.

19 For example, the equation assigns the
20 expected rate based on the weight of each risk
21 factor and the weight of each risk factor is
22 dependent on the actual prior outcomes within the

1 data set. The cohort method bypasses the
2 equation by assigning the expected rate based on
3 the actual prior outcomes.

4 The reason that I use the cohort
5 comparison method over logistic regression
6 modeling is that the cohort method is more
7 accurate due to the three limitations of using an
8 equation. First, is that the equation cannot
9 obtain accurate calculations if any of the risk
10 factors do not exhibit linear progression
11 throughout their range. Both fetal weight and
12 maternal weight gain do not exhibit linear
13 progression. Second, is that the equation cannot
14 obtain accurate results at the extremes. And
15 third, is that an equation based on a fixed data
16 set cannot account for changing practice
17 patterns.

18 Using a cohort of similar patients
19 means that nulliparous patients are only compared
20 to a cohort of nulliparous patients. And
21 multiparous patients are only compared to
22 multiparous patients. And this is the reason why

1 nulliparous and multiparous patients can be
2 included in the same measure. In fact, the
3 cohort used to assign the expected rate will be
4 similar in parity, onset of labor, fetal weight,
5 maternal pre-pregnancy BMI and maternal age,
6 maternal height, gestational age, and pregnancy
7 weight gain. Being able to provide risk
8 adjustment for eight risk factors is a
9 significant improvement over other measures that
10 only adjust for age or perhaps for nothing at
11 all.

12 In summary, measuring the effect of
13 the obstetrical care provider is extremely
14 complicated and only a complicated cesarean birth
15 measure will provide accurate results.

16 As I mentioned in the last phone call,
17 there is a 33-minute PowerPoint presentation on
18 my website that provides additional information
19 and explanation of my measure.

20 Lastly, also in the last phone call,
21 there was a question about statistical analysis
22 of reliability and validity. The statistical

1 analysis was done by Dr. E.K. Ahn, who trained at
2 Harvard, Columbia, and Stanford. I gave her the
3 data and the questions that needed to be
4 addressed and she provided the answers. And I
5 was asked to provide her analysis and I have
6 brought copies with me here today.

7 Thank you.

8 CO-CHAIR SAKALA: Thank you very much.

9 So, we will turn to our discussants to
10 begin a discussion of the evidence.

11 MEMBER LOWE: Just a couple of more
12 orienting factors and thank you, Dr. Roman, on
13 the measure so everyone is clear. The measure is
14 described as being a measure of the effect that
15 the obstetrical care providers' labor management
16 strategies have on their laboring patients' risk
17 for cesarean birth. The target population is
18 limited to women who attempt labor with a
19 singleton vertex pregnancy without a history of
20 prior cesarean birth and give birth between 37
21 and 42 weeks gestation. And an important point
22 to remember about this measure is it does include

1 both nulliparous and multiparous women in the
2 measure.

3 The level of analysis, according to
4 the report, is that the individual clinician or
5 the facility level and the data source is birth
6 certificate data. The numerator is the number of
7 women undergoing cesarean birth and the
8 denominator as described is all women without a
9 history of prior cesarean who attempted labor and
10 gave birth to a single baby in a vertex
11 presentation between 36 weeks, 4 days, and 42
12 weeks, 3 days.

13 And as described, the risk adjustment
14 is by cohort comparison to previously recorded
15 births to determine the expected cesarean rate
16 for the target population.

17 As a new measure, I expected to see
18 evidence of how this particular measure was
19 related to other identified outcomes and that was
20 not provided. The developer's summary of the
21 evidence is that there are many different labor
22 management strategies that have been used over

1 the years to assist women who are in labor. Some
2 of these strategies can decrease a woman's
3 inherent risk that labor will result in a
4 cesarean birth and others can decrease her
5 inherent risk. And examples were provided,
6 including doing an operative vaginal delivery or
7 an inpatient obstetrical provider as another
8 example.

9 While I agree that these things that
10 the provider and nurses do -- there was an
11 interesting about 20 years ago that nurses have
12 individual cesarean delivery rates, by the way,
13 primarily ignored but a very interesting analysis
14 -- to increase or decrease a woman's risk for
15 cesarean delivery, it is unclear how this
16 particular calculation does that.

17 Further, the developer did not specify
18 how this measure uniquely captures those dynamic
19 relationships, particularly the dynamic
20 relationships between maternal care truistics and
21 provider decisionmaking because it is not simply
22 additive. It would be multiplicative in some

1 cases. Nor did it provide evidence that this
2 outcome measure has any empirical relationships
3 to various specific processes of care.

4 So, my personal evaluation is that it
5 is a no-pass on the evidence.

6 CO-CHAIR SAKALA: So, I think that
7 actually what you are discussing is a little
8 later down the road in our discussion. I have
9 heard you say it should be the same as the other
10 evidence around --

11 DR. WINKLER: Well, it is just I would
12 say in terms of we just talked about a measure
13 that was about cesarean section rates. And this
14 is a measure about cesarean section rates. They
15 are very different. But nonetheless, it is still
16 measuring the same concept. And for evidence, we
17 are talking about the concept, not the specifics
18 of the measure, per se. That will come later on
19 when you are looking more at the reliability and
20 validity of the specifics of this particular
21 measure.

22 This is an outcome measure. If you

1 want to, we can quibble over it. It is a new
2 media or an outcome measure. And so really the
3 requirement for evidence for outcome measure is
4 are there processes, structures processes or
5 other activities care that can influence the
6 outcome and that is really the question for the
7 criteria for an outcome measure.

8 CO-CHAIR SAKALA: So, hold that
9 thought, Nancy, about other concerns. But let us
10 first assess whether the evidence is there for
11 improvability.

12 MEMBER LOWE: So, then we are talking
13 at the very high level, not this specific
14 measure, but we are talking at the high level.

15 CO-CHAIR SAKALA: Yes, about the
16 concept right now.

17 MEMBER LOWE: Okay.

18 CO-CHAIR SAKALA: And we will need to
19 vote on this, even though it is the same as what
20 we voted on.

21 MEMBER LOWE: It doesn't matter. This
22 is a new measure. It gets evaluated against

1 everything.

2 CO-CHAIR SAKALA: Okay. So, shall we
3 -- somebody down there go ahead?

4 MEMBER FLANAGAN: It was my
5 understanding in evaluating evidence that not
6 only was there a theoretical idea that you could
7 lower C-section but there was in fact an
8 intervention and a tested intervention that
9 showed that. And this measure makes the claim
10 that labor management affects C-section but there
11 is no testing of this anywhere.

12 So, I mean if you feel that my
13 comments are not relevant to the evidence here, I
14 will say it again, but honestly, I think that
15 almost every other measure we have evaluated has
16 some published data that shows something of
17 direct relevance to the measure and I don't see
18 that cited here.

19 CO-CHAIR SAKALA: No, you don't have
20 to do that. I just wonder if we should wait
21 until we get to the right place for this and just
22 --

1 DR. WINKLER: It will be helpful if we
2 go through the criteria appropriately but, as I
3 said, evidence is around the topic area, not
4 necessarily the specifics which is why, if you
5 noticed, we had several measures on infection.
6 They weren't the same but the evidence ultimately
7 will be the same for supporting both of them.
8 Similarly, I think we have got two measures that
9 address the issue around cesarean section. So,
10 the evidence should be similar, even though some
11 of the details, once we get into the specifics of
12 the measure, and the differences are where you
13 are going to have some divergence.

14 CO-CHAIR SAKALA: Diana, do you have
15 a comment about that first section? Okay.

16 MEMBER JOLLES: I just wanted to
17 mention the, and I apologize for not knowing how
18 to pronounce her name, Kozhimannil article that
19 was published in 2013. I'm concerned about its
20 lack of inclusion in the summary of evidence.

21 No one here can argue that risk
22 stratification and risk adjustment is important

1 in this outcome and that there has been
2 incredible epidemiologic large database studies
3 that show that these things affect cesarean rate.
4 However, importantly, what has been shown is that
5 actually low-risk women are more affected by
6 unwarranted variations in care and supply-
7 sensitive variation than women with risk factors.
8 And just because part of what we are supposed to
9 be doing is talking about our personal experience
10 and bringing our content expertise to the table,
11 I was just asked about Tuba City, the section
12 rate and their diabetes rate. Thirty percent
13 diabetes rate, primary section rate of nine
14 percent.

15 And if you look at the hospitals that
16 achieved the lowest cesarean section rate in the
17 Consumer Reports articles over the years, they
18 have very much held a high-risk population.

19 So, I am concerned about evidence.
20 I'm not discounting the evidence here. I'm just
21 saying that there is more evidence out there and
22 that the issue is complex.

1 CO-CHAIR SAKALA: Okay. So, the
2 evidence out there supports the importance of
3 this measure and the opportunity to improve.

4 Can we take a vote, please, on whether
5 the evidence is there for this measure concept?

6 MS. ROBINSON-ECTOR: Voting is now
7 open for evidence of Measure 2892.

8 All the 27 votes are in and voting is
9 now closed.

10 Ninety-six percent voted yes and four
11 percent voted no.

12 So, for evidence of Measure 2892, the
13 measure passes.

14 CO-CHAIR SAKALA: Okay and I think
15 probably our discussants would agree that the
16 opportunity for improvement is there. That is
17 the nature of the conversation that we have had.

18 DR. WINKLER: Yes, but we do want to
19 look at the specific data generated by this
20 measure because now we are talking about some
21 specifics, if at all possible. Because, in all
22 honesty, it is quite a different measure as you

1 start adding in the multiparous patients. You
2 have a much different denominator population.

3 CO-CHAIR SAKALA: Okay. So, do the
4 discussants want to add anything else to what you
5 have said so far?

6 Okay, Matt.

7 MEMBER AUSTIN: Yes, I noticed that
8 the data provided I think are from 2005 to 2007.
9 Do you have any more recent data that would
10 reflect what variation is? And also I think the
11 data were just from one state as well.

12 DR. SAN ROMAN: Correct. That is the
13 only data that I have.

14 CO-CHAIR SAKALA: And some of the
15 other data were excluding New York City from New
16 York State. Could you talk about your population
17 that you are adjusting to?

18 DR. SAN ROMAN: Sure. The data was
19 obtained from New York State Department of
20 Health. And there is two different systems, at
21 least at the time that I requested the data
22 between the city hospitals and the rest of the

1 state. So, the Department of Health had access
2 to the rest of New York State, not including the
3 city hospitals. So, the data that I have is from
4 hospitals outside of the five boroughs.

5 CO-CHAIR SAKALA: Okay. Matt, do you
6 have another comment? Okay.

7 Other comments? Jennifer.

8 MEMBER BAILIT: Hi, so I have lots of
9 issues with this measure but let me start on the
10 one that I think is relevant for performance,
11 which is that you say that the individual has an
12 appropriate level of evaluation for this and we
13 have shown that pretty much -- and I do have, as
14 you have mentioned, a lot of experience with
15 logistic models for this -- that it is inherently
16 unstable to look at the individual because there
17 is never enough numbers with any one person to be
18 able to get confidence intervals around the
19 expected-to-observed rates to get any sort of
20 stability and to know whether are falling outside
21 of.

22 So, can you tell us why yours would be

1 different than any other model, in terms of
2 numbers, since it is essentially a math problem
3 with a small problems when you get down to the
4 level of the individual?

5 So, I guess that is my question and my
6 comment.

7 DR. SAN ROMAN: That's correct. We
8 always worry about small numbers when are looking
9 at the individual and some doctors perform more
10 births than others. And some of the data that I
11 have brought into the submission show a hospital
12 that has 86 providers in it. And we do the
13 statistical analysis comparing the providers to
14 the average. And if they are statistically
15 significantly different from the average, based
16 on their numbers and their result, then we could
17 say that. If their numbers are small, they would
18 not be statistically significant.

19 MEMBER BAILIT: Right but the problem
20 is, if they have small numbers, they will never
21 fall outside the statistical significance. So,
22 your confidence intervals are so wide as to be

1 meaningless, typically.

2 DR. SAN ROMAN: Right. For those
3 providers, there will be some providers have
4 larger numbers and the confidence intervals will
5 give you the ability to determine that are they
6 significantly different or not.

7 I think what you can see at the
8 provider level is that there is a hospital that I
9 put in the submission that the hospital falls out
10 of the confidence interval as a hospital that is
11 doing too many cesarean births.

12 But if you look at the 90 or so
13 providers that are in that hospital, 80 percent
14 of them don't fall out. So, you have got 20
15 percent of the providers who are doing about 25
16 percent of the deliveries in that hospital that
17 that is where our problem is in that hospital,
18 not the whole hospital.

19 MEMBER BAILIT: I would argue that
20 your problem is small numbers for the other 80
21 percent.

22 DR. SAN ROMAN: Okay.

1 CO-CHAIR SAKALA: Kim.

2 CO-CHAIR GREGORY: I would just agree.

3 I agree with Jennifer.

4 CO-CHAIR SAKALA: Naomi.

5 MEMBER SCHAPIRO: So, here is my
6 difficulty about this. It seems like there is
7 definitely a performance gap like globally. But
8 just looking at this measure, I have some
9 concerns about the narrowness in which the data
10 were drawn and especially being drawn so long
11 ago.

12 For example, we have been talking
13 about the transition from the individual
14 obstetrician coming and delivering the baby to
15 laborists. And that has been really accelerated,
16 I think, in the last maybe ten years. I mean it
17 is not exactly my field but it is really a big
18 trend now and it hasn't been then.

19 So, if you have laborists and they do
20 come and go. So, you have laborists who are on
21 for a certain amount of time and then maybe
22 somebody else comes on shift in a way and

1 delivers the baby. That is really the
2 combination of two people's decisions during the
3 labor management. And so if you are just going
4 to put that on the person who actually did the C-
5 section, it might not be fair.

6 So, I am just having some trouble.
7 And again, I'm not expert. I am really more with
8 the teens trying to keep them from getting
9 pregnant but I am just having some trouble
10 wrapping my head around this as a concept in this
11 particular measure.

12 CO-CHAIR SAKALA: Yes.

13 DR. SAN ROMAN: So, let me just add
14 something to that statement because I think that
15 is very important.

16 What I have been doing is now the
17 National Vital Statistics has made available
18 national data. So, the 2011 birth certificate
19 data is available and I have pulled it into the
20 data set. So, the data set now has 2.4 million
21 deliveries in it.

22 So, now there is a greater volume of

1 cohorts that could be used to find the cohort of
2 100 patients. However, that data is not
3 hospital-specific. It is not provider-specific.
4 It is not even state-specific. So, I can't do
5 any analysis on that data itself, other than
6 providing a much more robust data set to find the
7 100 patients that we are going to compare to.

8 I always find in obstetrics, and I am
9 one of those dinosaurs in solo practice. I have
10 been doing it 26 years but I find that it is the
11 person who initiates the labor management plan
12 that really should take the responsibility for
13 how that labor is managed. And that could be the
14 doctor who comes in and admits the patients, says
15 we need to induce you because whatever. The guy
16 who comes on shift now is stuck with whatever his
17 predecessor has given him. So, in my mind, that
18 is really the person who should carry the weight.

19 And this is a new measure. So, I just
20 have the data that I have but the goal to move
21 forward is not to look at the individual provider
22 because it is a team of providers. I think the

1 lowest level you can look at is whatever that on-
2 call group is. If there is a group of four
3 doctors that share call, I think that really
4 would be the lowest level that you can look at
5 fairly.

6 Because even in our own institution,
7 we see doctors that are within a group who always
8 pass off the patients to somebody else and the
9 somebody else ends up doing the C-section.

10 The other is if you look at a team or
11 an on-call group, you can include midwives in
12 this measure. You can include birthing centers
13 that initiate a labor management plan and then
14 they will actually have a C-section rate because
15 that patient who needed to get transferred to the
16 hospital now would count against where that labor
17 management was initiated.

18 CO-CHAIR SAKALA: Nancy.

19 MEMBER LOWE: Yes, I'm struggling with
20 how to move us forward a little bit with this
21 because I think that in all the time, which was
22 considerable, I spent on this measure, when I

1 think of our purpose in NQF, I am not sure how,
2 at this point, this complex of a measure could
3 have much usability or feasibility for public
4 information that would be interpretable, for want
5 of a better word, by the general public.

6 And I am also struggling with the fact
7 that the analyses presented, the seven maternal
8 factors and so forth, are based upon historical
9 data from the data set. So, risk is calculated
10 on the basis of what happened to that woman,
11 which is, indeed, a reflection of what the
12 provider did.

13 So, to me, there is another step in
14 the analysis, which is teasing apart the provider
15 from the woman, which is multi-level modeling is
16 what that really is, from a statistical
17 standpoint.

18 So, I think there is more work to be
19 done. For example, publishing your work, where
20 it gets peer-reviewed by the scientific community
21 and showing how the measure, indeed, is related
22 to outcome would help us a lot.

1 So, I mean that is just where I am and
2 I am struggling with that whole piece.

3 CO-CHAIR SAKALA: Thank you. So,
4 could we have a quick response, please and then
5 Naomi and Juliet. And then let's plan to vote on
6 the question of opportunity for improvement. We
7 just need to go through the criteria to get to
8 the right point, so that we can weigh it.

9 MEMBER LOWE: Yes, right.

10 DR. SAN ROMAN: Quick response.
11 Totally agree that my work should be published.
12 I presented it to a dozen journals and it is
13 complicated. And as you see here in this
14 committee, it is not all that easy to grasp and I
15 am not the best person, perhaps, presenting that
16 information or writing it on paper. But the
17 responses I got from editors was it is good work
18 but maybe it is not important enough to be
19 published. But I have attempted to publish the
20 work.

21 CO-CHAIR SAKALA: Thank you. Juliet,
22 do you have a final comment before we vote on

1 opportunity for improvement?

2 MEMBER NEVINS: I had a question about
3 the cohort comparison. I think Nancy just
4 answered that. So, I will just end by saying
5 that I agree with your comments with respect to
6 the complexity of this model and the potential
7 for use.

8 CO-CHAIR SAKALA: Okay. So, could we
9 open the voting please for opportunity for
10 improvement using this measure?

11 MS. ROBINSON-ECTOR: Voting is now
12 open for performance gap for Measure 2892.

13 All the votes are in and voting is now
14 closed.

15 Seven percent voted high, twenty-six
16 percent voted moderate, twenty-eight percent
17 voted low, and nineteen percent voted
18 insufficient. So, this would be a grey zone.

19 DR. WINKLER: No, it's not. So, the
20 measure fails. And one thing I want to make
21 clear -- because we will stop at this point --
22 one thing I just want to understand is the

1 rationale. And is it because essentially the
2 data we have that is used in this measure is from
3 almost a decade ago and the performance is old,
4 in terms of this particular criteria? I know we
5 have talked about a lot of other things. I am
6 just wanting to be sure I can explain your vote
7 on this criteria.

8 MEMBER BAILIT: So, I think this is a
9 couple-fold. The question is can we change
10 performance gaps with this measure. My answer is
11 now for a couple of reasons. One is that it is
12 focused on the individual or the practice level
13 and not at a high enough level. Two, the methods
14 are non-standard. They are close to the
15 standard, sort of standard ways that people do
16 this but they are off enough and they are complex
17 enough -- and I will be honest, I stopped
18 publishing the stuff that you referred to because
19 Elliott came out with these NTSV and it was so
20 much cleaner and crisper and more usable that I
21 just stopped.

22 Yours is even more complex. So, I

1 think the ability to explain it -- if you can't
2 explain it to this group, your average 19-year-
3 old having a baby is going to have a really hard
4 time with it.

5 So, to the extent that I think this
6 measure can move us forward to change the
7 problems that we have, I'm concerned.

8 DR. WINKLER: Any other comments? I
9 just want to be able to reflect the reasoning
10 behind the vote. That's all.

11 CO-CHAIR SAKALA: Matt, your
12 rationale?

13 MEMBER AUSTIN: Yes, my rationale was
14 that the data are almost a decade old now and
15 that they were data just for one state. And I
16 think we have seen that practice patterns can
17 vary by region of the country. And so for me, it
18 was a very narrow snapshot of what data could
19 look like.

20 CO-CHAIR SAKALA: Nancy?

21 MEMBER LOWE: Yes, I think that the
22 performance gap that is represented is

1 represented from this very focus from 2005 to
2 2007 from New York and I think what we are
3 reacting to is our lack of confidence in this
4 measure to move that a performance gap in the
5 cesarean delivery rate. And I am not sure if
6 that is the exact question we are supposed to
7 answer, Reva, if we are a little bit beyond that
8 one question of the performance gap because I
9 think we all agree there is a performance gap in
10 cesarean delivery.

11 DR. WINKLER: But you're right. This
12 one is, we are talking about this particular tool
13 for understanding that gap. And so you are
14 right, there is an influence of how the tool work
15 --

16 MEMBER LOWE: Yes.

17 DR. WINKLER: -- for interpreting what
18 the actual results show us.

19 Cindy, did you have a comment?

20 MEMBER PELLEGRINI: Yes, I am hoping
21 you can clarify. And I think you just answered
22 part of this. But I am perplexed and a little

1 troubled that the vote on this is different from
2 the vote on the previous measure. Where on the
3 previous measure we said yes, big gap, big
4 problem and here we are like well, maybe not so
5 much.

6 I understand that there is the
7 influence of the tools here but you said on the
8 evidence we are dealing solely conceptually.
9 Here, we are dealing -- I just want to be clear
10 that we are talking about the performance gap no
11 longer just conceptually with regard to all C-
12 section and all that. Now, we are talking about
13 specifically whether this tool is useful for
14 closing that gap or addressing it.

15 DR. WINKLER: It is both the tool but
16 also the data that was presented by the developer
17 to make the case. And so we are not asking you
18 to go elsewhere and look at it.

19 Certainly, for a maintenance measure
20 if it were, we would absolutely would want to see
21 data from the use the measure.

22 MEMBER PELLEGRINI: Right.

1 DR. WINKLER: And so when we are able
2 to have that on the initial, that is also good
3 because, again, it is the use of that particular
4 tool to do the measurement to collect the data.

5 MEMBER PELLEGRINI: Right. Like I
6 mean I would have no trouble -- I hear the
7 concerns. I think they are largely on validity,
8 feasibility, usability. I think we look
9 inconsistent by saying the evidence may or may
10 not show a performance gap when we all know there
11 is a performance gap in this area.

12 CO-CHAIR SAKALA: Cindy, I just want
13 to read the Pathway Guide that we got for this
14 process. The first bullet here is briefly
15 describe any data presented on current
16 performance using this measure. Is there
17 opportunity for improvement?

18 MEMBER PELLEGRINI: On other measures,
19 we have accepted the other similar evidence or
20 past evidence.

21 DR. WINKLER: I think Cindy is raising
22 an important point for the committee to consider

1 in terms of is that the important part. But
2 remember that you are asked to look at the data
3 that was presented in front of you. And if your
4 concern was with that data, that is a legitimate
5 concern as well.

6 CO-CHAIR SAKALA: So, Naomi?

7 MEMBER SCHAPIRO: Yes, I mean in a way
8 I was sort of ceding to the expertise of the
9 folks in the room who have really looked at this
10 in-depth. But to me what actually solidified it
11 was that you said you hadn't been able to get it
12 published in any peer review journals. And I
13 feel like if there had been a history of
14 publication and then other people using the tool
15 and some evidence that it actually was really
16 helpful, I would have been more predisposed.

17 I voted insufficient because I just
18 felt like there wasn't enough evidence that this
19 could really add to the discussion in the
20 measurement of gaps.

21 CO-CHAIR SAKALA: Okay, and one more.
22 Matt? Oh, Jennifer, too.

1 MEMBER BAILIT: No, that's okay.

2 MEMBER AUSTIN: I mean I guess I
3 looked at it as sort of directed, which is when I
4 looked at the Joint Commission measure they
5 presented data from 2011 through 2014. Those
6 data represent national data.

7 Agreed that where we are at in the
8 healthcare space is no different with this other
9 measure but the data presented there was for 2005
10 to 2007 and was just one state.

11 So, for me, based on the instructions
12 we were given, that is how I was evaluating the
13 situation.

14 CO-CHAIR SAKALA: Yes, so is everyone
15 comfortable with staying where we are right now?
16 One dissent, maybe.

17 Okay, thank you.

18 Kim, we are going to turn it over to
19 you now.

20 CO-CHAIR GREGORY: The folks from
21 Children's Hospital of Philadelphia are tied up
22 and so we need to --

1 DR. LORCH: So, I am here but I will
2 probably have to leave in about 15 minute at the
3 very latest.

4 CO-CHAIR GREGORY: Okay.

5 DR. LORCH: I have got a moderating
6 session to go to.

7 CO-CHAIR GREGORY: And Scott, when
8 will you be finished?

9 DR. LORCH: If I push that late, I
10 mean I could probably go to 11:45 and be
11 available for about 20 minutes then. Then, I am
12 tied up until you guys are done as well.

13 Whatever is easiest for you guys.

14 CO-CHAIR GREGORY: Okay, go for it.
15 We'll go for it now.

16 DR. WINKLER: I think we are going to
17 go for it.

18 CO-CHAIR SAKALA: And there is a
19 request for you to speak up a little louder,
20 please.

21 DR. LORCH: Okay, I'm on my cell
22 phone, so I apologize for that. I will do the

1 best that I can. I will be quick on the
2 presentation of the initial measure that many
3 people have that in front of them and then spend
4 a little bit of time answering some of the
5 questions that were brought up in the work group
6 meeting that was held a couple of weeks ago.

7 This is a measure of neonatal all-
8 cause readmission rates, which parallels other
9 measures previously endorsed by NQF, including a
10 pediatric all-cause readmission rate and several
11 readmission rates in the adult literature.

12 The goal of this measure was to
13 evaluate potentially different aspects of care
14 quality from the inpatient/outpatient side,
15 including transitions of care and education of
16 high-risk families.

17 Data from our group and data that we
18 presented in this application suggests there is
19 approximately a 200 to 250 percent gap in
20 readmission rates at 30 days after discharge
21 between hospitals, when you have similar patients
22 of dissimilar gestational ages.

1 Infants, we propose a risk-adjusted
2 model as much for face validity as anything else.
3 Data suggests that younger gestational age and
4 the presence of a chronic complication of preterm
5 birth, including necrotizing enterocolitis,
6 intracranial hemorrhage and/or bronchopulmonary
7 dysplasia does raise the likelihood of a
8 readmission at the patient level. However, data
9 that we have done does not support well, really
10 supports a marginal change in the risk-adjusted
11 rate of readmission compared to unadjusted rates
12 at the hospital or state level.

13 However, because most neonatologists
14 would like to see everything risk-adjusted, at
15 least by gestational age, we proposed a risk-
16 adjusted model weighing the challenges of an
17 added complexity of a model of that nature
18 compared to having just an unadjusted measure.

19 To answer some of the questions that
20 were raised in the work group, the choice of
21 gestational age in this measure was infants born
22 at 23 to 34 weeks. That measure, that time

1 period was chosen to ensure infants who died by
2 gestational age categories would be almost 100
3 percent of the unit in the country admitted
4 automatically to that unit.

5 Infants below 23 weeks, there is high
6 variation in the aggressiveness of resuscitation
7 between units, leading us to be very leery about
8 including such gestational ages into any sort of
9 measure.

10 And infants beyond 34 weeks, while
11 having a nontrivial and indicated a very elevated
12 readmission rate, run into the problem of the
13 reasons for such readmission.

14 So, for infants 35 weeks and above,
15 about 80 percent of the readmissions are
16 secondary to jaundice and hyperbilirubinemia,
17 where there is some controversy about what an
18 acceptable readmission rate would be for those
19 infants, compared to needing to keep those
20 infants in the hospital for one, two, or three
21 extra days for further observation.

22 CO-CHAIR GREGORY: Hello?

1 MS. ROBINSON-ECTOR: Scott, are you
2 still there?

3 MS. THEBERGE: Operator, did we lose
4 Scott?

5 OPERATOR: Yes, his line disconnected.

6 CO-CHAIR GREGORY: Okay, discussant,
7 you want to start with a conversation about the
8 evidence?

9 MEMBER YOUNG: So, I will start with
10 a summary for this. This is essentially NICU
11 graduates from the ages of 23 to 34 weeks, who
12 are readmitted within 30 days of initial NICU
13 discharge, all-comers.

14 And the evidence that they provided
15 for us was about a ten-year set of data from
16 California and it was listed in Appendix 1, in
17 which it showed an incredibly wild variation in
18 readmission rates.

19 CO-CHAIR GREGORY: This is actually
20 between 23 and 34 weeks.

21 MEMBER YOUNG: Sorry, between 23 and
22 34. I apologize. I misspoke. Yes, NICU

1 graduates between 23 and 34 weeks within 30 days
2 of NICU discharge, their readmission rate.

3 CO-CHAIR GREGORY: So, from an
4 evidence perspective.

5 MEMBER YOUNG: So, my initial take on
6 the evidence presented was that this -- looking
7 at neonatal readmission rates or NICU grad
8 readmission rates was varied among the state of
9 California. That is just the one section.

10 And then there was some additional
11 data presented from New York and Utah, as well,
12 that I actually was able to find in the
13 literature and their rates were even more varied
14 from just California to New York.

15 So, the evidence out there is that
16 there is a high level of readmission rate but the
17 variance is so wild that it is very difficult to
18 assess whether this measure may or may not
19 provide any remedy.

20 DR. WINKLER: I just want to remind
21 you in terms of what the questions are around
22 evidence. This is an outcome measure. And,

1 therefore, what you are looking for is are there
2 any structures process of care that can influence
3 the outcome.

4 The data on the actual results is
5 around the gap opportunity for improvement.

6 So, you have got two different things.
7 So, it can get conflated but as we vote on them
8 sequentially, it is good to keep in mind what is
9 what.

10 CO-CHAIR GREGORY: Sindhu?

11 MEMBER SRINIVAS: It seems like the
12 evidence for this measure is similar to the
13 evidence for hospital, like adult, as I think
14 Scott was alluding to, the adult readmission
15 rate, and the idea that you improve transitions
16 of care on one hand to offset the time of
17 discharge could potentially alter readmission
18 rates that are unnecessary or avoidable.

19 CO-CHAIR GREGORY: And he also alluded
20 to the fact that there is already a pediatric
21 measure.

22 So, is everyone agreeable with being

1 able to vote on the evidence?

2 MS. ROBINSON-ECTOR: Voting is now
3 open on Measure 2893 for evidence.

4 (Voting)

5 CO-CHAIR GREGORY: And then if we can
6 have a --

7 MEMBER YOUNG: So for -- I'm sorry,
8 we're doing the next section, right? After
9 evidence?

10 CO-CHAIR GREGORY: No, we have to --
11 she has to tell us if it was approved or not.

12 MEMBER YOUNG: Oh.

13 MS. ROBINSON-ECTOR: Yes. We are
14 still missing one vote. We need 27. Thank you.

15 (Voting)

16 CO-CHAIR GREGORY: Scott, hold on. I
17 think we hear that you're back.

18 MS. ROBINSON-ECTOR: Okay. If
19 everyone could try to revote one more time,
20 please. That would be great.

21 (Voting)

22 MS. ROBINSON-ECTOR: Okay. Great.

1 Twenty-seven votes are in and voting is now
2 closed. Ninety-six percent voted yes. And four
3 percent voted no.

4 So for evidence, Measure 2893, the
5 measure passes.

6 CO-CHAIR GREGORY: So operator, is
7 Scott back?

8 OPERATOR: He has not joined the phone
9 line.

10 CO-CHAIR GREGORY: Okay. Then we're
11 going to keep going.

12 And now we do gap.

13 MEMBER YOUNG: So, in terms of gap,
14 what the author was saying is that there are --
15 there is a gap as mentioned previously.

16 And that gap is mostly due to the
17 quality of discharge planning, antibiotic use
18 during the inpatient stay. And the quality of
19 outpatient care.

20 And that in terms of disparities,
21 there was a high rate of African-American, black
22 individuals having higher rates of readmission.

1 DR. LORCH: This is Scott Lorch, I'm
2 back.

3 CO-CHAIR GREGORY: Hi Scott. We're
4 actually moving through voting. And --

5 DR. LORCH: Okay. That's fine.

6 CO-CHAIR GREGORY: Actually, if you
7 could stay on the line, if there are questions
8 that come up. Just so that you know --

9 DR. LORCH: Sure.

10 CO-CHAIR GREGORY: The first vote was
11 based on the evidence. And it was a vote in
12 favor that there's potential structural process,
13 or variables that could be -- that could
14 influence the outcome.

15 And therefore, we're moving through,
16 we are now discussing whether there's a gap. And
17 the discussants have indicated that there is one.
18 And we are -- unless there are any objections, we
19 are ready to vote on that. No? Okay.

20 MEMBER SHEA: I just have a question.
21 In terms of the data that you presented, if
22 there's any more recent data? You presented data

1 from 2006 to 2009.

2 DR. LORCH: So, we are obtaining the
3 data. Yes. This is a difficult data set to get
4 research on.

5 And so, yes, there will be more data.
6 California is the best data source for this.
7 But, it will take a little bit of time from that
8 standpoint.

9 National data set specialists like NIS
10 and KID don't have the readmission slag, which
11 allow us to have more recent data more readily
12 available.

13 But the data do exist for more recent
14 data. We just have to now finalize the obtaining
15 of the data and run the same analysis.

16 CO-CHAIR GREGORY: The references are
17 as current as 2013 though.

18 DR. LORCH: Well actually --

19 CO-CHAIR GREGORY: The data
20 references.

21 DR. LORCH: I didn't hear that.

22 CO-CHAIR GREGORY: I made a comment

1 that the references cited are as current as 2013.

2 DR. LORCH: That is correct.

3 CO-CHAIR GREGORY: So, if there are no
4 objections, we are going to vote on whether or
5 not there's a performance gap.

6 MS. ROBINSON-ECTOR: Voting is now
7 open for performance gap, Measure 2893. Option
8 one is high, two is moderate, three is low, and
9 four is insufficient.

10 (Voting)

11 MS. ROBINSON-ECTOR: All the votes are
12 in and voting is now closed. Fifty-four percent
13 voted high. Forty-two percent voted moderate.
14 Four percent voted low. And zero voted
15 insufficient.

16 So, for performance gap of Measure
17 2893, the measure passes.

18 CO-CHAIR GREGORY: So, now we're going
19 to move to a discussion on reliability.

20 MEMBER SHEA: So in terms of
21 reliability, this is -- it's administrative
22 claims data, electronic clinical data and

1 electronic health record at the level of the
2 facility and of the State.

3 And when I was reviewing this measure,
4 I thought about, actually it's more the
5 feasibility of actually collecting this data at
6 the state and facility level. But, looking at,
7 you know, border States and you know, where do
8 you put the child?

9 Do you put them in the hospital where
10 they delivered? Or put them in the State that
11 they reside in? And that there would be an issue
12 in terms of the State level data.

13 And I'll leave it at that. And you
14 know, get to feasibility later.

15 CO-CHAIR GREGORY: Any other comments?
16 Sheila?

17 MEMBER OWENS-COLLINS: Let's see, I
18 have a comment. I have a comment and a question.
19 I think this is a very relevant measure.

20 And speaking from the Medicare side,
21 these -- the micro preemies or the incidence in
22 the State of Maryland is increasing. And not

1 only are they high cost in the nursery, but
2 they're also high cost in the first year of life.
3 We're looking at that.

4 And I would bet that they also have
5 frequent ER visits. But, I know that's not a
6 progress measure.

7 But, I was wondering why congenital
8 anomalies was excluded? Because that is a
9 function of subspecialty care.

10 And I think at some point during the
11 conference call the availability of subspecialty
12 care as well as primary care providers was
13 mentioned as a factor. And the availability of
14 these providers as a factor in reducing the
15 admission rate.

16 DR. LORCH: Sure. I'm happy to answer
17 that question very briefly.

18 We felt that the distribution of
19 congenital anomaly patients between hospitals
20 were dramatically different then the distribution
21 of the typical premature infant. And we were
22 uncertain whether risk adjustment would

1 adequately be able to adjust for that issue.

2 And so we felt like it was a safer
3 measure to just look at the prematurely born
4 infants without a congenital anomaly. Many of
5 the congenital anomaly patients are born closer
6 to term.

7 But even if they're not, they're more
8 of a late pre-term period. It's just was a
9 little more of a reliable measure when we took
10 out those patients.

11 I readily agree with what your
12 comments are. It's just the reliability became a
13 little more challenging by including those
14 patients in the model.

15 MEMBER OWENS-COLLINS: Okay. Thank
16 you.

17 CO-CHAIR GREGORY: Any other comments?
18 Yes, Jaleel?

19 MEMBER MAMBARAMBATH: Yes. Like
20 Karen, I'm still a little -- finding it difficult
21 where to place this. Whether to place this in
22 reliability or feasibility.

1 But, since -- I thought I'd bring it
2 up over here because this question might spill
3 over to feasibility as well. But, since the
4 level of analysis is at the facility level or the
5 State level, I thought I would bring it up over
6 here.

7 So, this measure was tested with
8 hospital data from the California patient
9 discharge data, emergency department, ambulatory
10 surgery and a birth cohort linked with Vital
11 Statistics.

12 Now, -- and the developer and some of
13 the Committee members also brought this up that
14 there are similarities between this measure and
15 measures for readmission for pediatric patients
16 and for adult patients.

17 But, I think this is slightly
18 different because there are two different kinds
19 of NICUs. One is the delivery hospital NICU
20 where there is a mother and baby therein. And
21 there are also freestanding children's hospital
22 NICUs.

1 So, whenever a baby gets discharged
2 from a facility which only takes care of mothers
3 and babies, those babies do not get readmitted to
4 the same hospital. They get readmitted to a
5 pediatric hospital.

6 So, if you are looking at this at a
7 facility level, it might not be feasible. So, I
8 don't know whether this is -- if it's possible to
9 replicate this in other States and nationwide.

10 DR. LORCH: So we also have the data
11 for other States. Even some more administrative
12 data. When I think if you want to see, if the
13 question is whether the hospitals themselves can
14 obtain the data, they can. Many of them do not.

15 It doesn't take one of two issues.
16 One is a more regionalized electronic health
17 record if one is going to use such information.
18 Currently most hospitals do follow up with their
19 patients by phone if they're not going to
20 readmit.

21 Because even at a children's hospital,
22 they may not be readmitted at the same hospital.

1 That definitely is a situation that does not
2 always happen.

3 They could definitely be readmitted at
4 a nearby community hospital such -- depending
5 again on the -- where they live. And what the
6 preference of the outpatient provider was to
7 that.

8 So, it's definite at the State level
9 from the administrative perspective that type of
10 linkage allows you to see -- and both at that
11 level as well as the insurance level, you can see
12 where the patients were readmitted.

13 If the data are being collected at the
14 level of the hospitals themselves, what most
15 facilities are currently doing is doing primary
16 data collection of their patients after they come
17 home.

18 CO-CHAIR GREGORY: Raj?

19 MEMBER WADHAWAN: I had similar
20 concerns as what Jaleel raised. Because it's not
21 just the children's hospital issue. It's also a
22 very regional issue.

1 And I don't know how you would use
2 this nationally. Because there are communities
3 with three children's hospitals for a million
4 population. And there are communities with one
5 children's hospital and four million population.

6 So, where patients get admitted can be
7 quite variable. And who do you assign that to?
8 And how do you capture all of those patients, is
9 I think is a real reliability and feasibility
10 issue in this.

11 CO-CHAIR GREGORY: Janet?

12 MEMBER YOUNG: I was going to echo
13 that sentiment. I happen to work for a large
14 health system in Southwest Virginia that also
15 includes a catchment area from West Virginia and
16 Tennessee.

17 We are the regional children's
18 hospital as well. And so several of those are
19 states apart.

20 So, for us, this measure would be from
21 a reliability factor, would be quite difficult.
22 And also, it's a significant threat to validity

1 in terms of readmitting to a completely different
2 institution in a different State away.

3 CO-CHAIR GREGORY: Sheila?

4 MEMBER OWENS-COLLINS: So, you know,
5 we're in the era of HIEs. And so, I think that's
6 going to help with the information flow between
7 facilities as a first point.

8 And then the second point, especially
9 for Medicaid, the Medicaid population, you know,
10 I would think that the MCOs and care managers
11 would be better apt and able to track these
12 patients across facilities.

13 So, that may determine at what level
14 you want to make this metric.

15 CO-CHAIR GREGORY: So, I would like to
16 ask a question to the developer. Would not these
17 patients be picked up under the pediatric
18 readmission code because they're pediatric cases?

19 DR. LORCH: That's a great question.
20 And I know the developers rather well of the
21 pediatric one. They were, I don't want to say
22 explicitly excluded, but they were sort of

1 excluded from the measure.

2 The challenge is identifying them in
3 the data set explicitly. Which can become a
4 difficult because gestational age is not
5 necessarily in the data that are presented for
6 the pediatric measure itself.

7 So, we're actually working on that
8 very question of how well it's being captured.
9 But, both of us believe that it is a separate
10 measure itself. I'll leave it at that.

11 CO-CHAIR GREGORY: Okay. I understand
12 that the developer is going to have to leave in
13 about five minutes. So, I'm going to take an
14 opportunity to allow the panel to ask questions
15 that might be a little bit out of order so that
16 he has the opportunity to respond.

17 So, Jaleel, did you have any other
18 issues that you wanted to talk about?

19 MEMBER MAMBARAMBATH: Yes. The
20 question is whether there are structures and
21 processes available right now as we speak to
22 capture this information? I have not got a clear

1 answer on that from the developer.

2 DR. LORCH: At what level? And so,
3 there definitely are some at an insurance level.
4 There are at the facility level. They vary
5 between facilities.

6 As I said, most of them do rely on
7 primary data collection and follow up of the
8 families themselves. And/or contacting the primary
9 care physician who's maybe seen the patient after
10 discharge.

11 Explicit HIE types of capture rate are
12 in process. But there's nothing currently done
13 that I'm aware of that is being rolled out at the
14 present time.

15 And that obviously does include going
16 with the border State question that arise from
17 that.

18 MEMBER MAMBARAMBATH: I'm still not
19 convinced about this. I just want to give an
20 example of my own institution.

21 We have about four NICUs. Three of
22 which are delivery NICUs. And within those three

1 NICUs we have about 20 thousand deliveries that
2 happen.

3 And I am really interested in getting
4 this information. And have not had a chance to
5 get this information about readmissions to
6 different children's hospitals. There are three
7 different children's hospitals within the city.
8 And multiple other community hospitals.

9 So, I am not convince that yes, that
10 information is currently available. And also,
11 from the insurance point of view, some of these
12 are insurance still -- which is still not -- it's
13 still pending. Medicaid is pending and things
14 like that when they're discharged from the
15 hospital

16 So, I'm not sure whether we'll be able
17 to get that information from the insurance
18 companies. And insurance companies change as has
19 been mentioned in the document by the developer
20 himself.

21 And the other issues which has been
22 part of that already. I don't want to redirect

1 that again.

2 CO-CHAIR GREGORY: And for a point of
3 clarification, you intent would be that this
4 would always be obtained through a linked data
5 set?

6 DR. LORCH: That is what the
7 information that we currently have for this
8 measure. I'll leave it at that.

9 But yes, I think from a statewide
10 perspective that is the most efficient way to get
11 the information. And then deliver it back to the
12 hospitals themselves.

13 CO-CHAIR GREGORY: Greg?

14 MEMBER GOYERT: Just to clarify. So,
15 this measure as it stands now from the
16 developer's perspective is going to require new
17 data collection, correct?

18 DR. LORCH: And/or linkage of data
19 that many States do not give, yes.

20 CO-CHAIR GREGORY: Sheila?

21 MEMBER OWENS-COLLINS: I think this is
22 extremely important. Because this is a very

1 costly issue. Especially for health plans.

2 And health plans are, you know, at
3 least the ones that I have been working at now
4 and have worked at, are very interested in this
5 data. And they, you know, they are looking at
6 it.

7 You know, and it is possible that
8 there could be some cooperation at the State
9 level to look at this issue. Because, I mean,
10 these babies are just extremely costly. Not only
11 in the NICU, but after they go home.

12 And so, I think it is important that
13 we try to figure out which individuals will work
14 to keep them at home and out of the ER as well as
15 out of the hospital.

16 CO-CHAIR GREGORY: Okay. I'm going to
17 take three, looks like four more questions and
18 comments. And then I'm going to pull the agenda
19 back to order.

20 Jennifer?

21 MEMBER MOORE: So, I actually have a
22 question, a clarifying question to help me better

1 understand this measure.

2 So, when I was at AHRQ, I worked on a
3 project with Anne Elixhauser and Claudia Steiner
4 with the HCUP data. We produced Staff Brief
5 Number 153 in 2013 on readmissions to U.S.
6 hospitals by diagnosis.

7 And we looked at discharge data and
8 billing data linking pediatric patients to these
9 readmissions. So, I'm struggling to understand
10 how this measure is different. And I don't know.

11 And I apologize. I don't know if AHRQ
12 has, or maybe Reva knows, an NQF endorsed
13 measure.

14 DR. WINKLER: No, they don't.

15 MEMBER MOORE: Okay. So, it's just
16 based on the HCUP analysis we do. So, I guess
17 I'm struggling, what is the piece of information
18 that we aren't getting already?

19 And I'm directing it to you too,
20 because I'm kind of building off of your
21 comments. And I'm trying to understand.

22 Because I agree with you, there's a

1 piece missing. But, I'm not sure I fully
2 understand that piece that you're articulating.

3 DR. LORCH: And I'll just try to brief
4 you something here.

5 MEMBER MOORE: Yes, please.

6 DR. LORCH: Hospital administrative
7 data alone in our latest analysis is missing
8 gestational age in approximately 50 percent of
9 the premature access.

10 The crowd out of codes or with codes,
11 so now you're starting to make up, this looks
12 like it's a preemie. This looks like it's part
13 of the denominator.

14 I would love it if we could just do it
15 on hospital administrative data alone. But, from
16 a validity perspective, face validity at least,
17 we seem to need the linkage because the
18 information in the birth certificate with
19 specific birth weight and gestational age is very
20 critical.

21 There are a few States that do provide
22 that information in the hospital discharge

1 records. But, it's somewhat of a challenge.

2 The other thing with HCUP in
3 particular, it's following infants through their
4 hospital course. And identifying the discharging
5 hospital which can be a difficulty unless you
6 have linkage over the -- to collect it
7 publically, I think with AHRQ they have some of
8 the more -- with more identifiable to allow for
9 that transfer link.

10 But, what we are missing explicitly
11 there is the Vital Statistic data.

12 CO-CHAIR GREGORY: Matt?

13 MEMBER AUSTIN: Yes, so for me, and
14 maybe I'm not quite fully understanding the data
15 sources for this measure. But, my experience
16 with readmission measures is that really health
17 plans and maybe higher are where we can
18 reliably measure readmissions.

19 Until we have a unique patient
20 identifier, it's really hard to track
21 readmissions across facilities. And so, that
22 would be my concern from a reliability standpoint

1 with this measure.

2 CO-CHAIR GREGORY: Karen?

3 MEMBER AUSTIN: But I do think it's an
4 important issue. So, it's not like I'm
5 discounting the issue.

6 DR. LORCH: No. And to the point, I
7 may have misunderstood, but the levels as well.
8 So, again, I think it's whatever the group thinks
9 is the, you know, the data we do present is at
10 the -- it's using State administrative data.

11 Values are from individual hospital
12 level. But, the data do come from a State level
13 source. We did not choose to put in our
14 insurance level source because it's again, from a
15 liability it's potential issues with the data
16 they currently have.

17 So, if that changes, kind of some of
18 these, the framework of it that is, I mean,
19 obviously that's totally okay. It's not --
20 there's not a specific, I'm not wedded to any of
21 the potential levels. Just so the Committee to
22 understand that.

1 And I'm going to have to go in a
2 couple of minutes. I apologize to that.

3 CO-CHAIR GREGORY: Karen?

4 MEMBER SHEA: So no doubt I agree with
5 all of the comments that this is an important
6 issue. And one way in which we can look across
7 the spectrum at the entire episode of care is to
8 look at the insurer level data so that we can
9 look at, you know, from birth through this time
10 period, 30 days to see where the child's claims
11 are coming from. If indeed they're coming from
12 emergency rooms or, you know, different
13 hospitals, et cetera.

14 There's two things though. One is
15 that you're not presenting the measure at that
16 level of evidence. And two, I noticed that there
17 are multiple imputations that you mentioned for
18 exclusions around perhaps I'm assuming diagnosis
19 that you would expect maybe a readmission.

20 So, for example, a small premature
21 baby who's got a planned readmission for eye
22 surgery or for hernia repair. You know, how are

1 all of those planned readmissions excluded from
2 the data set?

3 DR. LORCH: Using ICD-9 codes
4 specifically. That's the best that we have from
5 that particular element.

6 We did find that the number of those
7 planned readmissions were small given current
8 changes in practice. So, from that perspective.

9 And, I'm trying to think the
10 imputation question for the --

11 MEMBER SHEA: So, within -- I didn't
12 see them. But, you know, somewhere within this
13 document, there's a list of all of those
14 exclusions by ICD-9?

15 DR. LORCH: Correct. When we looked
16 at those with the -- I'm sorry. Those are the
17 congenital anomaly issues going back to the
18 previous question that somebody asked about.

19 MEMBER SHEA: Okay.

20 DR. LORCH: So those are ICD-9 code
21 exclusions.

22 CO-CHAIR GREGORY: Okay. Janet and

1 then Nancy and then we're going to move on.

2 MEMBER YOUNG: So, back to the
3 hypothesis of this measure. Which is that
4 readmission rates are an indicator of quality of
5 care either at time of discharge in the
6 outpatient setting, or with the provider who is
7 taking care of that patient, or the patient's
8 actual illness severity.

9 How does this particular data set help
10 us drill down at the hospital level when there's
11 very little the hospital can do to change those
12 rates?

13 DR. LORCH: So, I think that gets into
14 the big question about how -- whether that
15 comment is actually true. I think that -- and
16 many of us think that there is some element of
17 readmissions that are likely not preventable.
18 That's the noise in the measure.

19 But, many of the readmission for this
20 age group are for conditions that one may argue
21 are either discomfort on the part of the
22 outpatient provider, or discomfort on the part of

1 the patient, whereby improved discharge teaching
2 and improved transition of care from the
3 inpatient to the outpatient setting, would reduce
4 these readmissions.

5 Many of the readmission reasons that
6 -- in this data set and others, other things like
7 feeding, failure to thrive, neglect, along the
8 opposite side, parental concern over a condition,
9 which is a V Code.

10 So, I think -- and when -- I think
11 I've said it, when I was off the line, I think
12 the challenges that for every population and
13 every case mix, it does differ what types of
14 implementations you need. And process of
15 treatment we may want to implement to minimize
16 these readmissions.

17 I don't think -- and no one is
18 actually saying that the rate should be zero.
19 That's impossible. But, I think that what we do
20 see is more hospital level, almost QI types of
21 intervention to identify the root causes and
22 their specific population.

1 That then may go onto reduce
2 readmissions either at the hospital level. And I
3 think it really depends on the system that one,
4 is practicing into the larger system as well as
5 the patients that we see.

6 We see -- and so, we have some data
7 that's not published yet on that topic showing
8 that people's discomfort with discharge and with
9 families anxiety over going home.

10 Which is highly variable between
11 patients. As well as variability on the
12 outpatient side in terms of the transitions of
13 care and the comfort of the patient.

14 So that's a kind of long answer to say
15 I think it's more of a QI process, which is
16 somewhat unsatisfying that we don't have a magic
17 here's what we can do to get everybody to reduce
18 readmissions.

19 I think like with other projects, I
20 think with other readmission measures, I think
21 it's really more on a QI framework at the local
22 level to understand what the root drivers are for

1 such a variation.

2 CO-CHAIR GREGORY: Okay. Thank you.
3 Final comment, Nancy. And then we're going to go
4 back to reliability.

5 MEMBER LOWE: So I think my struggle
6 with this is back in the specifications where the
7 level of analysis is the facility or the State.
8 And I don't -- that won't work in areas of the
9 country like where I live.

10 Where our children's hospital serves
11 the whole mountain west. And then we go over to
12 where Kristi is in Salt Lake City. And they take
13 the ones on the other side of the continental
14 divide.

15 So, it's like the State is almost
16 meaningless where we live. Because we care for -
17 - our children's hospital, our catchment area is
18 from the middle of Kansas, the Dakotas north, you
19 know, Montana, Wyoming, Colorado.

20 And so, I'm really struggling with
21 that. I totally agree. It's a great idea. But,
22 I don't know how it will work.

1 CO-CHAIR GREGORY: Okay. I'm going to

2 --

3 DR. LORCH: And I'm going to have to
4 step away. I apologize for that.

5 MEMBER SHEA: I know you have to step
6 away. But, I have one really quick question for
7 you on process.

8 DR. LORCH: Sure.

9 MEMBER SHEA: And that is, did you
10 make a distinction between actual admission and
11 observation stay in your data?

12 DR. LORCH: No. Because of high
13 variability between what a hospital may consider
14 observation. We considered both of those a
15 readmission. Just at the top.

16 Because in some places those would be
17 considered a readmission. They don't have an obs
18 unit. In other places, they're all on the obs
19 unit for a certain period of time.

20 So, we made no distinction in this
21 data set.

22 MEMBER SHEA: So, from your pulling

1 chart audit rather than claims-based data for
2 that for that description?

3 DR. LORCH: No. I mean, no we didn't.
4 It's claims. And I think what we -- what we have
5 is just they were admitted to the hospital with
6 these types of administrative data sets.

7 I think with the insurance you could.
8 But I am a little worried about that because of
9 pretty significant variability in what is
10 considered an observation ad -- if you don't call
11 it an admission, what an obs type of admission
12 would look like between hospitals.

13 So we excluded that out.

14 CO-CHAIR GREGORY: Okay. Thank you.
15 Good luck on your --

16 DR. LORCH: Okay. Thank you very
17 much.

18 CO-CHAIR GREGORY: Moderating session.

19 DR. LORCH: Thank you.

20 CO-CHAIR GREGORY: Sheila?

21 MEMBER OWENS-COLLINS: I had a
22 question for Nancy. I'm not sure since you have,

1 you know, you're one hospital for a large area,
2 you would have a large data base.

3 So, I'm not sure, you know, why you
4 would have problems getting readmission data?

5 MEMBER LOWE: But the children might
6 be readmitted anyplace. Not in our hospital.

7 MEMBER OWENS-COLLINS: Oh, okay. All
8 right.

9 MEMBER LOWE: So, like they go back to
10 Montana.

11 MEMBER OWENS-COLLINS: Okay.

12 MEMBER LOWE: And if they have an
13 acute illness in the next three weeks, they're
14 going to be in a Montana hospital. They're not
15 going to come back to us unless they need the
16 level of care at which they'd get airlifted back
17 to us.

18 So, --

19 MEMBER OWENS-COLLINS: Yes. But you
20 could do a longitudinal, you know, study for the
21 30 days for all the patients that you've
22 discharged and see what happens.

1 CO-CHAIR GREGORY: Sorry, I'm going to
2 make one comment and then I think we should go
3 back to the right way.

4 I know that using the California data
5 set that he used, there's actually a record
6 linkage number. And so you could in fact, it
7 doesn't matter where you got readmitted. They
8 could in fact identify those admissions at
9 different hospitals.

10 So, I would like my discussants to
11 summarize their feelings about the reliability.
12 And then we will decide on whether we're going to
13 vote or not.

14 I know, but I mean, if we need more
15 discussion, we'll go with that.

16 MEMBER SHEA: So I believe we all have
17 concerns about the ability to reliably collect
18 the data which more so goes to feasibility. But,
19 if you can't collect it then it's not going to be
20 that reliable.

21 The other issue that I brought up last
22 is the difference between a 24-hour stay or an

1 actual hospital admission. You're not going to
2 see an observation showing up as an admission in
3 the claims data set.

4 CO-CHAIR GREGORY: There's going to be
5 a bill though.

6 MEMBER SHEA: I think, you know, the
7 planned admission issues, you know, is another
8 exclusion. It may be a few, but it's going to
9 confound the data somewhat.

10 I think that, you know, looking at the
11 ability to collect the data across the different
12 states, New Jersey, New York, it really has to be
13 at a payer level in order for this to make sense.

14 And I'm not seeing that the study has
15 been done at the payer level. And so, I would
16 say it's a good measure.

17 I mean, it's a good concept. It's
18 something that's really important. But, I would
19 say it needs to be baked more at maybe a payer
20 level.

21 And just really show the evidence.
22 And then come back to the Committee.

1 CO-CHAIR GREGORY: Okay. Cindy?

2 MEMBER PELLEGRINI: Yes, a question I
3 think for Reva. And it may not be an entirely
4 fair one. Because it's a very broad NQF
5 question.

6 But, just looking into QPS, there are
7 I'd say at least a dozen readmission measures.
8 There's all cause readmission, there's
9 readmission after myocardial infarction, after
10 vascular procedures, after coronary intervention,
11 after COPD hospitalization.

12 And I imagine that a lot of the things
13 that we're talking about are not unique to this
14 readmission measure. So, either are we holding
15 this one to a different standard than other
16 Committees have on other measures?

17 Or are there insights from some of
18 those other measures that you might be able to
19 give us on things like these patients don't come
20 back to my facility?

21 DR. WINKLER: What I can tell you is
22 that's a common question. But, I do think some

1 of you have raised something that is somewhat
2 unique.

3 And that is the whole issue around
4 children's hospitals and maternity hospitals in
5 terms of the amount of difference between where
6 patients go. So it's always a question.

7 I can't quantify it. But, it does
8 seem that this maybe something that is somewhat
9 different. And so, that would be the one thing I
10 could say, Cindy.

11 MEMBER SHEA: I also think in this
12 particular population where you are dependent
13 upon the training and the competence of the
14 parent to care for the child after discharge, it
15 makes it a little bit different.

16 MEMBER AUSTIN: It maybe just worth
17 looking at the level of analysis for those
18 measures. I think they're mostly at the health
19 plan level.

20 CO-CHAIR GREGORY: Sheila?

21 MEMBER OWENS-COLLINS: Yes, I agree,
22 at the health plan. And also, the parent issue

1 that was just raised. That makes it even more
2 important.

3 Because the parents are, you know, the
4 primary people accountable. And it's very
5 important that they understand.

6 And so, to the degree that they do or
7 do not understand, it is reflected to how well we
8 do with this measure.

9 MEMBER SHEA: Also, I want to bring up
10 that the CMS readmission rate is for the same
11 diagnosis within a certain period of time. And
12 we're dealing with one admission, which would be
13 for a diagnosis of prematurity.

14 And then the repeat admission could be
15 for anything, including pneumonia, all cause,
16 right.

17 CO-CHAIR GREGORY: All right. I am
18 going to ask if we can vote on the reliability?

19 MS. ROBINSON-ECTOR: Voting is now
20 open for reliability of measure 2893.

21 (Voting)

22 MS. ROBINSON-ECTOR: All the votes are

1 in. Four percent voted high. Twenty-six percent
2 voted moderate. Sixty-three percent voted low.
3 And seven percent voted insufficient.

4 So, for reliability the measure does
5 not pass.

6 CO-CHAIR GREGORY: That failed. Okay.
7 So, then we can stop?

8 DR. WINKLER: Yes.

9 CO-CHAIR GREGORY: You guys saved
10 yourselves. Because now we can do Antenatal
11 Steroids.

12 And without bias that should be a slam
13 dunk. And you can go to lunch. Or no we can't.
14 We've got eMeasures.

15 Okay. Antenatal Steroids. Okay.
16 Developers?

17 MS. MILTON: All right. This is
18 Celeste from the Joint Commission. This next
19 measure is Antenatal Steroid initiation.

20 And what we're looking at in the
21 denominator are those mothers that are delivering
22 pre-term newborns at 24 to less than 34 weeks of

1 completed gestation. And of those, mothers in
2 the numerator would be those where Antenatal
3 Steroids were initiated prior to delivery.

4 The original measure was looking at a
5 full course of Antenatal Steroid administration.
6 And we learned that it was a problem for
7 hospitals. It was a great burden to be looking
8 for the second dose because in many times the
9 mother had already delivered.

10 So, we did do a modification to where
11 we're looking at just the initiation. Because we
12 found that when they ordered it, they always
13 ordered it and said repeat it in 24 hours.

14 And the goal here of course, is to get
15 this at 100 percent.

16 CO-CHAIR GREGORY: Discussant?

17 MEMBER BELL: Hey, this is Amy Bell.
18 There has been no new evidence since the last
19 time this measure was endorsed.

20 And so, we actually move that we
21 accept this based on past evidence.

22 CO-CHAIR GREGORY: Any opposition to

1 that?

2 (No response)

3 CO-CHAIR GREGORY: Let's talk about
4 the gaps.

5 MEMBER BELL: Do you all have anything
6 else to add about the gaps? No? Okay.

7 Although there has been improvement
8 over the last four years, the last data being in
9 2014, there still is a significant gap in the
10 performance. So, we recommend that we continue
11 to endorse this measure based on what has been
12 shown with opportunity for improvement.

13 CO-CHAIR SAKALA: And just to clarify,
14 pretty impressive movement in three years, 54
15 percent to 82 percent. And again, a very wide
16 practice variation around that.

17 CO-CHAIR GREGORY: I'm going to call
18 for a vote.

19 MS. ROBINSON-ECTOR: Voting is now
20 open for performance gap of Measure 0 -- oh, I'm
21 sorry.

22 CO-CHAIR GREGORY: Question?

1 MEMBER KEATS: Yes. In terms of new
2 evidence, ACOG put out the practice advisory a
3 month ago about potentially extending this now to
4 36 and 6/7th rather than 34 based on something
5 called the Antenatal Late Preterm Steroid Trial.

6 So, is that going to going to be
7 incorporated at some point into this measure? Or
8 how does that affect what's going on here in
9 terms of evidence?

10 DR. MAIN: That is brand-new news.
11 That paper was presented and published in
12 February of this year.

13 So, that was certainly long after this
14 was submitted. But, I think we want to be sure
15 that this becomes a part of routine practice.

16 We're not sure that every single 36-
17 week mom should get steroids if they come in in
18 normal spontaneous labor at that point. So, the
19 exclusions are still to be determined in that
20 population.

21 It's pretty rock solid under 34 weeks.
22 And that's where we intend to stay for the time

1 being.

2 MEMBER GOYERT: So the corollary would
3 be what about going the other way? You're going
4 to leave the measure as it is, but I'm talking
5 about the 23 to 24-week window.

6 DR. MAIN: That does vary from center
7 to center. I think 23 weeks would be a
8 reasonable choice. There are mothers who decline
9 intensive care at 23 weeks.

10 And I think we'd have to have an
11 exclusion for that if we were going to go there.
12 Again, I think the intention was to say what is
13 the rock solid areas that everybody agrees on and
14 is focused on those.

15 CO-CHAIR GREGORY: Sindhu?

16 MEMBER SRINIVAS: At what point, I
17 mean this is showing great improvement over sort
18 of in trending the time. And what point do we
19 think about like when do you actually retire a
20 measure?

21 Or is that more a philosophical
22 question I guess? I'm just more -- I'm asking

1 kind of for it.

2 DR. WINKLER: Actually, that's sort of
3 the question on the table right now under
4 opportunity for improvement. Because really, the
5 underlying question is, what's the quality
6 problem?

7 What does the data show as the quality
8 problem? And so, that's what you're evaluating
9 on the opportunity for improvement, is whether
10 there is continued improvement. And there are a
11 lot of factors that go into it.

12 CO-CHAIR GREGORY: Dr. Bailit?

13 MEMBER BAILIT: I know when we looked
14 at this in the OPQC, Ohio Perinatal Quality
15 Collaborative Network, what were found
16 improvements were from was increased in better
17 coding. And that was still more administration.

18 For the more -- when people were
19 getting up into the high 90s, they were like, oh,
20 the baby's crowning. Here's your shot. Okay.
21 You can push.

22 Like there's got to be a it's too late

1 part. And you don't want people doing that just
2 to get their box checked off.

3 So, to the extent that I think -- I
4 think was Sindhu, was it you who brought that up?
5 I think there's a real point there.

6 The numbers would suggest that we're
7 not as good as we could be. But, I don't know
8 how much of that is coding versus how much of
9 that is administration.

10 MEMBER BELL: I would just add one
11 thing about delivery within a few hours of
12 actually the patient being admitted. If there is
13 a qual that the provider rights in the notes that
14 addresses that, then that patient is actually
15 excluded from the measure.

16 MEMBER BAILIT: That depends on the
17 center. In other words, some places are giving
18 the shots up until literally crowning.

19 MEMBER BELL: They don't --

20 MEMBER BAILIT: It's ridiculous.

21 DR. WINKLER: Would you call that an
22 unintended consequence?

1 DR. MAIN: On the other hand, if
2 someone is six or seven centimeters and you think
3 they may deliver, they may not for even a day or
4 two.

5 So, you know, of course crowning is
6 silly. But six or seven centimeters is not
7 necessarily a bad move.

8 CO-CHAIR GREGORY: And there is some
9 data to suggest that we're giving too much. And
10 that you know, we really want them to deliver it
11 within 48 hours to seven days. And that came out
12 also in February.

13 But, we are voting on the measure in
14 front of us right now. And so, I think that
15 based on the information we have, do we think
16 that there is a gap and still an opportunity for
17 improvement.

18 MS. ROBINSON-ECTOR: Voting is now
19 open for Measure 0476 for performance gap.

20 (Voting)

21 CO-CHAIR GREGORY: Someone left.

22 MS. ROBINSON-ECTOR: Yes. All the

1 votes are in. And voting is now closed. Twenty-
2 seven percent voted high. Fifty-four percent
3 voted moderate. Nineteen percent voted low. And
4 zero voted insufficient.

5 So, for performance gap of Measure
6 0476, the measure passes.

7 CO-CHAIR GREGORY: Okay. So,
8 validity. I'm sorry, reliability. I think we
9 can take previous. Is there any new reliability
10 testing I need to know about?

11 MEMBER BELL: No.

12 CO-CHAIR GREGORY: And the same for
13 validity? Oops, Jaleel, I'm sorry.

14 MEMBER MAMBARAMBATH: I have a
15 question again about the denominator exclusions.
16 One is enrolled in clinical trials. So, that's
17 something that should be brought up again.

18 These are high-risk moms who will most
19 probably in academic centers be enrolled in one
20 trial or the other. And it's probably prudent to
21 take that out.

22 The second one is more a part for me

1 from my point of view is the documented reason
2 for not administering antenatal steroids. So,
3 that is giving an out for the physician who's
4 taking care of the patient.

5 And what I can tell you from my own
6 institution, two of the documented reasons for
7 not giving steroids was preeclampsia or any
8 pregnancy induced hypertension, and diabetes.
9 That constitutes about 50 to 60 percent of the
10 population.

11 So, on paper they have 100 percent
12 concurrence with the measure. But when you look
13 at it, the real numbers, it was very low. And it
14 took a lot of time to convince them to change
15 that practice.

16 So, it would be good to take it out as
17 well.

18 CO-CHAIR GREGORY: Okay. Juliet?

19 MEMBER NEVINS: Or just be more
20 specific as to what is an appropriate exclusion.

21 CO-CHAIR GREGORY: Go ahead.

22 MS. MILTON: I wanted to make sure.

1 There are certain things that would be considered
2 appropriate exclusions like chorio -- I can't
3 ever say it, chorio. You all know what it is?
4 Okay.

5 So, you wouldn't, if that was present,
6 that would be a reason why you wouldn't do that.
7 We also look at they're saying it's an imminent
8 delivery.

9 And we've talked without technical
10 advisory panel and they suggested that within the
11 first two hours you're going to know whether
12 that's imminent or not. So, you should be
13 initiating that dose.

14 If they deliver six or seven or eight
15 hours later and didn't get that, that wouldn't be
16 considered an imminent delivery. Therefore, it
17 wouldn't be a reason for not initiating it.

18 Also, we would look at any case where
19 they know that the fetus has anomalies that are
20 incompatible with life. Again, this would be a
21 reason why you wouldn't initiate steroids.

22 MEMBER MAMBARAMBATH: So, there is a

1 risk.

2 MS. MILTON: We provide notes for
3 abstraction to the abstractors to be looking for
4 this sort of documentation. And I'm kind of
5 surprised about the diabetes thing, because
6 that's never ever been a question.

7 And I want an answer to all the
8 questions.

9 MEMBER MAMBARAMBATH: So, there are
10 concerns within the OB community, at least in the
11 place where work. And I'm assuming that there
12 are many other places too. At least some other
13 places too.

14 That the initial studies which were
15 done with Antenatal -- initial studies which were
16 done with Antenatal Steroids did not specifically
17 include the moms with hypertension and moms with
18 diabetes.

19 Or -- so, and there is a significant
20 concern in the OB community that well, if you are
21 going steroids to these moms with hypertension,
22 are you going to delay the delivery of that

1 patient for the steroids to act?

2 So, with the hypertension, are you
3 putting the mom in more danger? And are you
4 putting the fetus in more danger?

5 So, that is a concern that they had.
6 Or at least our OB community had. And of course
7 a significant population.

8 CO-CHAIR GREGORY: I think -- all
9 right, I'll be blunt. We would be more than happy
10 to come give grand rounds there. Parkland's
11 unique.

12 Greg? Nancy? Okay. All right, so --
13 go ahead Rajan?

14 MEMBER WADHAWAN: Just a clarification
15 question for you also. When you say the reason
16 for not initiating Antenatal Steroid therapy, is
17 it sort of a free test choice or is it only a few
18 categories that you can pick?

19 Because if that is being the case,
20 that preeclampsia and diabetes shouldn't even be
21 there. That shouldn't even be allowed.

22 And some of the other ones that are

1 valid like somebody's crowning and shows up at 24
2 weeks and delivers should be included.

3 DR. MAIN: The three on the list that
4 I recall are chorioamnionitis, imminent delivery,
5 and anomalies and compatible with life.

6 CO-CHAIR GREGORY: You want one more?
7 Go for it.

8 MEMBER MAMBARAMBATH: Yes. The
9 practice has changed now at the hospital, so.

10 (Laughter)

11 CO-CHAIR GREGORY: All righty then.

12 MEMBER MAMBARAMBATH: But I think it's
13 an important question. Because if you are
14 putting that as a documented reason, and if it is
15 not only these three or four, because I remember
16 from my -- from previous data that I have looked
17 at from my own institution, it was under question
18 for those patients who they felt that it was not
19 manageable.

20 CO-CHAIR GREGORY: Okay. We are going
21 to vote on the reliability of this measure.

22 MS. ROBINSON-ECTOR: Voting is now

1 open for reliability of Measure 0476.

2 (Voting)

3 MEMBER MAMBARAMBATH: Are we taking
4 out the enrolled in clinical trials in this one?
5 Or no?

6 MS. MILTON: Yes, we are. We're
7 removing that.

8 CO-CHAIR GREGORY: Do the discussants
9 have any comments regarding validity? Oh, I'm
10 sorry. I'm trying to catch us up. I am so
11 sorry.

12 MS. ROBINSON-ECTOR: Okay. All the
13 votes are in. And voting is now closed. Eighty-
14 eight percent voted moderate. Twelve percent
15 voted low. And zero voted insufficient.

16 So, for reliability of testing for
17 Measure 0476, the measure passes.

18 MEMBER BELL: We do not have any
19 additional comments related to validity. I mean,
20 empirical validity testing did occur. So, we
21 recommended it to continue.

22 CO-CHAIR SAKALA: Okay. I could just

1 note a few changes in this. Not -- there's the
2 continuous feedback and collection.

3 They switched to ICD-10 codes. The
4 numerator changed from steroids administered to
5 initiated. And the denominator broadened from it
6 used to be 24 through 31 weeks. Now it's through
7 33 weeks.

8 I think those are the important
9 changes in their measure specification.

10 CO-CHAIR GREGORY: So, shall we vote
11 on the validity? Yes? Vote on validity. Go for
12 it.

13 MS. ROBINSON-ECTOR: Voting is now
14 open on validity for Measure 0476.

15 (Voting)

16 MS. ROBINSON-ECTOR: All the votes are
17 in. And voting is now closed. Fifty-six percent
18 voted high. Forty-four voted moderate. Zero
19 voted low. And zero voted insufficient.

20 So, for validity of Measure 0476, the
21 measure passes.

22 CO-CHAIR GREGORY: Feasibility.

1 MEMBER BELL: So, for feasibility,
2 facilities are currently collecting this data.
3 As the facility number of deliveries drops from
4 11 hundred to three hundred, it may become more
5 burdensome for those smaller facilities to
6 collect that data.

7 Although a lot of those facilities
8 would not be delivering patients that are less
9 than 34 weeks to start with. But, if there's,
10 you know, inclement weather, things like that,
11 they're going to have some of those here and
12 there.

13 But, feasibility we didn't see any
14 issues really with this either.

15 CO-CHAIR GREGORY: So, shall we vote
16 on feasibility?

17 MS. ROBINSON-ECTOR: Voting is now
18 open for feasibility of Measure 0476.

19 (Voting)

20 MS. ROBINSON-ECTOR: All the votes are
21 in. And voting is now closed. Sixty percent
22 voted high. Forty percent voted moderate. Zero

1 voted low. And zero voted insufficient.

2 So, for feasibility of Measure 0476,
3 the measure passes.

4 CO-CHAIR GREGORY: And finally
5 usability and use.

6 MEMBER BELL: This measure is
7 currently publically reported. And is used in
8 accountability programs. We do not see any new
9 information.

10 CO-CHAIR SAKALA: I could share that
11 this is -- as a population measure, is included
12 in the MAP Medicaid Adult Core Set.

13 CO-CHAIR GREGORY: So, we shall vote.

14 MS. ROBINSON-ECTOR: Voting is now
15 open for usability and use of Measure 0476.

16 (Voting)

17 MS. ROBINSON-ECTOR: All votes are in.
18 And voting is now closed. Eighty-five percent
19 voted high. Fifteen percent voted moderate.
20 Zero voted low. And zero voted insufficient.

21 So for usability and use of Measure
22 0476, the measure passes.

1 CO-CHAIR GREGORY: Okay. So our next
2 measure is Measure -- oops, I'm sorry.

3 (Laughter)

4 CO-CHAIR GREGORY: Shall we endorse
5 this Measure? Shall we vote to recommend for
6 endorsement of this Measure?

7 MS. ROBINSON-ECTOR: Voting is now
8 open for overall suitability for continued
9 endorsement of Measure 0476. Option One is yes,
10 and Two is no.

11 (Voting)

12 CO-CHAIR GREGORY: We need to put that
13 on our script. That extra little step. That's
14 what it is.

15 MS. ROBINSON-ECTOR: All the votes are
16 in. And voting is now closed. One hundred
17 percent votes yes. And zero voted no.

18 So, for recommendation for continued
19 endorsement of Measure 0476, the measure passes.

20 CO-CHAIR GREGORY: So, we have five
21 minutes before we do our public comment. Okay,
22 we'll do it early.

1 So this is my suggestion. My
2 suggestion is that we break for lunch, do a
3 working lunch to get through the rest of these
4 measures.

5 Alternatively, we can power through
6 the next measure and then break for lunch. So,
7 how many people want to do a working lunch?

8 (Show of hands)

9 CO-CHAIR GREGORY: Perfect. Okay,
10 operator, we would like to open the line for
11 public comments.

12 OPERATOR: Okay. At this time, if you
13 would like to make a comment, please press star
14 then the number one.

15 And there are no public comments at
16 this time.

17 CO-CHAIR GREGORY: Okay. Is there
18 anyone in the room who would like to make a
19 public comment? Perfect. Thank you, sir.

20 DR. SAN ROMAN: Hi. This is Dr.
21 Gustavo San Roman again. And unfortunately I
22 wear two hats at this meeting today.

1 One is as a developer. And one is as
2 a member of the public. And it is Committees
3 like this one that are given the responsibility
4 to provide guidance for other stakeholders that
5 are perhaps not as skilled at math or science.

6 Unfortunately, without scientific
7 guidance, other stakeholder may move forward with
8 plans that lack math or science. As is now
9 evidence in Section 5.03 of the new 2017 contract
10 for Cover California.

11 The new contract states that
12 contractors must exclude hospitals from their
13 provider networks if the hospital is unable to
14 achieve an unadjusted NTSV C-section rate below
15 23.9 percent.

16 Twenty years of science and math
17 confirm the importance of risk adjusting the NTSV
18 Cesarean birth rate. If that rate is to be used
19 as a Cesarean birth measure. And until this
20 year, Measure 0471 has had a risk adjustment for
21 age.

22 Just to be clear, this Committee has

1 just endorsed the removal of the risk adjustment
2 from that Measure based on only one graph with
3 data only from California that claims that the
4 risk of age is completely cancelled out by BMI.

5 I am dumbfounded that anyone can come
6 to the conclusion that age and BMI completely
7 cancel each other out based on one graph and one
8 published study when the published study provided
9 doesn't even include BMI as a risk factor.

10 Extensive prior research has shown
11 that the NTSV Cesarean birth rate increases with
12 age within a hospital.

13 Since age and BMI do not cancel each
14 other out within a hospital, in order to claim
15 that age and BMI cancel each other out when
16 comparing hospitals, somehow every hospital
17 across the nation must attract the exact
18 combination of NTSV patients where a risk due to
19 age and the risk due to BMI completely cancel
20 each other out while still maintaining a rate
21 that increases with age.

22 Math and science do not support the

1 claim that age and BMI cancel each other out.
2 Every hospital across the country with older NTSV
3 patients will be adversely affected by a Cesarean
4 birth measure that does not have any risk
5 adjustment for age.

6 This adverse effect will soon become
7 evident to hospitals in California. More
8 concerning is that hospitals with unadjusted NTSV
9 Cesarean birth rates of over 23.9 percent will
10 not be able to justify their higher rate by
11 claiming that they have higher risk patients.

12 This is because according to the Joint
13 Commission, a risk adjusted model, which included
14 age, BMI, race, hypertension, and diabetes, found
15 differences limited to only one to two percent.

16 Or in other words, all hospitals
17 should be able to achieve an unadjusted NTSV
18 Cesarean birth rate within one to two percent of
19 the average regardless of their patient
20 population.

21 Six years ago, I was the only one who
22 recognized the flaw in the risk adjustment for

1 Measure 0471. And today, I am the only one who
2 recognizes the disaster that is coming with an
3 unadjusted NTSV rate.

4 To fully understand the disaster that
5 is coming to California, one only needs to look
6 back to 1997. That was the year with the lowest
7 reported national unadjusted NTSV Cesarean birth
8 rate.

9 And that year saw an overall Cesarean
10 birth rate of 20.8 percent. The data from 1997
11 revealed that in 1997 if a hospital had NTSV
12 patients with an average age of 34, they would
13 have had an unadjusted NTSV Cesarean birth rate
14 of about 27 percent.

15 This means that if a hospital in
16 California that has 34 year old NTSV patients
17 currently achieves a rate as good as the best
18 year on record, it will still be excluded from
19 the Cover California provider network.

20 God help those hospitals in
21 California. And God help us all if this
22 Committee doesn't check the math. Because a

1 flawed Cesarean birth measure is worse then
2 having no measure at all.

3 Thank you.

4 CO-CHAIR GREGORY: Thank you. Are
5 there any other comments?

6 (No response)

7 CO-CHAIR GREGORY: All right. Then
8 I'm going to charge the Committee to get lunch.
9 And then we'd like to resume at 12:30.

10 (Whereupon, the above-entitled matter
11 went off the record at 12:14 p.m. and resumed at
12 12:29 p.m.)

13 CO-CHAIR GREGORY: I'm very proud of
14 you guys all coming back on time. If we have our
15 developers at the table, could I have everyone's
16 attention?

17 We're about to get started again.
18 Actually before we do the next measure, we're
19 going to get a primer on eMeasures so we can chew
20 our food.

21 DR. WINKLER: All right, eMeasures.
22 Over the last few years, there's been a real

1 growth in the development of eMeasures, and just
2 to be clear, what we're talking about are not
3 just measures that use, say, electronic health
4 records as a data source.

5 But eMeasures, or the federal
6 government calls them eQOMs, electronic clinical
7 quality measures, are in a very specific format.
8 The HQMF, health care quality measures format,
9 that is an industry standard.

10 And so we are talking about a measure
11 that is specified using that HQMF format. It
12 also specifies value sets that are registered in
13 the National Library of Medicine at the Value Set
14 Authority Center.

15 So an attempt that as eMeasures are
16 being developed to put some structure around the
17 idea of an eMeasure. Okay?

18 So it's not just if you're using EHR
19 data and, because you can go into an EHR and
20 abstract all sorts of data, but that's not an
21 eMeasure. All right?

22 So I do want to make sure we

1 understand the difference. Now how can eMeasures
2 get developed? Well, all sorts of ways we're
3 finding. You can make a brand new eMeasure.

4 And one of the hopes and dreams about
5 eMeasures is that with the capabilities of EHRs
6 that we don't have in other data systems, we
7 might be able to start seeing new and greater and
8 better and more wonderful measures, still
9 waiting. But nonetheless, that's, those are the
10 hopes and dreams.

11 And so that's a de novo measure. I
12 mean, it's not going to have an antecedent other
13 type of measure. It's its own thing. We're
14 starting to see an occasional one of those, but
15 not that many.

16 What we're tending to see are measures
17 that are based on existing measures. And you
18 know, it's totally internal to NQF and probably
19 irrelevant to you all, you know, whether we call
20 them respecified or legacy because they're in use
21 in federal programs. Doesn't matter.

22 The point is there is an antecedent

1 existing measure based either on claims, paper,
2 registry, something. And the eMeasure is an
3 attempt to create the -- or the eMeasure is a new
4 version.

5 Because of the unique aspect of
6 eMeasures, NQF treats them as separate measures,
7 and they have numbers that are different,
8 although we are in the process of reworking our
9 data system to combine the numbers of the two
10 versions of the measures so that you know they're
11 two versions and they are kind of all related to
12 the same parent measure, but yet are distinctly
13 different.

14 So what you see in our next group of
15 measures is two of the Joint Commission core
16 measures and their new eMeasure version. And so
17 go to the next slide.

18 And so technically I'll tell you these
19 are what are known as legacy measures just
20 because they are in use as the original version,
21 and the eMeasure is now the new version, or
22 another version, if you will.

1 And so you can start to see how the
2 numbers are going to get a little confounded, but
3 the eMeasure version will relate back to the
4 original antecedent number.

5 And so what we do is we will look at
6 them as one and then the other because there's a
7 great deal of crossover. And you'll find in the
8 measure information form that essentially the
9 information around evidence and opportunity for
10 improvement is an identical, you know,
11 information on the two, so re-having that
12 conversation twice doesn't make a whole lot of
13 sense.

14 So we'll be able to hopefully look at
15 some things a little bit more efficiently. One
16 of the things about eMeasures is the challenge
17 that developers are struggling with in terms of
18 being able to formally test those measures for
19 reliability and validity because a lot of the use
20 of eMeasures, particularly through the federal
21 meaningful use programs, has relied on
22 attestation of the provider to say I can do it.

1 But there's no data. So in the
2 absence of numbers, there's really hard to do any
3 analysis on numbers. So this is the quandary
4 that is evolving and resolving over time, and we
5 can anticipate seeing more data, you know, fairly
6 soon actually.

7 But nonetheless, we're fairly limited
8 now. As an alternative to support the, you know,
9 the understanding about the data reliability and
10 validity, if you will, and feasibility, there is,
11 there are synthetic tools that can be used where
12 you create a database.

13 You know, it isn't real patients, but
14 you create a data set, and then test the measure
15 against that data set to see if you can produce
16 results, and whether those results were, reflect,
17 you know, what it is you input.

18 So that is acceptable at this point in
19 time. This is a transitional kind of thing. I
20 mean, it's going to change as we are able to
21 collect data.

22 I know one of the questions we asked

1 on the workgroup calls that the Joint Commission
2 was able to help us with was understanding that
3 now the Joint Commission's collecting data with
4 the eMeasures and there are a certain number of
5 healthcare organizations submitting data actually
6 through the eMeasure, as well as the traditional
7 avenues.

8 So that's the world of eMeasures at
9 this point in time. And so, does anybody have
10 any questions? Okay.

11 PARTICIPANT: So can you just kind of,
12 a little bit more about the, there's a fake data
13 set?

14 DR. WINKLER: Right. There is a fake
15 data set. Okay, there are several tools, but the
16 most commonly used one is called Bonnie, and it
17 is, you know, you create a synthetic data set.
18 You know --

19 PARTICIPANT: It has discharge codes
20 and --

21 DR. WINKLER: It has the codes you
22 need and the data you need to make it work.

1 PARTICIPANT: Is that commercially
2 available?

3 DR. WINKLER: Yes. Actually it is
4 commercially available free of charge is my
5 understanding. Yes. It's a fed, the feds
6 created it. Diana.

7 MEMBER RAMOS: Has the accuracy of the
8 data that's been inputted been analyzed, because
9 obviously if it's all going to be free, you want
10 to make sure that the information is correct,
11 accurate, so that the interpretation can be
12 reliable.

13 DR. WINKLER: I think what we need,
14 one of the conversations that's probably
15 reasonable to have is with the folks, because the
16 Joint Commission isn't, is doing this measure
17 with eMeasures, although, you know, still early,
18 not tons of experience, but you've got some.

19 And those are the questions we'll ask
20 them. You know, what are you doing in terms of
21 looking at your data. Okay? Any other questions
22 about eMeasures in general before we get to the

1 specifics of these measures?

2 PARTICIPANT: May I ask a process
3 question? So when they review the measures are
4 they reviewing them as independent of each other?

5 DR. WINKLER: Yes. However, we'll be
6 able to carry over a lot of -- any of the
7 similarities, so we don't have to have the same
8 conversation, you know, when it doesn't apply.
9 But you will be looking at them twice, or
10 separately. Okay. With that, back to the
11 chairs.

12 CO-CHAIR GREGORY: Sorry. We're going
13 to do measure 0469. No. Is it? Yes. Elective
14 Delivery by the Joint Commission as the
15 developer, and our discussants are Tracy, Sheila,
16 and Jennifer.

17 MS. MILTON: Hi. Celeste from Joint
18 Commission. Now, what we're looking at and the
19 denominator here are going to be those patients
20 that have delivered at 37 weeks of completed
21 gestation to less than 39 weeks, so it would be
22 38 and six days, and of those patients, how many

1 had an elective delivery.

2 The goal here is to reduce that
3 number, but I think we've already had a little
4 bit of conversation that the goal is not to get
5 to zero.

6 It has never been the intent, because
7 there are going to be certain circumstances that
8 are virtually impossible to identify all of.

9 One example would be a patient that
10 needs to receive chemotherapy for a certain type
11 of cancer. That may not hold true for every
12 patient that has cancer. It could be a specific
13 type.

14 So there's going to be circumstances
15 where some patients will need to be delivered
16 early, and there is a medical indication.

17 But what we've done is we've tried to
18 get the majority of those, and our analysis has
19 shown that we've gotten about 98 percent of them
20 by the use of ICD codes and also with the data on
21 it called prior uterine surgery, where specific
22 types of prior surgeries would be reasons to

1 perform an early Cesarean delivery. And that's
2 it.

3 CO-CHAIR GREGORY: Discussants?

4 MEMBER FLANAGAN: So just to say a
5 little bit more about this measure. I think for
6 many of us in the room, we're very familiar with
7 this measure.

8 It was, as mentioned by the
9 presenters, that it was meant to decrease non-
10 medical elective deliveries that were pre 39
11 weeks. And the intent was to decrease neonatal
12 morbidity and mortality.

13 Also with the hope of decreasing the
14 rate of C-section, which we'll get to a little
15 bit later. It was originally endorsed in 2008,
16 and the most recent endorsement was 2012. It is
17 a process measure and I think I'll stop there as
18 far as introduction to the measure.

19 CO-CHAIR GREGORY: Is there any new
20 evidence that you'd like to share?

21 MEMBER FLANAGAN: The evidence, should
22 I keep going?

1 CO-CHAIR GREGORY: Yes, please.

2 MEMBER FLANAGAN: So the evidence put
3 forward was last discussed in 2012. I don't see
4 any additional evidence.

5 And, but just as an update, ACOG
6 reaffirmed the practice bulletin for induction of
7 labor, including information in this area, and
8 there was an ACOG opinion that reaffirmed the
9 evidence for non-medically, for, and provided
10 guidance for non-medically indicated early term
11 deliveries.

12 CO-CHAIR GREGORY: So I would like,
13 unless there are any --

14 MEMBER BAILIT: I actually, I actually
15 do want to add some new evidence that wasn't
16 listed but I think is relevant.

17 And this is actually supporting of the
18 measure, which is, there's always been a concern
19 that were we increasing the stillbirth rate with
20 the NTSV going down, and I think there is new
21 evidence that we are not causing harm of the
22 stillbirth rate.

1 So to the extent that that's not
2 directly to the point, but it is, I think,
3 additional confirmation of safety. It's
4 relevant.

5 CO-CHAIR GREGORY: So unless anyone is
6 opposed, I would like to suggest that we vote to
7 accept this evidence.

8 MEMBER OWENS-COLLINS: I just had a
9 question I wanted to clarify.

10 CO-CHAIR GREGORY: Please.

11 MEMBER OWENS-COLLINS: Okay. And I
12 agree that the concerns about not doing C-
13 sections have been, or have not been founded.
14 But I do have a question about the terminology
15 when you talk about elective versus medically
16 necessary versus medically indicated.

17 I mean, there seems to be some
18 contraindication there. Because when I first
19 read it, I was, my first thought, and I asked one
20 of my OB colleagues, I mean, who would do an
21 elective C-section. I mean, elective is just, I
22 mean, it's just, for a neonatologist, I guess --

1 CO-CHAIR GREGORY: Who will address?
2 Yes, so who would do that?

3 MEMBER OWENS-COLLINS: Right. And
4 would write and document it secondly. So, right,
5 so, right and document it is the biggest part.
6 So you know, I think that, you know, so the
7 example of someone that has cancer, I wouldn't
8 necessarily consider that elective.

9 I mean, that's maybe more medical
10 necessity or medically indicated for the mother.
11 Now I think we need to be careful with those
12 terms because, you know, I mean, elective is
13 going to raise flags and potentially, you know,
14 get people in a lot of trouble. So it's really
15 medically indicated.

16 MEMBER FLANAGAN: So let me add that
17 there is a huge appendix that spells out pretty
18 much every medical condition you can think of,
19 but it's never going to be completely inclusive.
20 There's always weird things that come up.

21 MEMBER OWENS-COLLINS: Yes.

22 MEMBER FLANAGAN: There are medical or

1 real indications, but there's a huge list of
2 what's considered medically indicated.

3 CO-CHAIR GREGORY: Juliet?

4 MEMBER NEVINS: So I just wanted to
5 comment and to answer your question. There are
6 many obstetricians who will do an elective
7 Cesarean section. You know, the patient is
8 afraid of pain, she demands it.

9 There are many obstetricians who feel
10 that the woman has a right to choose her mode of
11 delivery. So it's, you know, I've seen it done
12 many times.

13 CO-CHAIR GREGORY: Okay. Without any
14 further comments, I suggest that we vote on the
15 evidence, and that we vote to accept the evidence
16 that was previously, oh, you're right. You're
17 right. That's right.

18 Okay, so that means that we can now go
19 to reliability. I'm sorry, the gap. I'm tired.
20 Let me get my little script here.

21 MEMBER FLANAGAN: I'll talk faster.

22 So there still remains a gap, although the gap

1 has been narrowing over time. The rate has gone
2 from 13.6 down to 3.3.

3 However there is going to be an
4 additional number of hospitals coming onboard in
5 January 2016, which should had, which should
6 include 80 percent of all birthing hospitals.

7 So I think we would expect to see the
8 newly reporting hospitals to show wider variation
9 than we're seeing right now. Right now the
10 variation is between zero and 8.7 percent,
11 roughly. Between 10th percentile and 90th
12 percentile there's of course a wider range than
13 that.

14 But the variation has narrowed, but it
15 will probably go up again with the inclusion of
16 new hospitals. And by the way, there's a typo on
17 this document.

18 It says all hospitals with greater
19 than 110 births. I think it meant to say 1,000
20 and 110 births. And it's consistent through the
21 document, that typo.

22 CO-CHAIR GREGORY: Okay. Jennifer?

1 MEMBER BAILIT: So in terms of the
2 evidence gap, I am concerned with this one in
3 particular because of some work that I did prior,
4 while at HHS, and I also know that this work is
5 now going to be published.

6 And we brought this up during our
7 workgroup call and we talked about this issue of
8 gaming of the system and then, you know, this
9 notion of the definition and recognizing that
10 we're trying to capture early term elective
11 deliveries that are non-medically indicated.

12 There's a lot of subjective terms in
13 that, which makes, which makes this challenging.
14 And I'm not saying that we shouldn't collect this
15 information, but I think that we need to
16 recognize the limitations of this, and also be
17 cautious.

18 I know there was some sidebar
19 discussion about, should we retire this measure
20 because we've met our goals.

21 But I just think that we really need
22 to think about what is it that we're measuring,

1 how are we measuring it, are we really capturing
2 it, and then bringing into light this issue of
3 gaming of the system which we all know exists and
4 is happening.

5 And if we really want to move the
6 needle on this issue, how do we, how do we
7 measure this topic in a way that's meaningful,
8 and we don't assume that we've accomplished our
9 goals.

10 CO-CHAIR GREGORY: Do you want to --

11 MEMBER FLANAGAN: I think for those of
12 us who have been looking at this measure for a
13 long time, I'm just going to respond to what you
14 said. I think one of the glaring things that
15 comes out are non-medically inductions that
16 happen after 39 weeks, which is not before us,
17 but I think that sort of speaks to some of the
18 issues you're talking about.

19 CO-CHAIR GREGORY: Actually I'll speak
20 to it too. I think that what happens is you get
21 so good at it, but then you forget. And as soon
22 as you forget, it pops back up again. So, in

1 fact, they wait for you to stop looking.

2 DR. MAIN: I think the issues around
3 this, around the indications that are covered in
4 this measure can, are in several different
5 categories.

6 The most common one that was a problem
7 before was scheduling of elective repeat C-
8 sections. Not primary C-sections so much, but
9 repeats.

10 And that's where the actually most of
11 the neonatal morbidity was, was doing a section
12 at 37 weeks. That's pretty much eliminated now.
13 You know, and I think that's a big change.

14 I think some of the induction
15 indications are being shaved a little bit, but
16 that's not the big driver of morbidity here in my
17 book.

18 So you know, you can't police every
19 last birth and every last hospital, but you're
20 looking for big trends, and big numbers, and I
21 think we're actually making a big impact.

22 MEMBER MOORE: So I guess my question

1 back is, should we be, and I've sat in meetings
2 with ACOG on those where the question is, do we,
3 do we capture elective induction of labor as the
4 measure, or do we look at overall induction of
5 labor?

6 Because if we are reducing the
7 elective, then we're overall reducing induction
8 instead of trying to deal with this gray zone and
9 trying to deal with some of the inherent issues
10 with trying to capture elective. And I'm not
11 expecting you to have an answer.

12 DR. MAIN: That's why there's a pretty
13 long list of ICD codes that makes a stab at it.
14 They're pretty loose though. It's any
15 hypertension, any diabetes, which you know,
16 gestational diabetes really shouldn't be
17 delivered at 38, 37, 39 weeks.

18 So it's looser than what many people
19 would like it to be. But it's also trying to
20 balance out, you know, what, you know, working
21 with obstetricians in the field to --

22 MEMBER MOORE: I would never advocate

1 for using ICD-10 codes, so that's an area where
2 because of the way that the payment system is for
3 maternity care, typically we lose, in terms of
4 capturing those other data sets, we have pretty
5 fair accuracy in terms of vaginal birth and C-
6 section, but the other subsequent measure, or
7 codes aren't as accurate. So I would agree with
8 your statement.

9 CO-CHAIR GREGORY: Sheila.

10 MEMBER OWENS-COLLINS: I don't really
11 have anything else to add. I think your
12 limitations are, have been well stated before, as
13 well as the pros of this measure, so --

14 CO-CHAIR GREGORY: Sindhu? Your card
15 is up, that's why I called on you.

16 MEMBER OWENS-COLLINS: Oh, got to fix
17 it.

18 MEMBER SRINIVAS: I just wanted to say
19 something and comment to the issue of all
20 inductions. I think while the indications are
21 loose and lead to some area for a little bit of
22 fudging here and there, I, in practice, have also

1 seen the sort of opposite happen where sick women
2 with preeclampsia don't get delivered.

3 And while the stillbirth rate might
4 not be sort of increasing, there's a lot of, you
5 know, other balancing sort of maternal morbidity
6 and other things that I think anecdotally lots of
7 providers around the country have seen and sort
8 of pushed back, like oh, I can't deliver her
9 because she's not 39 weeks, but she actually does
10 have a medical indication.

11 And so there's a little bit of adverse
12 creep as well. So when you start talking about
13 all inductions, I would really worry about that
14 actually having a negative impact on maternal
15 health.

16 CO-CHAIR GREGORY: Cindy?

17 MEMBER PELLEGRINI: So at the March of
18 Dimes, I get to hang out on a daily basis with a
19 whole lot of people who think this is still a
20 really, really important measure.

21 This is brand new practice change,
22 right? We're talking about this rate going down

1 over three years, and I think Dr. Gregory is
2 absolutely right that that's not enough time to
3 just say, okay, our work is done, and walk away.
4 Because it will simply come right back up.

5 We need to give this more time to be
6 in place. But it's also continuing to play, I
7 think, an important role in a couple of other
8 areas, which may not by themselves be reasons to
9 maintain a topped out measure, but in addition to
10 everything else illustrated, it's important.

11 One of them being that, is that this
12 measure has played and continues to play a very
13 important role with policy makers as kind of
14 their entry point into understanding and learning
15 about quality improvement.

16 This is kind of showcased as one of
17 the, as an understandable example of how we can
18 drive quality change, quality improvement, and
19 effect, both cost and outcomes.

20 It's something that we talk about a
21 lot on the state level when we're just trying to
22 start explaining to an elected official what this

1 whole quality improvement enterprise is.

2 I think it's also continuing to play
3 a role in understanding the processes, the sort
4 of different stages that a measure goes through
5 to full success.

6 So right now we're happily in the
7 stage of, how do we get those outliers? How do
8 we get those late adopters that are still not at
9 the rate we want them to?

10 What are the additional barriers and
11 how do we communicate or support them? So just a
12 strong vote to continue, to keep this in place.

13 CO-CHAIR GREGORY: Deb?

14 MEMBER KILDAY: And I'm just going to
15 jump on your bandwagon. Having the opportunity
16 to hit some of those outliers, I go to those
17 hospitals. I work with them.

18 I am often amazed at some of the
19 gaming that goes on, even in those that are
20 meeting the measures, and you do sort of that
21 quality improvement work at the local level.

22 So I see both ends. I see a lot of

1 gaming. I'm just going to put it out there.

2 It's happening. But also see, I see primarily
3 smaller institutions where there are cultural
4 barriers, and they are really struggling with
5 implementing this.

6 And I also hear from organizations
7 that have implemented it, their provider's
8 feedback in that they can't wait for it to really
9 relax because they want to go back to the old
10 way. And don't think for a minute that isn't
11 there.

12 CO-CHAIR GREGORY: Matt.

13 MEMBER AUSTIN: So to continue the
14 bandwagon, I would reinforce the notion that we
15 still have opportunities with this measure.

16 The Leapfrog Group has actually been
17 measuring hospital performance on this for now
18 seven years, since we've had the opportunity to
19 look at hospital data longitudinally on this
20 measure.

21 There's still a fair number of
22 hospitals that remain with significant rates, and

1 we actually see some hospitals who are moving in
2 the, quote, wrong direction, i.e. they are -- had
3 low rates and actually are climbing back up. So
4 I would vote for continuing to put importance on
5 this measure.

6 CO-CHAIR GREGORY: Diana?

7 MEMBER RAMOS: Yes, in Los Angeles
8 County where we have 60 delivery hospitals, we
9 actually are bringing down the state in terms of,
10 well, we have the highest rate of primary C-
11 sections, and just, you know, just we need a lot
12 of help on the quality measures.

13 So I think this is really an
14 opportunity, even though California as a whole
15 looks good, Southern California is the one that's
16 bringing down the state.

17 CO-CHAIR SAKALA: So just a comment,
18 I did the calculation for 2014, looking at those
19 two weeks gestational age, and 3.3 percent
20 performance, it's under one percent of all of our
21 babies that then fall into that still vulnerable
22 range and recognizing that it should never get to

1 zero.

2 And looking at most of those babies
3 who will do well, I'm not arguing for retiring
4 this, but I just want it to fit into the
5 discussion about, you know, big time impact, and
6 point out, and I also agree that I think we need
7 to wait and see what those hospitals look like
8 with 300 or more births, the point you made,
9 Tracy. But I just want to point out what the
10 actual numbers are there.

11 CO-CHAIR GREGORY: One more.

12 DR. MAIN: One quick point about the
13 potential for gaming. I think everybody
14 recognizes there are some cases here and there,
15 but I think sort of the proof of the pudding is
16 the reports first from Ohio and then from the
17 National Center for Health Statistics that the
18 rate of 38 and 37 week births in the United
19 States has fallen significantly.

20 And that's sort of the bottom line, if
21 you would. I think there are other collateral
22 benefits of this, which is that the rate of 36

1 week births has fallen significantly.

2 You know, and lowering the pre-term
3 birth rate in the United States, as people start
4 reevaluating who needs to be induced and when.
5 So I think those are two nice benefits overall.

6 CO-CHAIR GREGORY: Last comment.
7 Naomi?

8 MEMBER SCHAPIRO: I'll be, I'll be
9 brief. I just wanted to emphasize the importance
10 on the pediatric end of this in that it was
11 really only recently, if you think about the long
12 term, that we have to even recognize that 37 to
13 39 weekers have significantly more problems and
14 more hospital re-admissions.

15 And I don't think that's really
16 penetrated to the entire like population of moms.
17 So I think the more we can keep this measure in
18 the public eye, that's really good for kids.

19 CO-CHAIR GREGORY: So if no one is
20 opposed, I'm going to call for a vote on the,
21 whether or not there is a gap in opportunity for
22 improvement.

1 MS. ROBINSON-ECTOR: Voting is now
2 open for performance gap of measure 0469. Okay.
3 All the votes are in and voting is now closed.

4 Forty percent voted high, 52 percent
5 voted moderate, eight percent voted low, and zero
6 voted insufficient. So for performance gap of
7 measure 0469, the measure passes.

8 CO-CHAIR GREGORY: Okay. Discussants,
9 can you share with us any new information about
10 reliability?

11 MEMBER FLANAGAN: So reliability, a
12 couple things that have happened in that there
13 have been changes through the years to actually
14 more specifically measure what I think it was
15 intended to measure.

16 Just to lay those out, first of all,
17 there's going to be, this is not in the past just
18 coming, the ICD-9 being converted to ICD-10, and
19 it's unclear how that's going to affect the
20 reliability of this measure.

21 The numerator also included
22 population, the numerator included population for

1 medical induction of labor now requires a check
2 for the presence of labor prior to the procedure
3 of induction.

4 And that was, I think, and enhancement
5 actually to the measure. Also, prior uterine
6 surgery was better defined, and there was also
7 some work around, I believe it's excluding the --
8 unable to determine no prenatal care patient who
9 comes in where you can't determine the
10 gestational age and that was considered a ding.

11 I think the one thing that many people
12 have talked about that still troubles, especially
13 small hospitals, is that sampling is allowed. And
14 because sampling is allowed, and the
15 specifications for sampling, it allows for wide
16 variation from quarter to quarter because we have
17 such low numerators.

18 I can speak personally from my own
19 system that you can go wildly, you know, you
20 happen to be unlucky one time and your sample of
21 25 includes two outliers, you can go wildly
22 between zero and, say, even 12.

1 So that's the one criticism, and I
2 think the -- when there's no sampling, and
3 there's larger numbers, that variation goes away.
4 I'll stop there. Anybody want to add anything?

5 CO-CHAIR GREGORY: I guess I just want
6 to add that, from a reliability perspective, that
7 it's still a pain when the lady's clearly in
8 labor, but it was, somebody wrote latent phase
9 and you can't get that to count. I mean, like
10 could be five centimeters dilated and --

11 MS. MILTON: We changed it. We
12 changed it.

13 CO-CHAIR GREGORY: Oh, thanks.

14 MS. MILTON: July 1st.

15 CO-CHAIR GREGORY: How is that changed
16 exactly?

17 MS. MILTON: The inclusion area for
18 labor. Latent. Yes. We heard from the field.

19 MEMBER FLANAGAN: I'm going to also
20 add one more comment. It was included that there
21 was a, what did they call it?

22 Interrelator reliability performed by

1 ORYX vendor. This is, I don't think it was
2 recent. I think it was before the last version.

3 And the agreement rate was very high
4 on the two areas that were of concern, which is
5 active labor and gestational age. I don't know
6 if you want to add anything on that.

7 MS. MILTON: Just that fact that it's
8 from before. Yes.

9 CO-CHAIR GREGORY: Any other comments?
10 Then I guess because there's been a change, we
11 should vote on the, I'm sorry, I didn't see that,
12 Jaleel.

13 MEMBER MAMBARAMBATH: I have the same
14 thing as usual. Enrolled in clinical trials.

15 CO-CHAIR GREGORY: Enrolled in
16 clinical trials.

17 MS. MILTON: It's gone.

18 CO-CHAIR GREGORY: So if, I think we
19 should vote on this one because there's been a
20 change. So --

21 MS. ROBINSON-ECTOR: Voting is open
22 for reliability of measure 0469. It looks like

1 we're missing one vote. If everyone could
2 resubmit their vote please. Great. All the
3 votes are in and voting is now closed.

4 Ninety-six percent voted moderate,
5 four percent voted low, zero voted insufficient.
6 So for reliability of measure 0469, the measure
7 passes.

8 CO-CHAIR GREGORY: Are there any new
9 additions with regard to validity that you'd like
10 to share?

11 MEMBER FLANAGAN: I think the, we
12 already mentioned the change to the specs, the
13 sampling and narrow performance interval.

14 I would like some explanation from the
15 presenters on the, I don't know what page it
16 would be, page seven I believe, on the
17 distribution of outliers and what that was
18 intended on showing.

19 I find it -- I've read it at least
20 five times, and I went to the detail on page 27
21 and I still couldn't understand.

22 That 97 percent were considered

1 neutral, results not significantly different from
2 target range, and 2.5 percent unfavorable. Can
3 you explain that?

4 MS. MILTON: Stephen, are you on the
5 phone? Ran the numbers.

6 PARTICIPANT: The operator says
7 disconnected. He's not on the phone.

8 MEMBER FLANAGAN: I mean, my
9 interpretation of this -- I'll keep speaking for
10 a second. This looks oddly like an attempt to
11 measure out performance and performance
12 percentiles, and what I think this says with
13 narrow variation is that even though you see this
14 10th, 25th, 50th and 70 and 50th percentile, then
15 a lot of situations it's not statistically
16 different from the target rate, and only in the
17 very big outliers is it really statistically
18 significant, which says that quartiles or
19 percentiles may not be relevant for evaluating
20 performance. But I'm not sure if that's correct.

21 MS. MILTON: As I look at this, this
22 is what we submitted the last time. This is 2011

1 data because we weren't asked to change that.

2 But I know we did some updated testing, so that's
3 in a different section, I believe.

4 MEMBER FLANAGAN: Can you explain what
5 this is trying to say?

6 MS. MILTON: I think based on what he
7 did five years ago, that the majority were
8 considered to be neutral.

9 In other words, there wasn't really
10 anything that was distinct there and there was a
11 very small number that were considered to be
12 unfavorable or considered to be outliers. That
13 most everybody fell within the range.

14 MEMBER FLANAGAN: If that's the case,
15 then I would caution, I mean, as a caution to
16 reporters like Leapfrog to not make distinctions
17 that are not statistically significant in
18 quartile reporting.

19 Not that that's the purview of this
20 committee, but I mean, I think that's what you're
21 trying to say here from the standpoint of
22 validity.

1 Does this measure what it's supposed
2 to, and is there meaningful difference between,
3 you know, four different quartiles of
4 performance?

5 MEMBER AUSTIN: Thanks for that
6 feedback, Tracy. We can -- we'll consider that.
7 Thank you.

8 CO-CHAIR GREGORY: So does the
9 committee feel we need to vote on validity, or
10 should we accept what's previously been accepted?
11 I'm going to take that as accept what's
12 previously accepted, and move to feasibility.

13 MEMBER FLANAGAN: I don't have much to
14 say about this except that it is a measure that
15 primarily, that does involve some degree of
16 manual review.

17 However, almost all of the hospitals
18 have been doing this for a while and I don't
19 think there would be any change in burden. But I
20 welcome any other comments on that.

21 MEMBER BAILIT: I would just say I
22 think it actually decreases the burden with the

1 additional coding. I think the burden's gone
2 down probably.

3 CO-CHAIR GREGORY: So I think we
4 should vote on this. Yes ma'am?

5 MEMBER SHEA: I just have a question
6 about the collection of gestational age that's
7 used in this measure, and if you could just
8 school me.

9 Is it at the time of delivery? Is it
10 at the time of admission to the ICU? Is the
11 gestational age on the birth certificate? What
12 are the specifications around gestational age?

13 MS. MILTON: We like them to get it
14 closest to the time of delivery because you could
15 come in and be in the hospital for a few days and
16 still be at 38 and 5 and eventually go to 39.

17 So we -- that's what we put in the
18 notes for extraction, that it should, it should
19 be at the time of delivery, and it's my
20 understanding that's how the birth certificate
21 data is collected.

22 It would be gestational age at the

1 time of delivery, and we do allow that as an
2 allowable data source, if they're able to
3 electronically retrieve that information from
4 vital records reports from their states. Some
5 states like California have that capability of
6 doing that.

7 MEMBER SHEA: The reason why I ask is
8 because I don't know all the specifics behind it,
9 but I do understand that the way in which
10 gestational age is now collected and reported by
11 the CDC has changed over the last year, and that
12 has, you know, then resulted in lower pre-term
13 birth rates.

14 And so I'm just wondering, is this
15 gestational age an estimate of gestational age
16 based on, you know, EDC or is it by exam?

17 DR. MAIN: No. The, what the National
18 Center for Health Statistics came out with,
19 recommendation for all birth certificates in the
20 United States is that it's based on a best
21 obstetric estimate, which is generally
22 ultrasound.

1 And ideally in agreement with last
2 menstrual period. Previously they had used last
3 menstrual period, which is not very accurate.

4 So this is a more accurate assessment
5 of gestational age. And if you had the EDC, then
6 it's easy to calculate the gestational age at the
7 time of delivery.

8 MEMBER SHEA: So for the most part we
9 might say is gestational age that's recorded on
10 the delivery room record.

11 DR. MAIN: Yes. Yes.

12 MEMBER SHEA: Because if there's any
13 opportunity for gaming here, that's where we see
14 it. We see that the gestational age that's
15 perhaps recorded on the delivery room record is
16 not the same gestational age that's recorded by
17 perhaps the healthcare provider in the notes, and
18 we see a little bit of a difference coming
19 through.

20 CO-CHAIR GREGORY: In general, most
21 electronic records are automatically correcting.
22 So if you come in at admission and you put 33 and

1 1, then on your delivery date, it automatically
2 updates to 31, 33 and 2.

3 So it's pretty, they would have to
4 blatantly go in and make a change for it to be,
5 but I'm going to call for a question on
6 feasibility.

7 MS. ROBINSON-ECTOR: Voting is now
8 open for feasibility of measure 0469. All the
9 votes are in and voting is now closed.

10 Sixty percent voted high, 40 percent
11 voted moderate, zero voted low, and zero voted
12 insufficient. So for feasibility of measure
13 0469, the measure passes.

14 CO-CHAIR GREGORY: We're going to do
15 usability and use.

16 MEMBER FLANAGAN: So I think everybody
17 knows that it's extensively used in quality
18 check, hospital accreditation, hospital compare,
19 hospital and patient quality reporting. It goes
20 on.

21 And I think that what I found actually
22 very revealing is Cindy's comment earlier about

1 how it has opened the door to understanding of
2 maternity by a wider audience.

3 I actually thought it was a very
4 profound statement because for so long, the area
5 of maternity has not been really looked at. So I
6 appreciate that comment.

7 The, as far as impact and improvement,
8 it'll be very to see what happens when the
9 additional numbers of hospitals come onboard.

10 Unintended consequences, I think we
11 already talked about that. There's a section on
12 expected findings, which I think we covered
13 already, which was that there were some omissions
14 in the original specs, lack of clarification on
15 uterine surgery, which has now been clarified.

16 Those who didn't receive prenatal
17 care, that where the gestational age was
18 undetermined, that's been clarified, and the
19 sampling issue. But I think it's, I think it
20 passes on usability. That's my own opinion.

21 CO-CHAIR GREGORY: Comments? Vote.

22 MS. ROBINSON-ECTOR: Voting is now

1 open for usability and use of measure 0469.

2 Okay. All the votes are in and voting is now
3 closed.

4 CO-CHAIR GREGORY: So now we need to
5 vote on whether or not we would like to recommend
6 that this be a measure --

7 MS. ROBINSON-ECTOR: Oh, just for the
8 record, I need to read the --

9 CO-CHAIR GREGORY: Oh, I'm sorry.

10 MS. ROBINSON-ECTOR: It's okay. For
11 usability and use, 84 percent voted high, 16
12 percent voted moderate, zero voted low, and zero
13 voted insufficient. So the measure passes.

14 CO-CHAIR GREGORY: And now we would
15 like to vote on the overall suitability for
16 endorsement.

17 MS. ROBINSON-ECTOR: Voting is now
18 open for overall suitability for continued
19 endorsement of measure 0469. Option one is yes,
20 option two is no. All the votes are in and
21 voting is now closed.

22 One hundred percent voted yes, and

1 zero voted no. So for recommended continued
2 endorsement of measure 0469, the measure passes.

3 DR. WINKLER: Yes, so the next measure
4 to discuss, this is the eMeasure version of this
5 measure. All right?

6 So if you look at the two measure
7 information forms, they're identical when it
8 comes to evidence and gap.

9 So if anybody, unless you have an
10 objection, we can just carry over your prior
11 discussion and votes and say, yes, they apply to
12 this one too, which means we start out at the
13 discussion of the eMeasure on the, you know, the
14 specifications, what we know about reliability,
15 validity, and the real, the things that are
16 really specific to an eMeasure that haven't
17 already been talked about in the other.

18 PARTICIPANT: Just a brief
19 introduction to the eMeasure. It is the same
20 complete description.

21 We are evaluating patients with
22 elective vaginal deliveries or elective Cesarean

1 births greater than or equal to 37, or less than
2 39 weeks gestation.

3 This version of the measure was first
4 specified in 2012, and it's updated annually.
5 Those updates address the clinical updates to
6 maintain alignment with the chart abstracted
7 measures, so the evidence and the statements are
8 exactly the same for the measure populations.

9 The updates also address updates to
10 the standards for eMeasures, which are rapidly
11 evolving. From a submissions standpoint in, as
12 Reva was saying earlier, these specifications
13 were developed in 2012.

14 Up until this year, hospitals have
15 attested to CMS, that they're able to capture
16 data on eMeasures, and they attest to their
17 aggregate rates. The Joint Commission has not
18 collected that data to date.

19 Beginning last year, we're accepting
20 electronic submission of the measures, which is
21 actually sending us raw patient data for
22 calculating the measure rates.

1 And last year we had six hospitals,
2 yes, seven hospitals submit PC-01, and in 2016,
3 there are 69 hospitals that plan to send us data.

4 We'll receive that data in 2017, so we
5 don't have it to look at yet. And we received
6 the 2015 data this March. So we are still
7 reviewing it on those seven hospitals that have
8 submitted.

9 CO-CHAIR GREGORY: Would our
10 discussants like to -- so we are accepting the
11 evidence, and we are moving on to reliability.

12 Right, so we accepted the evidence,
13 and we've accepted the gap, so we're moving on to
14 reliability, and we're discussing this
15 specifically because it's an eMeasure, and any
16 comments the discussants would like to share.

17 MEMBER FLANAGAN: So I'm going to take
18 reliability and validity almost together because,
19 in this situation, I'm not exactly sure how to
20 separate them, and I invite my statistical
21 colleagues who are non-clinical to help me with
22 this.

1 But my understanding in reading these
2 two sections is that the way this gets validated,
3 what you're trying to do is through a clinical
4 upload, exactly replicate the measure without
5 chart review, and with minimum burden.

6 I mean, that's the point of this. And
7 so the question is whether what you do actually
8 replicates what you think you're doing.

9 And what the presenter puts forward on
10 this measure is a Bonnie testing of a simulated
11 data set of 51 patients, and then kind of
12 matching to see whether they pass or fail on the
13 data included with each data element matched.
14 This is the best of my ability of understanding.
15 And then, and it in fact did pass. But I will
16 just top there before I get myself into trouble
17 of not understanding better than that.

18 CO-CHAIR GREGORY: Okay. Does anyone
19 have any comments or questions? Yes, Matt.

20 MEMBER AUSTIN: Is the expectation
21 that you would get the same rates? Because I
22 noticed that the summary was that they match in

1 terms of passing or failing, but --

2 PARTICIPANT: The Bonnie testing tests
3 the measure specification accuracy, is the
4 exclusion excluding the codes we're looking to
5 exclude.

6 It's not testing the performance rates
7 on a representative population. So it's really
8 just testing to make sure that the measure is
9 working as expected.

10 We won't be able to compare measure
11 rates until we have a significant data set with
12 the eCQM to compare to chart abstracted. Does
13 that answer your question?

14 MEMBER AUSTIN: Yes.

15 MEMBER FLANAGAN: I'm going to add a
16 comment on this in that I can't imagine that the
17 -- given that there's good, there's good
18 correlation from element to element that this
19 will in any way approach the variability and
20 problems with reliability with sampling. And
21 this takes away sampling, essentially.

22 PARTICIPANT: That's correct. There's

1 no sampling with the eCQM.

2 DR. WINKLER: I guess one question I
3 have which sort of pulls all of it together is,
4 now that you're going to be getting the data from
5 the eCQM from 60 hospitals this year, seven last
6 year, whatever it was, how are you, the Joint
7 Commission, looking at that data for those
8 particular healthcare organizations?

9 This is what they're giving you for
10 their performance, and then everybody else is
11 doing it the old way.

12 How are you looking at their results?
13 Are they the -- are you just saying it's kind of
14 the same as everybody else?

15 Are you doing, going to do any
16 particular analyses to ask whether they are
17 comparable results, or are we assuming they are,
18 or are you going to keep them in their own bucket
19 and look at them separately?

20 PARTICIPANT: I wish Stephen --

21 MR. SCHMALTZ: This is --

22 PARTICIPANT: Oh, good.

1 MR. SCHMALTZ: This is Steve Schmaltz
2 from the Joint Commission. I think I can respond
3 to that, at least a little bit.

4 For 2015, we actually received some
5 data from hospitals for the PC-01 measure, and
6 we're in the process of analyzing that right now.
7 We didn't actually have hospitals that sent in
8 both of them at the same time, so what we're
9 doing is looking at data element by data element
10 level.

11 Looking at data from the same
12 hospitals for the previous year, and then looking
13 at patterns of missing data or the type of data
14 they tend to populate to kind of look at whether
15 they're kind of reliable that way.

16 We actually have some stroke data that
17 we're looking at where we can look at the same
18 hospitals sending both at the same time, but we
19 don't have that opportunity with the eMeasure or
20 with the PC measure.

21 CO-CHAIR GREGORY: Kristi.

22 MEMBER NELSON: We've actually been

1 watching this both ways because we knew the
2 electronic was coming and the caution is to, you
3 have to educate your coders. That's where the
4 biggest difference is.

5 CO-CHAIR GREGORY: Greg.

6 MEMBER GOYERT: Exactly. I think
7 there's going to be a significant spread. It
8 would seem to be valuable for the individual
9 institution or symptom, or systems, rather, to
10 look at both sets because, you know, after
11 talking to the coders multiple times for every
12 single fall, I never knew my parents weren't
13 married.

14 But they informed me of that along the
15 way. Because I see every single case that falls
16 out in our system, and so there's going to be, if
17 we don't get a bite at that apple to explain to
18 the coder the minor error of their ways, there's
19 going to be a disconnect.

20 CO-CHAIR GREGORY: Or the doctor. And

21 --

22 MEMBER GOYERT: Coders.

1 CO-CHAIR GREGORY: And I guess they,
2 with the eMeasure then, it should be a population
3 measure and not a sample? Like, I mean, if it's
4 an eMeasure, it's every single, 100 percent,
5 cohort is the word I want. Okay.

6 MEMBER FLANAGAN: Let me add another
7 comment on that. And if you're going to do side
8 by side comparisons, it better not be a sample.
9 It has to be the same denominator.

10 CO-CHAIR GREGORY: So I think if there
11 are no further comments, we can, we'll do two
12 back to back votes. One on the reliability, and
13 one on the validity. Is that correct? Okay?

14 MS. ROBINSON-ECTOR: Voting is now
15 open on reliability for measure 2829.

16 CO-CHAIR GREGORY: Do we need to vote
17 again?

18 MS. ROBINSON-ECTOR: No. Okay. So
19 all the votes are in and voting is now closed.

20 Eighty-eight percent voted moderate,
21 eight percent voted low, four percent voted
22 insufficient, so for reliability of measure 2829,

1 the measure passes.

2 CO-CHAIR GREGORY: The next one.

3 MS. ROBINSON-ECTOR: Voting is now
4 open for validity of measure 2829. Option one is
5 moderate, two is low, and three is insufficient.

6 DR. WINKLER: In terms of feasibility,
7 I think this is one where the eMeasure is very
8 different from the other, and the issues around
9 eMeasures, and I think you've spoken to some of
10 it.

11 So I do think this is one where they
12 are different inherently, feasibility is
13 frequently about the data source and the
14 collection of the data.

15 MS. ROBINSON-ECTOR: All the votes are
16 in and voting is now closed.

17 Ninety-two percent voted moderate,
18 four percent voted low, and four percent voted
19 insufficient. So for validity of measure 2829,
20 the measure passes.

21 CO-CHAIR GREGORY: Okay. Discussants,
22 can you please share with us information related

1 to feasibility of the eMeasure?

2 MEMBER FLANAGAN: Are folks in the
3 room using this measure as an eMeasure? Kristi,
4 you mentioned --

5 FEMALE 3: We're watching it, but I
6 don't think we've submitted it that way.

7 MEMBER FLANAGAN: No, but you're
8 actually doing it. I just emailed my data
9 abstracter who for all of, we're not even going
10 to intend to do it for two years, which is
11 interesting because I actually thought, I love
12 your beginning comments.

13 I've been told for years we're doing
14 now what's called clinical upload, but that is
15 not the same thing as eMeasure.

16 Clinical upload means that we create
17 some -- we take as much from our electronic
18 medical record, but we're still doing it
19 according to the traditional way of submitting
20 it, and there is no intention of going to
21 anything, to using the eMeasure.

22 CO-CHAIR GREGORY: I guess I don't

1 know, as a committee member, I see that all of
2 the eMeasures are, I mean, they're the goal, and
3 they are corollary measures. But we don't know.

4 And so I think that if we've approved
5 one measure and we've gone through the validity
6 and the reliability of what we think the
7 measure's going to do, I think the feasibility
8 and usability has to be tabled until we have some
9 more data.

10 DR. WINKLER: I think because it's
11 part of the criteria for evaluation, you do have
12 to make some comment on it.

13 CO-CHAIR GREGORY: Okay.

14 PARTICIPANT: You could say it's
15 efficient.

16 DR. WINKLER: Possibly.

17 MEMBER FLANAGAN: Well, I heard our
18 presenter say that there are six hospitals doing
19 it. Can you comment on feasibility?

20 PARTICIPANT: I think I would be silly
21 to say six hospitals is the country. I won't try
22 and do that. You know, this has been used by

1 hospitals since 2012 through attestation, and so
2 I don't have the numbers that the hospitals doing
3 that.

4 I think the number seven for this
5 measure is lower than we see for some other
6 measure sets, but I think that's not necessarily
7 related to the feasibility of this measure as it
8 is the applicability of this measure to the
9 population, or the vendor's interest in
10 developing this measure for their hospital
11 systems based on the number of available medical
12 surgical measures.

13 So I think it's hard to comment on
14 feasibility by saying six or seven is high or
15 low, but there were seven hospitals that are able
16 to submit this data to us.

17 We've also received feedback on the
18 measure from EHR vendors and specifically coming
19 to mind, Epic and McKesson and Cerna review the
20 measures each year and provide their feedback on
21 the measures, in addition to some other EHR
22 vendors.

1 And one piece of advice we took from
2 the vendors this year is that around capturing of
3 gestational age and how many vendors are doing a
4 calculation based on estimated due date.

5 And so not in the version of the
6 measure we submitted, but in the next upcoming
7 version we've included guidance on, that will, we
8 would allow that calculation. So we are
9 improving the feasibility of the measure over the
10 time through feedback.

11 CO-CHAIR GREGORY: So maybe there
12 should, I don't know. There should be a comment
13 about that in the future. I'm going to -- unless
14 there's any -- we've been tasked to vote, so if
15 there are no other comments, I would like to
16 vote.

17 MS. ROBINSON-ECTOR: Voting is now
18 open for feasibility of measure 2829. It looks
19 like all the votes are in and voting is now
20 closed.

21 Eight percent voted high, 64 percent
22 voted moderate, zero voted low, and 28 percent

1 voted insufficient. So for feasibility of
2 measure 2829, the measure passes.

3 CO-CHAIR GREGORY: And then usability.

4 MEMBER FLANAGAN: I don't think there
5 are any additional comments beyond the prior
6 measure.

7 If we can get this right and believe
8 it, which is really my shorthand way of saying
9 that it correlates with the old measure; it
10 should be very usable.

11 CO-CHAIR GREGORY: I'd like to suggest
12 that we let the prior vote count. Can you let me
13 do that? Okay. Okay, we're going to move to
14 overall votes.

15 Whether we're going to, we are going
16 to move to whether we would like to recommend
17 this be endorsed for a measure. It's a one, two
18 vote.

19 MS. ROBINSON-ECTOR: Voting is now
20 open for overall recommendation of suitability
21 for endorsement of measure 2829. Okay, all the
22 votes are in and voting is now closed.

1 Eighty-eight percent voted yes and 12
2 percent voted no. So for recommendation of the
3 overall suitability for endorsement of measure
4 2829, the measure passes.

5 CO-CHAIR GREGORY: So the good news is
6 we're getting there.

7 We are now going to talk about measure
8 0480: Exclusive Breast Feeding and the subset
9 measure Exclusive Breast Milk Feeding Considering
10 Mother's Choice, and our developer is the Joint
11 Commission.

12 So they get a two minute overview, and
13 the discussants are Diana and myself, and we have
14 no exclusions.

15 MS. MILTON: Good to go? Okay. For
16 this measure, we're looking at single term
17 newborns that have been discharged alive from the
18 hospital, and of those newborns, we looked to see
19 if they were only fed exclusively breast milk
20 during the entire hospitalization.

21 This is a process measure. The goal
22 is to improve the rate. The goal is not to get

1 to 100 percent, because we understand that there
2 are going to be circumstances, maternal or
3 neonatal, where you can't successfully breast
4 feed.

5 And we do know there's going to be
6 cases where mothers choose not to breast feed.
7 But we've chosen to make this a very simply
8 measure. It is your rate.

9 So we're not taking any exclusions
10 out, and based on that, in our analysis we feel
11 that an achievable goal should be about 70
12 percent of those newborns only fed breast milk
13 during the hospitalization.

14 CO-CHAIR GREGORY: Okay. Diana.

15 MEMBER JOLLES: So as a maintenance
16 measure, are we reviewing evidence? There's no
17 change in evidence, and the evidence is rated --
18 is high quality. There's over 27,000 articles
19 and systematic review. What?

20 CO-CHAIR GREGORY: And so we wanted to
21 say that we will accept the prior evidence and
22 talk about the gap.

1 MEMBER JOLLES: Okay. Moving on,
2 unfortunately, there's still quite a performance
3 gap with much room for improvement. This is felt
4 by the committee and during previous discussions
5 to be still rated as a high opportunity for
6 improvement.

7 The goal of 70 percent is achievable.
8 Less than 50 percent, the rate -- in less than 50
9 -- in over half of the Joint Commission hospitals
10 that reported, they achieved less than 50 percent
11 rates.

12 And then there were, in the 10th
13 percentile, the hospitals were achieving 22
14 percent rate. Importantly, there are significant
15 disparities on this measure with great room for
16 improvement.

17 CO-CHAIR GREGORY: Right. And I'd
18 just like to add that over time, they've gone
19 from 166 hospitals to 1,400 hospitals reporting.

20 So as more hospitals report, the
21 disparity or the opportunity for improvement is,
22 increases. So if there are no objections, yes,

1 we have one. Yes, Jennifer.

2 MEMBER BAILIT: So I may be the only
3 person in the America who's willing to say this
4 publicly, but I am all for breast feeding. I get
5 that.

6 But we are putting tremendous pressure
7 on patients to breast feed when sometimes that's
8 not appropriate. Who am I to tell someone who's
9 working at a fast food job that she is a bad
10 mother if she's not pumping in the bathroom on
11 her only 15 minute break?

12 There are reasons that are good that
13 people don't breast feed, and I think people get
14 so caught up in this measure that they are not
15 giving patients choice, even when the choice for
16 that patient's life may actually be the right
17 thing.

18 I'm not saying health-wise, but big
19 picture, you know, she's got to keep a job.
20 She's got to feed the family kind of picture
21 stuff.

22 So I guess what bothers me here is we

1 don't have a balancing measure for this, and I
2 don't even know what a balancing measure would
3 be.

4 But I think this is a situation where
5 the healthcare system puts tremendous moral, I
6 will say, pressure because of this measure, and I
7 think we just need to be aware of that when we
8 talk about performance gap. That there's a price
9 for that.

10 CO-CHAIR GREGORY: Cindy?

11 MEMBER PELLEGRINI: I was going to
12 bring up two points. One is similar to what Jen
13 said, and I don't know -- I know that Joint
14 Commission, when they kind of put out these
15 measures, I don't know how much, you know,
16 guidance or resources they have for hospitals
17 that are looking for how to balance some of these
18 things.

19 And the other, I guess, question is,
20 does the Joint Commission have data on hospitals
21 that are -- have like Baby-Friendly status or
22 other status, you know, sort of statuses and

1 whether the rates are variable by that type of
2 program to show whether there's ways to improve.

3 I think hospitals struggle with
4 programs with how to actually improve this metric
5 in some way, and is there any sort of assistance
6 with that.

7 DR. MAIN: There are some national
8 toolkits on this. I think there's U.S. Breast
9 Feeding is one that we've distributed to many of
10 our hospitals, as well as the Baby-Friendly,
11 which obviously is much more involved and
12 expensive.

13 But U.S. Breast Feeding is a very good
14 source, very specific about the steps. And it
15 has some sample language, because I think this is
16 all about language, as Jen was saying, about how
17 you present it to your staff, as well as to
18 women.

19 You know, there are certainly
20 hospitals with large minority groups that do well
21 over 70 percent, so this is not just a minority
22 versus, you know, more privileged population

1 issue.

2 But I think it is about how our line
3 staff understand and present, and go about their
4 daily work with it. I think that's an
5 opportunity.

6 MEMBER PELLEGRINI: Can I, sorry, can
7 I bring up one other point? Just because, when
8 Jen, you just mentioned, what would a balancing
9 measure be.

10 One of the things that we noticed,
11 because we just went through this, the Baby-
12 Friendly process, and we noticed actually that
13 our infant fall rate went up in that process.
14 Infant falls.

15 And you know, part of Baby-Friendly is
16 a little more intense in terms of the rooming in
17 and the amount of time the babies can spend in
18 the nursery or not really having a nursery.

19 And there's a lot of implications that
20 are sometimes difficult for hospitals, and we
21 noticed that our fall rate increased, and I don't
22 know in the future if that's something that is a

1 consideration for a balancing measure.

2 CO-CHAIR GREGORY: Okay. Thank you.
3 I think it's time to vote on whether there is an
4 opportunity for improvement.

5 MS. ROBINSON-ECTOR: Okay. Voting is
6 now open for performance gap of measure 0480.

7 CO-CHAIR GREGORY: Are you good?

8 MS. ROBINSON-ECTOR: Oh, I'm still
9 waiting for more votes to come in.

10 CO-CHAIR GREGORY: More votes. Vote
11 again everybody.

12 MS. ROBINSON-ECTOR: Great. Here we
13 go. Okay. All the votes are in and voting is
14 now closed.

15 So 75 percent voted high, 21 percent
16 voted moderate, four percent voted low, and zero
17 voted insufficient. So for performance gap of
18 measure 0480, the measure passes.

19 CO-CHAIR GREGORY: Okay, we're going
20 to talk about reliability. And is there anything
21 new?

22 So it was updated to ICD-10, and

1 they're removing the sub-measure of exclusion of
2 mothers who declined to breast feed, and this was
3 actually based on stakeholders asking them
4 because they felt that this was in -- too much
5 burden to get this extra data. Do you want to
6 add anything?

7 MEMBER JOLLES: I would just add that
8 the reliability testing came out at 97.53
9 percent, which would rate it at a moderate.

10 CO-CHAIR GREGORY: So should we vote?
11 Raj?

12 MEMBER WADHAWAN: Does that include
13 patients who are in the neonatal ICUs as well?
14 Term infants who are moved to neonatal ICUs, or
15 is it just newborns?

16 MS. MILTON: Yes. Any newborn
17 admitted to a NICU would be excluded from the
18 measure, as well as those with galactosemia or
19 receiving TPI or if they expired, or if they had
20 a length stay greater than 120 days.

21 CO-CHAIR GREGORY: Although there is
22 data that it's better for the NICU babies to get

1 breast milk, so I just wonder why we would --

2 MS. MILTON: We totally agree, but
3 we're only focusing on the healthy term newborns,
4 the singletons.

5 CO-CHAIR GREGORY: Okay. All right.
6 Kristi?

7 CO-CHAIR GREGORY: What about the
8 special care nursery?

9 MS. MILTON: Unless it meets the AAP
10 definition of the highest level of care, that
11 would be a no.

12 So we have to have specially trained
13 staff, all of the appropriate equipment to take
14 care of complex and extremely ill newborns in
15 order to be considered a NICU.

16 MEMBER NELSON: I thought the measure
17 was something about life saving treatment.

18 MS. MILTON: We have adhered to the
19 AAP definition of the highest level of NICU care.

20 MEMBER NELSON: Okay.

21 CO-CHAIR GREGORY: So shall we vote on
22 reliability?

1 MS. ROBINSON-ECTOR: Voting is now
2 open for reliability of measure 0480. Okay.
3 Looks like we're missing just one vote. If
4 everyone could resubmit their vote please.

5 CO-CHAIR GREGORY: Two people left.

6 MS. ROBINSON-ECTOR: That's included.
7 Great. Thanks. Okay. All the votes are in, and
8 voting is now closed.

9 CO-CHAIR GREGORY: Okay, validity.
10 Oops, I'm sorry.

11 MS. ROBINSON-ECTOR: It's okay. So 91
12 percent voted moderate, nine percent voted low,
13 and zero voted insufficient. So for reliability
14 of measure 0480, the measure passes.

15 MEMBER JOLLES: So for validity, this
16 is rated at the moderate, I believe, because it's
17 being evaluated at the data element level, of
18 note perhaps to validity, when we look -- when
19 the data is presented on the exclusions, it's of
20 interest that there were zero galactosemia and
21 zero pre-term exclusions, which, but otherwise --

22 DR. WINKLER: The only thing I would

1 notice is they did add additional empirical
2 testing of the measure score. So that does put
3 the possibility of a high rating on the table.

4 MEMBER JOLLES: Oh, okay.

5 CO-CHAIR GREGORY: So, shall we vote?

6 Great.

7 MEMBER JOLLES: Any discussion on
8 that?

9 CO-CHAIR GREGORY: There's a couple
10 up. Okay. All right everyone. Greg.

11 MEMBER GOYERT: Just want to make the
12 note that I'm going to present alone. When you
13 look at the validity testing, the phrase is, the
14 measure score correctly reflects the quality of
15 care provided.

16 It does not. It reflects what
17 patients choose to do. It doesn't reflect the
18 counseling, the education, the time investment,
19 so on and so forth.

20 So this is a measure where the
21 institution is being evaluated on the basis of
22 the choices that our patients make. It's not

1 necessarily a reflection of the quality of the
2 care that we provide. Sermon's over.

3 CO-CHAIR GREGORY: Okay. Cindy, was
4 your --

5 MEMBER PELLEGRINI: Yes, can I just,
6 I just want to note that I think sometimes we
7 hold this measure to a higher standard than
8 everything else.

9 Almost everything we do with patients
10 reflects their choices, whether they decide to
11 have a procedure, whether they decide to take
12 their medicine, whether they decide to come to
13 the doctor at all. So I'd encourage us to think
14 about that fact.

15 CO-CHAIR GREGORY: Sindhu, is your
16 back, your card up? Sheila.

17 MEMBER OWENS-COLLINS: I just want to
18 echo what everybody else is saying. And I mean,
19 there's a very strong cultural and ethnic
20 component to this that I'm not sure is included,
21 that I think we should be sensitive to and
22 address it and not penalize facilities for that.

1 CO-CHAIR GREGORY: Tracy?

2 MEMBER FLANAGAN: Right around the
3 time about a year or two ago, I think it was
4 Joint Commission was proposing an excellence
5 standard according to performance on this
6 measure.

7 And when I looked at what -- that
8 there were hospitals in the 100 percent, I don't
9 believe that a hospital can be at 100 percent,
10 and so it made me question what kind of oversight
11 Joint Commission was doing on this.

12 I can tell you that in our hospital
13 system, the way we submit this is every feeding
14 from every nurse, the whole hospital.

15 So I had lots of doubts about the
16 validity of the people who were up beyond 95
17 percent. So I'd love to hear some comments on
18 that.

19 MS. MILTON: I don't believe there are
20 that many that are above 95 percent. There was
21 one hospital out in California, and we
22 interviewed them, but they're about the only one

1 that I'm aware of.

2 Again, we're not looking at 100
3 percent. I want to stress that. Seventy percent
4 is where we feel it should be, where a hospital
5 should strive to achieve, because there are
6 personal preferences, and there's going to be
7 conditions.

8 Mother's HIV positive, it's not a very
9 common thing. When we did an analysis, a 12
10 month analysis, only two percent of the
11 exclusions were due to medical conditions.

12 So we're not looking for anyone to get
13 anywhere near 95 percent. But I know that there
14 are a lot of hospitals that are above, not a lot,
15 but there are some that are already above 70
16 percent.

17 MEMBER FLANAGAN: Let me restate that.
18 I think that for those hospitals that are super
19 high, I mean, maybe we choose 90 percent, maybe
20 we choose 85 percent, I think it would be
21 interesting for Joint Commission to perhaps
22 prioritize them for audit.

1 CO-CHAIR GREGORY: Juliet. Oh, you
2 wanted to say something?

3 DR. OWENS: We actually do audit them.
4 We have, I alluded to this earlier, but we have
5 actually a pretty rigorous -- not pretty, a very
6 rigorous process for checking the quality of the
7 data that we receive.

8 Healthcare organizations collect the
9 data. They submit them to like a, we call them
10 performance measurement systems, but basically
11 they're vendors.

12 They run all of these quality checks.
13 They are contracted with us. They are contracted
14 with the hospital.

15 They're required to do inter-rater
16 reliability and that kind of a thing. We're
17 pretty confident that the numbers that we're
18 getting are good. And we do check them on a
19 routine basis.

20 CO-CHAIR GREGORY: Juliet.

21 MEMBER NEVINS: I'll start by asking
22 a question, because I don't know the answer in

1 terms of the percentage of women who start breast
2 feeding in the hospital who then continue for
3 even a week, you know, two weeks past that point.

4 And the reason I'm asking this
5 question is because I'm sort of piggybacking on
6 Jennifer's comment. I think it's something that
7 as a society we really need to strive for,
8 because it's so important, and the health
9 benefits have been so well demonstrated.

10 But patients don't want to start
11 something that they can't finish. And we need,
12 we, you know, America, we send our patients back
13 six weeks after vaginal delivery, and eight weeks
14 after a C-section.

15 Most of the time they can't, they
16 can't breast feed in that work environment, even
17 with the new laws requiring that a place for them
18 to pump and store be provided.

19 So you know, in terms of holding
20 hospitals accountable for breast feeding, even
21 though this measure is only for measuring members
22 or patients who breast feed in the hospital, it

1 sort of has -- it extrapolates beyond that time
2 to moms who breast feed for at least six weeks, I
3 think. So I just wanted to throw that out there.

4 CO-CHAIR GREGORY: But the data is
5 clear that six weeks is better than none, so I
6 would -- but I do appreciate your perspective.
7 Naomi? Diana.

8 MEMBER SCHAPIRO: So when I was in
9 nursing school, which was like 1972, there was
10 only one woman in my entire OB rotation who
11 breast fed.

12 So we, you know, we've done a really
13 like an incredible job since then, and I've
14 worked all my entire, pretty much present career
15 with very low income women and families, and I
16 would say that the more this becomes standard,
17 the more conditions change to enable people.

18 That there are a lot of women in not
19 very high status jobs who actually can pump now.
20 And every woman goes home from the hospital with
21 a pump if she's nursing, breast feeding. A
22 really good pump.

1 You know, so I feel like if we relax
2 the standards in some ways, then we relax the
3 conditions that allow women who are in more
4 difficult circumstances to absolutely choose to
5 breast feed for longer, and I agree they need
6 that.

7 So I, that's kind of, I understand
8 choice, but choice is really dictated by
9 circumstances, and so I really feel that this
10 measure helps keep the circumstances there that
11 allow more women to breast feed if they want to
12 for longer. And I really support it.

13 MEMBER MOORE: I'm going to build off
14 two comments that were made. Essentially they
15 made my comment, but I wanted to ask additional
16 pieces there.

17 The concept of measuring exclusive
18 breast feeding, or the intentions of exclusive
19 breast feeding, really doesn't apply to long term
20 breast feeding, and I think that this measure is
21 what, we assume that that's what's happening, and
22 I think that we need to look at how we actually

1 measure breast feeding long term, because that's
2 where the true benefits are, not that you have
3 intentions during that discharge out of the
4 hospital. The other piece, I love your comment
5 Naomi, but I'm really struck by Jen's comment,
6 too.

7 And I feel like there's this, there's
8 this balancing between the two. And knowing that
9 I'm in the Medicaid space and knowing that 50
10 percent of births on Medicaid, they're low income
11 women, they're going back to work way before
12 four, six weeks, and they're going into jobs
13 where being able to pump, those accommodations
14 are not being made for them.

15 And this notion that we put all this
16 pressure on women that they're not good moms,
17 that they're not getting what's best for their
18 newborns, coupled with this notion of, well,
19 let's keep that threshold at 70 percent to help
20 move the nation forward.

21 I mean, I'm really challenged by the
22 two comments, and it's hard with this measure,

1 and to expect that we'll be at 70 without
2 considering the patient's situation as occurring
3 right now.

4 CO-CHAIR GREGORY: Okay. So I see
5 one, two, three, four cards up. It's 10 to 2:00.
6 The meeting is supposed to adjourn at 2:00 and we
7 still have one more measure. So keeping that in
8 mind, Diana. Diana you're next.

9 MEMBER JOLLES: Well, I just, I'm only
10 going to say this because I think it's important
11 in general as we debrief over our entire
12 portfolio.

13 So this measure is one of two measures
14 that affects population health. We're looking at
15 a large population of over four million child
16 bearing women.

17 The minority of our measures are
18 addressing those, that population movement. This
19 measure is affecting life course health, chronic
20 disease. This issue of women being pressured is
21 a lack of process.

22 So I just want to raise awareness

1 about this. The Baby-Friendly hospitals have a
2 very good process, and it is easy for people to
3 opt out and sign and never be harassed again.

4 So if people are being harassed, it's
5 because they're in systems that aren't embracing
6 improvement and process. I must sit as a midwife
7 and say that I ran a service in Washington, D.C.
8 that served African American women and we had the
9 highest breast feeding rate in this entire city
10 across all socio-demographic groups.

11 We had group prenatal care, and most
12 importantly, peer counselors. And we did not
13 pressure anybody. And so this is a process
14 measure that has extreme supply-sensitive
15 provider preferencing, and poor quality.

16 So please ride this measure out and
17 watch it until we can retire it and then get into
18 those issues.

19 CO-CHAIR GREGORY: Okay, Deb.

20 MEMBER KILDAY: Okay. Apparently I
21 need a nap. I'm just going to sort of echo on
22 what you were stating.

1 Having the observation to look at how
2 hospitals perform and how they use their quality
3 initiatives, a lot of hospitals are talking about
4 breast feeding.

5 I do hear you about patient
6 preference, and maybe it's the patients, but from
7 my clinical experience and from my observational
8 experience in consulting with all these
9 hospitals, I see a tremendous clinician culture,
10 nursing predominantly, including pediatrician and
11 obstetrician education and knowledge, and some
12 resistance between those three sort of effects in
13 furthering our process.

14 So I see less with patients, but I see
15 a lot of babies in nurseries these days, which we
16 don't think we're supposed to see.

17 I see a lot of formula sitting out all
18 over the place, which we're really not supposed
19 to see. And then when I do chart abstraction
20 quite frequently when I do these quality
21 assessments because, you know, you really get
22 into the weeds by opening the chart.

1 And we're feeding babies a lot of
2 things we shouldn't be feeding them, and when you
3 ask the parents, because I do that on my
4 assessments, they're like the nurse told me that
5 it would probably be better if I get some rest.

6 So I'm going to echo your statement
7 that we have tremendous process problems within
8 our culture of healthcare, and I'd like to
9 continue to take a look at that.

10 CO-CHAIR GREGORY: All right. We have
11 two more comments. I hope they're pertinent to
12 validity. Cindy.

13 MEMBER PELLEGRINI: This is a
14 challenging issue, but that is not the measure's
15 fault. We can do better. We need to do better,
16 and the measure can help track our progress to
17 getting there.

18 But when we have patients who smoke,
19 we don't say, well, they're addicted to tobacco
20 and we should change the measure. We say, do we
21 have the supports, do we have programs in place,
22 do they have access. We don't say -- we don't

1 throw our hands in the air.

2 CO-CHAIR GREGORY: Okay. I think this
3 was all very exciting discussion, and we will not
4 vote on whether this is --- if the measure has
5 validity.

6 MS. ROBINSON-ECTOR: Voting for
7 validity of measure 0480 is now open. It looks
8 like we're looking for 23 votes, so we're missing
9 one vote, if everyone could resubmit.

10 CO-CHAIR GREGORY: Okay.

11 MS. ROBINSON-ECTOR: So 22 votes are
12 in, so voting is now closed.

13 CO-CHAIR GREGORY: Okay.

14 MS. ROBINSON-ECTOR: So 36 percent
15 voted high, 55 percent voted moderate, 9 percent
16 voted low, and 0 voted insufficient. So for
17 validity of measure 0480, the measure passes.

18 CO-CHAIR GREGORY: Okay. With regard
19 to feasibility.

20 MEMBER JOLLES: Feasibility is rated
21 high. It's used by Quality Check, Joint
22 Commission, the Hospital Inpatient Reporting

1 Program, eClinical measure, CMS9, and meaningful
2 use. So that would be a high.

3 CO-CHAIR GREGORY: I would -- I have
4 nothing to add to that, so we can vote on
5 feasibility.

6 MS. ROBINSON-ECTOR: Voting for
7 feasibility, measure 0480 is now open.

8 CO-CHAIR GREGORY: We're going to vote
9 on usability. Any comments on usability? I'm
10 sorry. Keep me on it.

11 MS. ROBINSON-ECTOR: For usability --

12 CO-CHAIR GREGORY: Oh, sorry.

13 MS. ROBINSON-ECTOR: Okay. So all the
14 votes are in and voting is now closed. Seventy-
15 eight percent voted high, 22 percent voted
16 moderated, zero voted low, and zero voted
17 insufficient. So for feasibility of measure
18 0480, the measure passes.

19 CO-CHAIR GREGORY: So with regard to
20 usability, it is currently being used, it is
21 publicly reported, and it is part of
22 accountability programs. Would you like to add

1 anything?

2 MEMBER JOLLES: Currently until the
3 eMeasure is adopted, there is lack of public
4 performance data available to consumers, and I
5 would add that an important part of usability is
6 improvement, progress, and the ability to have
7 impact, and as we already spoke about, this is a
8 high impact measure.

9 CO-CHAIR GREGORY: Any comments?
10 Okay. We shall vote on usability.

11 MS. ROBINSON-ECTOR: Voting is now
12 open for usability and use of measure 0480.

13 CO-CHAIR GREGORY: I'm sorry. Ashley?

14 MEMBER BELL: Just quickly, it's not
15 probably going to affect this, but I didn't know
16 when to bring it up and maybe in more in gaps
17 actually, but I know this measure was discussed
18 with the Medicaid MAP.

19 It was last, I guess, yes, last year.
20 And it was really debated, like we knew that
21 breast feeding was important, but I think that
22 exclusivity and maybe Carol, if you remember, you

1 were on the MAP as well.

2 I think that's what was problematic
3 about it, that there was concern with kind of
4 current practice I guess, maybe with
5 pediatricians wanting to intervene with weight
6 loss in the newborn, kind of pushing the
7 supplementation that exclusivity was really
8 impossible to achieve.

9 I know that the data are about 50
10 percent, but if we just think about how we can
11 improve this measure given those kinds of
12 concerns or think about adding another measure
13 that really just captures initiation versus
14 exclusivity.

15 CO-CHAIR SAKALA: So what I recall is
16 there was nobody in the room who was providing
17 care to childbearing women, and the concern was a
18 focus on the coercion aspect, and a lack of
19 recognition of the system issues and the
20 potential to have very good process, and also
21 that the -- it was added as a candidate measure
22 the day of, rather than included in the list.

1 So I think it's going to be included
2 in the list later on this month, and let's see
3 what happens at that point in time.

4 It -- I was a little concerned about
5 the way the discussion played out because of lack
6 of understanding of these -- an impression
7 without having firsthand experience.

8 CO-CHAIR GREGORY: Okay. So we're
9 going to vote on usability and use.

10 MS. ROBINSON-ECTOR: Voting is still
11 open for usability and use of measure 0480. All
12 the votes are in and voting is now closed.

13 Sixty-one percent voted high, 35
14 percent voted moderate, 4 percent voted low, and
15 0 voted insufficient information. So for
16 usability and use of measure 0480, the measure
17 passes.

18 CO-CHAIR GREGORY: And now we'll vote
19 on whether or not we would like to put it forth
20 for continued endorsement.

21 MS. ROBINSON-ECTOR: Voting is now
22 open for overall recommended suitability for

1 continued endorsement of measure 0480. Okay.

2 All the votes are in and voting is now closed.

3 CO-CHAIR GREGORY: All right, we're
4 going to count and make sure we still have a
5 quorum.

6 MS. ROBINSON-ECTOR: So 91 percent
7 voted yes, and nine percent voted no. So for
8 recommended suitability for continued endorsement
9 of measure 0480, the measure passes.

10 CO-CHAIR GREGORY: So just a second.
11 Are we good with quorum? We're okay. So I'm
12 going to ask Reva to help me through this because
13 it is a corollary measure, and I will try to only
14 do the votes we need to do, and have the
15 discussion we need to have.

16 DR. WINKLER: Okay, so let me help
17 drive this one. Okay. Evidence and gap, it's
18 the same information, so we can carry it over
19 from the one you just discussed. We're done.
20 Okay.

21 Reliability and validity really are as
22 we discussed with the prior eMeasure, the

1 specifications that are unique to the eMeasure,
2 as well as the Bonnie testing.

3 So we do want to have a conversation
4 about that. The feasibility is probably going to
5 be the same as it was for the other eMeasure,
6 right?

7 CO-CHAIR GREGORY: Right.

8 DR. WINKLER: If you like, we can
9 carry that one over. Usability you felt was
10 still, you know, a little hard to get your hands
11 around. Probably going to be the same as the
12 other. We could carry that over.

13 So if you would just talk about, you
14 know, the specs for this measure, the Bonnie
15 testing, and then we'll do an overall, that might
16 get us there quickly.

17 CO-CHAIR GREGORY: Can you help Diana
18 out?

19 MEMBER JOLLES: So beginning with
20 quality construct?

21 CO-CHAIR GREGORY: The reliability and
22 the validity for the eMeasure.

1 DR. WINKLER: Really the
2 specifications and then the Bonnie testing.

3 MEMBER JOLLES: Okay. So this is,
4 this is easy to get through. Its HQMF
5 specifications have been made. They've been
6 vetted through USAC.

7 Value sets exist, Bonnie testing
8 occurred, which was demonstrated to be reliable.
9 And then it is a legacy eMeasure that's being
10 used for meaningful use. It's already got SNOMED
11 mapping. So the quality construct is there, is
12 present.

13 CO-CHAIR GREGORY: Okay. So we will
14 vote on the reliability. It's a one, two, three,
15 right?

16 MS. ROBINSON-ECTOR: Yes, it's
17 moderate or --

18 CO-CHAIR GREGORY: So it's moderate,
19 low, or insufficient. Moderate is one, low is
20 two, and insufficient is three.

21 MS. ROBINSON-ECTOR: Yes. So voting
22 is now open for reliability measure 2830, or

1 2830. Option one is moderate, two is low, and
2 three is insufficient.

3 CO-CHAIR GREGORY: You're looking for
4 20 votes I believe.

5 MS. ROBINSON-ECTOR: Okay. So all the
6 votes are in and voting is now closed.

7 CO-CHAIR GREGORY: Fabulous, and --

8 MS. ROBINSON-ECTOR: 89 percent voted
9 moderate, 5 percent voted low, and 5 percent
10 voted insufficient, for reliability of measure
11 2830, the measure passes.

12 CO-CHAIR GREGORY: Would you like to
13 comment on validity?

14 MEMBER JOLLES: Sure. Bonnie testing
15 was conducted of the eMeasure, 528 cases passed
16 at 100 percent.

17 CO-CHAIR GREGORY: So we'll now vote
18 on validity.

19 MS. ROBINSON-ECTOR: Voting for
20 validity of measure 2830 is now open. Like we
21 have, okay, all of the votes are in and voting is
22 now closed.

1 Seventy-nine percent voted moderate,
2 21 percent voted low, zero voted insufficient.
3 So for validity of measure 2830, the measure
4 passes.

5 CO-CHAIR GREGORY: So our last vote of
6 the day is whether or not this will be
7 recommended for consideration for endorsement,
8 and it's a yes or no vote. You said we're
9 carrying it over? That's why I had --

10 MS. ROBINSON-ECTOR: Voting is now
11 open for overall recommended, recommendation for
12 suitability of endorsement for measure 2830. All
13 the votes are in and voting is now closed.

14 CO-CHAIR GREGORY: I would like to
15 thank everyone and commend you for your --

16 DR. WINKLER: And, yes. I'll take
17 over for this one. No, again, I echo Kim, and I
18 can't thank Kim and Carol enough for what they've
19 done. There were a couple questions about, okay,
20 now you've done this, now what.

21 What you would've done is act as a
22 proxy to the multi-stakeholder membership of NQF

1 and the public at large.

2 And so you have made the sort of first
3 pass recommendations back to NQF about which
4 measures should be endorsed.

5 So this is the first step, or an early
6 step, okay, going forward. So we will be writing
7 a draft report, and then we will, with your
8 recommendations, and we will be soliciting public
9 comment. Okay?

10 MEMBER OWENS-COLLINS: When will that
11 be?

12 DR. WINKLER: We'll announce it to
13 you. It'll be in about a month. It's in the
14 month of June pretty much.

15 And so then anyone is welcome to
16 comment and submit written comments, then we will
17 collate those comments and come back to you.

18 We have a scheduled meeting at some
19 point, a call at some point. There's a date
20 already set. And we'll discuss and ask you to
21 respond to those comments and perhaps if they
22 make any influence in your decisions of making

1 your recommendations.

2 After that, those recommendations,
3 after considering the comments, will go for an
4 NQF member voting, and that's in August. And
5 then it goes to our Consensus Standards Approval
6 Committee, which is a subcommittee of the Board
7 of Directors, who looks at the more detailed
8 aspects of the process and leading up to granting
9 the final endorsement by CSAC, by recommendation
10 of the Board by ratifying it.

11 So through the summer, we'll be sort
12 of finishing the details. So you're at the
13 beginning of this process that'll go over the
14 next couple of steps. So I know somebody had a
15 few questions. So I wanted to go over that.

16 MEMBER WADHAWAN: What is the process
17 after reviewing public comments? If there is a
18 desire to re-look at the measure and change the
19 recommendations. Is there a repeat vote?

20 DR. WINKLER: Yes.

21 MEMBER WADHAWAN: Is it by phone or --

22 DR. WINKLER: Yes. You would be

1 repeating the vote, discussion and vote. Yes.
2 Absolutely. Okay. So I just wanted to respond
3 to that before we lost too many more people.

4 Now I understand that we do have
5 someone on the phone who wants to make a comment.
6 Or in person, fine. And for our last opportunity
7 for public comment today.

8 MS. SANTA-DONATO: I'll be brief, I
9 promise. Is this on? Hello? Okay. Hi, I'm
10 Anne Santa-Donato, and I represent the
11 Association of Women's Health Obstetric and
12 Neonatal Nurses.

13 I'm the director of Obstetric
14 Programs, and on behalf of the organization, I
15 just want to thank you for the opportunity to
16 attend this meeting and to let you know that our
17 organization fully supports the mission and the
18 work of the NQF as well as the measures that were
19 endorsed today.

20 I just want to provide you with a very
21 brief update about AWHONN's Women's Health and
22 Perinatal Nursing Care quality measures.

1 We've developed a series of 12
2 measures over the last few years, and we are now
3 in the testing phase, and two of those measures
4 are currently being tested.

5 One is immediate skin-to-skin care
6 following birth, and the second one is the
7 continuation of, duration of continuation of
8 interrupted skin-to-skin care during the birth
9 hospitalization.

10 And those measures are being tested
11 through the NPIC hospitals, particularly some of
12 the CWISH hospitals that are part of NPIC. In
13 addition to that, we have a maternal fetal triage
14 index, which is designed to help the, to
15 facilitate the very first assessment of women who
16 are coming into labor to be evaluated, modeled
17 after the Emergency Nurse's Association scheme
18 for initial assessment of the patient to
19 prioritize care.

20 In order to be able to test that
21 measure, a tool was necessary to be developed
22 that had some standardization to it.

1 So that tool was developed and tested,
2 and so that measure will be ready for testing,
3 hopefully within the next few months.

4 So I just wanted to provide you with
5 those updates, and thank you so much.

6 DR. WINKLER: Okay. At this point,
7 what we always like to do before we finish up is
8 kind of look back over our portfolio to kind of
9 see where we are.

10 You know, we've talked about several
11 new measures. Not all of them were recommended
12 by you, but I think in the course of looking at
13 the various measures, the idea that there are
14 probably areas that aren't being measured that
15 represent quality problems within that portfolio.

16 And you have the opportunity to make
17 some recommendations on those areas. We call
18 them gaps. But one way to think about them is
19 really around where are the quality problems that
20 would be amendable and responsive to measurement.

21 Not everything can be fixed with a
22 measure. But our focus is measurement. And so

1 as we look at our portfolio of measures say in
2 reproductive health and antenatal care, it seems
3 we're a little light on antenatal care measures.

4 And hello. Go back. Thank you.

5 And again, I would, you know, with
6 three new contraceptive care measures, it starts
7 to really add some weight to the reproductive
8 health area.

9 Realizing that there's a significant
10 overlap between whether we categorize something
11 as reproductive health versus women's health, we
12 do have measures in general women's healthcare,
13 and we only pulled the ones that have very
14 specific focus on reproductive health.

15 But your thoughts around the measures
16 we have and the measures we don't have. And
17 perhaps what might be happening out there in your
18 world of the things that you're looking at and
19 attending to and finding that they are problems
20 that you're trying to address through, perhaps
21 local measurement or something like that.
22 Thoughts from anybody? Go ahead, Cynthia.

1 MEMBER PELLEGRINI: A quick plug for
2 preconception care, which is of course a subset
3 of women's health, and March of Dimes is starting
4 to have some conversations with CMS about taking
5 some of their existing preventive measures and
6 pulling them together into either a formal or an
7 informal preconception measure set.

8 The interesting thing about what else
9 would be missing from that.

10 MEMBER FLANAGAN: Just a couple
11 comments along the same lines. I think an area
12 that really needs some focus is perinatal
13 depression.

14 And the second area that I think we
15 could do better in and actually could even create
16 a measure or entertain a measure is
17 identification of intimate partner violence or
18 DV.

19 CO-CHAIR SAKALA: Yes. So I have had
20 some conversations with our reproductive health
21 team, and this is a little bit of an echo of what
22 Lorrie Gavin said they're working on that I just

1 would like to put a support for it.

2 Patient-reported experience of
3 contraceptive composite measure, whether women
4 felt respected, whether they were informed and
5 whether they experienced shared decision making,
6 which would be a nice balancing measure for
7 those.

8 And also in more broader settings than
9 just once at our, extensively focusing on
10 contraception, a measure to track whether women
11 were screened for pregnancy intention and desire
12 to use a contraceptive measure.

13 MEMBER AUSTIN: Yes, and I may be sort
14 of stating the obvious, but looking at the
15 pregnancy measures, I mean, those two both ran
16 into some challenges yesterday.

17 So there seems to be a lot of good
18 discussion around what would be a meaningful
19 prenatal care measure or the elements of that.
20 So that might be worth exploring.

21 MEMBER BAILIT: So having publicly
22 come out against breast feeding measure that

1 exists, I'd like to see something better.

2 You know, is it a pediatric measure,
3 some breast milk at six weeks, at six months, and
4 our pick of time. And it should be some and not
5 exclusively would be my thought.

6 MEMBER KEATS: So is depression
7 screening in the perinatal period being worked
8 on, did you say?

9 Or, I mean, that's not a measure
10 that's in development right now. Or Tracy,
11 you're the one that brought that up.

12 MEMBER FLANAGAN: The U.S.
13 Preventative Services just came out with
14 recommendations in January endorsing this with, I
15 think, moderate strength evidence.

16 MEMBER KEATS: Yes, it was --

17 MEMBER FLANAGAN: But as far as I
18 know, I don't know of any measure developer at
19 this point, while there's a lot of interest.

20 MEMBER KEATS: Yes, okay. So a
21 developer has not been identified is what you're
22 saying. Okay, great. Thank you.

1 CO-CHAIR SAKALA: I just want to say
2 that the PCPI set has a composite postpartum
3 measure which does include depression screening.

4 And I'll put in a general plug for the
5 AWHONN's that Anne just discussed, and the PCPI
6 set that have a lot of great potential for
7 clinician level measures that are, for the most
8 part, languishing for lack of testing support.

9 DR. WINKLER: Who does?

10 CO-CHAIR SAKALA: AMA-PCPI and AWHONN
11 for nursing measures.

12 TL: What is PCPI? I've not ever
13 heard of that.

14 CO-CHAIR SAKALA: Physician Consortium
15 for Performance Improvement. It's with the AMA,
16 and in this particular case, it was the
17 collaboration with ACOG and NCQA in a multi-
18 stakeholder process that worked those measures
19 out.

20 DR. WINKLER: Okay. Cindy, are you up
21 now?

22 MEMBER PELLEGRINI: I was waiting to

1 see if somebody else would get it first. Opioids
2 prescribing during pregnancy, screening for
3 pregnancy when prescribing, all that.

4 DR. WINKLER: Yes, right. Sindhu.

5 MEMBER SRINIVAS: I was going to say
6 that too, and then I also, looks like we're on
7 the same page. Now I know, we have a similar
8 name so it goes along.

9 The other thing I was going to say is
10 sort of thinking about, and this is a more
11 difficult one I think, but thinking about all the
12 counseling that's supposed to happen during
13 prenatal care, and how it's not really -- it's
14 not easy for clinicians or providers to do that
15 counseling in terms of like nutrition counseling,
16 weight gain, contraception, all the stuff that's
17 supposed to happen sort of during the course of
18 prenatal care, and somehow coming up with a
19 measure that would be -- allow us to kind of
20 really push that movement forward.

21 MEMBER FLANAGAN: One of my other
22 committees that I sit on is the International

1 Committee for Healthcare Outcomes, which is the
2 patient centered outcomes around maternity.

3 And the final set is just about being
4 finalized right now, and they're looking for
5 testers of it, and it does include women's
6 perspective of their own prenatal care, which I
7 actually think is probably a better indicator of
8 good care than, you know, some of the more, what
9 we might call medical ones.

10 DR. WINKLER: Tracy, who was doing
11 that?

12 MEMBER FLANAGAN: International
13 Consortium of Healthcare Outcomes. Yes. The
14 last two years has been dealing with pregnancy
15 specifically.

16 DR. WINKLER: Hold on. Let me, let me
17 get it specifically. Because I don't want to get
18 it wrong. Let me get it on my iPhone.

19 MEMBER SRINIVAS: Can I ask another
20 question?

21 DR. WINKLER: Sure.

22 MEMBER SRINIVAS: The PCPI that you

1 just mentioned, is that, what, like once that's
2 developed, like what happens?

3 DR. WINKLER: Well, it, this is really
4 fascinating because it just shows you some of the
5 silos we all live in.

6 The PCPI actually has been responsible
7 for the development of both the measures used in
8 all of the physician, you know, PQRS. Yes.

9 That's where they all came from, and
10 the fact that obstetrics is sort of, doesn't play
11 in that field is interesting.

12 And so they have developed with a lot
13 of the specialty societies, clinician level
14 measures. I don't know what the status is
15 because the PCPI measures are kind of languished.

16 They were looking for opportunities to
17 test them, and were not able to, and it's been a
18 while since I've heard what their status is. But
19 they did create a set of, I don't know if it was
20 5 or 6.

21 CO-CHAIR SAKALA: 10.

22 DR. WINKLER: Oh, was it 10? Okay.

1 Measures. I haven't seen them in a while. We'll
2 see if we can figure out what may or may not be
3 happening. But again, the challenges are testing
4 these measures.

5 As you've seen, this is not a minor
6 undertaking. And it tends to be the major
7 challenge for any measure development, is getting
8 the adequate testing and the resources and the
9 people involved. Ashley.

10 MEMBER HIRAI: Comment on that. So
11 that's actually -- it's the Behavioral Health
12 Risk Assessment, and the steward is the PCPI in
13 addition to NCQA and ACOG, and it's actually a
14 prenatal, it's not a postpartum measure.

15 I think something parallel to that
16 could be developed in the postpartum period. It
17 does capture depression screening, alcohol use,
18 tobacco use, drug use, which would include
19 opiates, and intimate partner violence screening.

20 So it is this composite measure. It's
21 been part of the Child Core Set for Medicaid. I
22 don't know how many years. I think it's newly

1 added.

2 So only two states reported it in the
3 last MAP report, so that was fiscal year,
4 reflecting fiscal year '13 data.

5 So there's some problems reporting it,
6 but I think everyone was really interested in
7 that, and it captures a lot of different domains
8 that then, and that may reduce some of the
9 measurement burden versus parsing these out as
10 separate measures.

11 But then, what are you truly
12 reflecting, and what do you have to improve? Is
13 it one of those, or is it a couple of them? So
14 there's some problems, I think, with the
15 composite approach.

16 But yes, if anything we can do to
17 encourage them to continue seeking that NQF
18 endorsement, and to extend that to the postpartum
19 period, because a lot of those same screenings
20 are relevant for the postpartum population as
21 well.

22 MS. ALLEN: So the Behavioral Health

1 Risk Assessment is in the Child Core Set.

2 However, states have been having some
3 difficulties reporting that measure because it
4 relies heavily on chart data.

5 Over the past several years, when it
6 became -- it was included in the Core Set in
7 2013, and so only two states reported it. For
8 2014, only four states had reported the measure.

9 So CMS is really trying to increase
10 data on the measure, but they're having some
11 challenges with that.

12 MEMBER HIRAI: Thanks, Nadine. And
13 just to move us along maybe, in Kim's spirit, I'm
14 just going to say one thing about the perinatal
15 measures then, and actually Cindy mentioned this
16 yesterday with the concern about postpartum not
17 continuing it or retiring it without having a
18 replacement.

19 The same can be said for risk
20 appropriate perinatal care. I thought that was
21 kind of a revelation that we didn't pass that new
22 measure proposed, and then Elliot is, didn't

1 apply to continue the risk appropriate perinatal
2 care, so now we have no NQF-endorsed measure
3 capturing that, and it's a very important
4 measure, I know to March of Dimes.

5 And we know that it causes death when
6 babies are not born in the appropriate facility.
7 And I guess I just think that's going to be a gap
8 now that we don't have a measure for that.

9 I will just encourage colleagues at
10 CDC who have taken some ownership of that to
11 maybe start to work on an application.

12 CO-CHAIR GREGORY: I guess I would
13 just like to make a plug for outpatient measures
14 of the content of care, as well as
15 overutilization.

16 I hesitate to say that as an MFM, but
17 I definitely think that there's some
18 overutilization going on. And a measure of
19 maternal morbidity, or a measure of total outcome
20 of care.

21 DR. WINKLER: Do you know if anybody
22 is working on something like that? Has anybody

1 even thought about what might be included in
2 that?

3 MEMBER HIRAI: I think actually CDC is
4 working maybe on an application for severe
5 maternal morbidity using claims data.

6 DR. WINKLER: Okay. Interesting.
7 Okay.

8 MEMBER HIRAI: Or hospital discharge.

9 CO-CHAIR SAKALA: Population level or
10 health plan level. It doesn't go down too low,
11 right?

12 MEMBER HIRAI: Yes, it can go to
13 facility. Yes.

14 MEMBER BAILIT: NICHD with the APEX
15 trial, did put together maternal morbidity
16 outcome measures that are risk-adjusted.

17 They are based on chart review though
18 and not on diagnosis codes, and for a variety of
19 complicated reasons, it's hard to get the NICHD
20 to be a sponsor.

21 So to the extent that somebody would
22 want to work as a partner and be a developer, I

1 think those have a lot of potential.

2 DR. WINKLER: When we report your
3 recommendations out, it's in a report that will
4 contain some of these other things acknowledging
5 the issues in the portfolio. Sheila, you wanted
6 to say something?

7 MEMBER OWENS-COLLINS: All right.
8 Couple of things. Okay. So I agree that the
9 postpartum care exam is something that we should
10 look at, but I just have tremendous angst with
11 the way it's being reported now, and the
12 consequence, the financial consequences that it
13 has had on health plans because of the narrow
14 window.

15 So I would strongly encourage that we
16 really take a look at that, widen the window or
17 make it a little bit easier to obtain.

18 Because it is used as a carrot or a
19 stick for the health plans. Also, I'm involved
20 with a grant from the state of Maryland to look
21 at gestational diabetes in women in the follow-up
22 care, and in this process, I have found that

1 there is a gap, and there are lots of
2 opportunities.

3 Even for the six week exam, six week
4 postpartum exam to look at those women because of
5 the high risk of developing Type 2, the issues
6 of coordination of care between the OB and the
7 PCP and the transition of care.

8 So I would recommend that we take a
9 look at that. And lastly, going back to that
10 postpartum, you know, and if we could be more
11 specific in terms of if we're going to stick to
12 the narrow window of specific conditions that are
13 amenable to looking at specifically at six weeks.

14 And the gestational diabetes one is a
15 piece. The neonatal admission rate, I think is
16 extremely important, and maybe, at the health
17 plan level it will be easier to get the data, but
18 I think that that is a very high cost, very
19 prevalent condition, and that we should continue
20 to look at that, even though it's sort of stalled
21 right now.

22 The infection rate, I recommend that

1 we make it more comprehensive to include the
2 larger babies, to include GBS, because I think
3 that infection is a source of considerable
4 mortality and morbidity, not only in the low
5 birth rate, but also in the larger babies.

6 And lastly, to Ashley's point, I was
7 also disappointed in the structural attributes
8 for maternal care, and I think, you know, I think
9 that we should look at that and look at other
10 states that are looking at that, looking at the
11 ACOG, the ACOG recommendations, because I think
12 that can tie in to the infant mortality rate and
13 the maternal mortality rate that we're looking to
14 find out more about.

15 And so, you know, I'm hoping we can
16 fine tune that measure and come back with some
17 that is more feasible and usable. Thank you.

18 MEMBER FLANAGAN: Just one quick
19 comment. ICHOM, International Consortium for
20 Health Outcomes Measurement. The contact is
21 Stephanie Wissig. ICHOM.

22 International Consortium for Health

1 Outcomes Measurement. It's a very new bundle
2 that literally is being finalized last month.

3 MEMBER AUSTIN: Their goal is to
4 develop standardized measure sets for different
5 health conditions that we, as an entire world,
6 would be monitoring. And so they've taken on, I
7 think, like 12 or 15 at this point different
8 conditions.

9 DR. WINKLER: The other slide's on the
10 portfolio. Okay. Go back. Back. There we go.
11 Yes. Where we started.

12 So just to go through, any other
13 thoughts on some of these other topic areas if
14 you felt we were just focused? Naomi, what did
15 you, did you have something you wanted to offer?

16 MEMBER SCHAPIRO: Yes. It's not, I'm
17 not sure if there's anything like this is the
18 database yet, but when we were talking about
19 contraception and adolescence, there was not as
20 much attention paid to the kind of, well it was
21 the 15 to 18, I would even say 14 to 18 is, would
22 be a really important age to look at.

1 And so if anybody's developing, and I
2 think there's a lot of attention paid to like
3 legal issues around confidentiality and what they
4 are in different states, and there's a lot of
5 attention paid to pregnancy rates for
6 adolescence, and for pregnancy, delivery,
7 abortion rates, but I'm not aware of a measure of
8 an access to contraception, which is the
9 preventive measure.

10 So I think, I'm not, and I'm not sure
11 if anybody's developing it, although I'm going to
12 sort of look into it.

13 But I would just encourage as to say
14 that that's an important area, and that often in
15 the way the data's collected for 15 to 21, we
16 don't really get to see the folks who can't
17 consent all the time.

18 DR. WINKLER: Okay. Well, obviously
19 we've lost a lot of our colleagues, so I don't
20 see any reason why we would need to keep going
21 with this, but so thank you all very, very much
22 for all the time you've put in, the

1 thoughtfulness, the discussions were great.

2 I apologize we've run over just a
3 little bit. But the intensity of these
4 conversations sometimes we end up doing that.
5 Last words from our co-chairs, Nadine, Suzanne?

6 CO-CHAIR GREGORY: I would just say
7 that this has really been an exciting process and
8 you guys have contributed greatly and I really
9 appreciate all of your input and I've learned
10 from all of you.

11 DR. WINKLER: All right, so I think
12 we're --

13 MS. THEBERGE: Thank you.

14 DR. WINKLER: We're adjourned.

15 (Whereupon, the above-entitled matter
16 went off the record at 2:29 p.m.)

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In the matter of: PERINATAL AND REPRODUCTIVE
HEALTH STANDING COMMITTEE

Before: NQF

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