NATIONAL QUALITY FORUM

Moderator: Perinatal -
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OPERATOR: This is Conference #66720093.

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

Suzanne Theberge: Good afternoon, everyone, and welcome to the Perinatal and Reproductive Health Committee Post-Comment Call. Thank you so much for joining us this afternoon. This is Suzanne Theberge. I'm the senior project manager on the team.

And as we get started, I'm just going to start off with a couple of quick housekeeping notes before we do roll call and then get into the topics for discussion today. As always, with our conference calls and webinars, the committee members, you have an open line. So please put yourselves on mute if you're not actually speaking. And please don't put us on hold. And then finally, if you are on both the phone and the webinar, please turn your computer speakers off so that we don't get some feedback. And just as a reminder, you'll need to be on the phone to speak and the webinar on your computer to vote.

So, with that, I think that's all of our housekeeping notes. And next slide, we're going to do, just do a quick roll call and find out which committee members are on the phone with us today. So next slide, Nadine.

OK. Matthew Austin?

J. Matthew Austin: I am here, present.

Suzanne Theberge: Thank you. Jennifer Bailit?

Jennifer Bailit: I'm here.

Suzanne Theberge: Thank you. Amy Bell? Tracy Flanagan? Gregory Goyert?

Gregory Goyert: I'm here. Thank you.

Suzanne Theberge: Thank you. Kim Gregory?

Kimberly Gregory: I'm here as well. But …

Suzanne Theberge: Thank you.

Kimberly Gregory: … if we're both on the same website, then the votes – you'll get two votes on that same line.

Suzanne Theberge: OK, we will connect with the operator about this offline. We'll get that sorted out.

Kimberly Gregory: OK, great.

Suzanne Theberge: OK. Ashley Hirai? Ashley, I see you on the webinar. So if you are not on the phone, please dial in to the phone as well.

Ashley Hirai: Hi, Sue, I'm on. I'm sorry there's a delay to get me off mute. Thank you.

Suzanne Theberge: Thank you. Mambarambath Jaleel? Diana Jolles? John Keats? Deborah Kilday?

Deborah Kilday: Present.

Suzanne Theberge: Thank you. Nancy Lowe?

Nancy Lowe: Here.

Suzanne Theberge: Thank you. Sarah McNeil? And I thought I saw Sarah on the webinar, too, earlier.

Oh, somebody has their computer speakers on.

OK. Jennifer Moore? Kristi Nelson?

Kristi Nelson: Yes, I am here.

Suzanne Theberge: Thank you. Juliet Nevins?

Juliet Nevins: I am here.

Suzanne Theberge: Thank you. Sheila Owens-Collins.

Sheila Owens-Collins: I'm here.

Suzanne Theberge: Thank you. Cindy Pellegrini?

Cindy Pellegrini: Present, thanks.

Suzanne Theberge: Thank you. Diana Ramos? Carol Sakala?

Carol Sakala: Yes, hello.

Suzanne Theberge: Hi. Naomi Schapiro?

Naomi Schapiro: I'm here.

Suzanne Theberge: Thank you. Karen Shea? Marisa Spalding?

Marisa Spalding: Yes, I'm here.

Suzanne Theberge: Thank you. Sindhu Srinivas? Rajan Wadhawan?

Rajan Wadhawan: Yes, I am here.

Suzanne Theberge: Thank you. Carolyn Westhoff?

Carolyn Westhoff: Here.

Suzanne Theberge: Thank you. And Janet Young?

OK. And if there are anybody who was on mute or is just joining us a couple minutes late and the other committee members on the phone? I see …

(Crosstalk)

Suzanne Theberge: Oh, go ahead.

(Crosstalk)

Karen Shea: This is Karen Shea. I just want to make sure you heard me.

Suzanne Theberge: Hi, Karen.

Karen Shea: All right, great.

Tracy Flanagan: Hi, Tracy Flanagan.

(Crosstalk)

Tracy Flanagan: I'm now on audio. Can you hear me?

Suzanne Theberge: OK. Yes, Tracy, we can hear you. I know there's somebody else …

Tracy Flanagan: Great.

Suzanne Theberge: … too.

Diana Jolles: Diana Jolles.

Suzanne Theberge: Great, thanks. OK. Thanks everybody for joining us. OK. And next slide.

So I want to talk briefly about the agenda and the process so that everybody is on the same page. We're going to start by rediscussing and revoting on the consensus not reached measure. That was measure number 1517, Prenatal and Postpartum Care. Reva will introduce that measure and talk briefly about

the history of the committee's discussion just to remind everybody of where we're coming from on that.

We will need you to revote on this measure. So, as mentioned, you'll need to be on your computer. And we're going to have to pull up some voting slides so there might be a slight pause as we get that set. But that will be coming. And then, once we've had that discussion and the committee has revoted on that measure, we're going to hope that the committee can come to consensus either way. After that, we are going to go over the comments that we received on the rest of the measures.

So you all received the memo last week, summarizing the content of the comments. The staff have pulled out comments that we think the committee should discuss. But you should feel free to add in anything else that we did not flag for discussion, please feel free to make sure that you add that in, and we want to make sure that everything is addressed.

We have provided some draft responses for your consideration, (first one with the) comments. But for others, we have just marked that we need the committee to discuss, and then we will write up a formal response after you have all weighed in. We do ask in the memo if you wish to reconsider any of the measures where comments were raised, but you're not – certainly not required to. That's just the option that you have is to either continue with your recommendation as it was made at the committee or to revote on it.

And just quickly to summarize, we received quite a few comments in this project, 178 comments. They came from 10 NQF member organizations and 35 non-members, both organizations and individuals. The bulk of the comments that we received agreed with the committee's recommendations. They supported measures, they just wanted to weigh in and support. And then we (did) see some other themes. Carol will go over that when we get to that part of the discussion.

Next slide. And we just have a couple of three slides summarizing where the committee landed at the end of the in-person meeting. We had 18 measures

that were recommended. And you see here, we've got the reproductive health, labor and delivery, and high-risk pregnancy recommended measures.

Next slide. And this is the rest of the recommended measures covering newborns and premature and low birth weight babies, and postpartum measures.

And the next slide. We have one measure that didn't achieve consensus and then we have five measures that were not recommended at the committee meeting. And I'll just note, we included this in the memo. But I'll just note that NCQA has elected to withdraw 1391 so that measure is no longer under consideration for endorsement. It was not recommended. It's now not going to be – not going to move forward at this point.

We do have information about the previous discussions that you had, all of your votes, and we can make that accessible at any point. So, if you have any questions on how you would have lost time, where you want some details about what some issues were, just let us know and we will pull that information up.

So, I will pause here and see if there are any questions.

OK. And just as always, we will close out the call with a brief public comment period and then wrap up with the next steps so you all know where the project will be going after this.

So, with that, I will turn the call over to Reva to begin summarizing what happened with Measure 1517. Reva?

Reva Winkler: Great. Thank you, Suzanne. So, the first order of business is for the committee to revisit Measure 1517, Prenatal and Postpartum Care. Consensus was not reached particularly on the validity criterion and then the overall vote. And so, I just want to briefly go through the committee's evaluation during the meeting so that it puts you back with the context you need to consider the comments that came in. And have further discussion in preparation for voting again on validity which is a must-pass criterion as well as another overall vote.

So, this measure, 1517, Prenatal and Postpartum Care, is the percentage of deliveries of live birth between November 6th of the year prior to the measurement year and November 5th of the measurement year. In other words, a calendar year's worth of days.

For these women, the measure assesses the following status of prenatal and postpartum care. There are two rates contained in the measure. The first one addresses timeliness of prenatal care, the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. So that's prenatal care. The second rate is postpartum care, and it's a percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

So that's the measure. It is a measure for health plans and integrated delivery systems. It is not at the clinician level. It's – the measure is collected primarily using administrative claims, though other additional data may be used to augment that data.

So in terms of the first criterion, importance to measure and report, the committee agreed that the evidence – empiric evidence presented was insufficient to meet NQF's evidence criteria. However, you invoked the exception to evidence so that the measure did pass the evidence criterion by exception. You felt that the performance gap continues to be an issue and that there is further opportunity for improvement.

In terms of the scientific acceptability of the measure, you accepted the prior evaluation of reliability, you looked at the changes in the specification since the last review, particularly using (instant) claims to identify deliveries being removed. And then there was some clarification about the kinds of tests that would be included to indicate an obstetrics visit.

So reliability was passed. Validity, on the other hand, was an issue. And you had measure concerns particularly around the limited number of codes and the lack of information on the content of those visits. And that the measure is really all about counting the visits and not what happened during the visits.

In terms of feasibility, generally, the measure passed. There were no significant issues particularly since the measure is based on administrative claims. In terms of usability and use, the measure is actively used in programs for both health plans and state reporting. And so, the measure passed that criteria as well.

So, what we'll need to do is revisit discussion of this measure, particularly around the validity of the measure, so that you will be able to revote on that criteria. And we will make a determination on whether you've reached consensus or not.

All right. With that summary, I'm going to turn the discussion over to Kim Gregory whose turn it is to leave this portion of the agenda. Kim?

Kimberly Gregory: Sure. Can you just refresh our memory on the vote for that section? What we – it was 60/40, right? Is that about – am I remembering it correctly?

Reva Winkler: The overall vote was 12 yes and 14 no.

Kimberly Gregory: Oh, OK.

Reva Winkler: Which is, what, about 40 some percent, 48 percent. So, it requires 60 percent, greater than 60 percent to recommend the measure.

Kimberly Gregory: OK. OK. Did everyone get a chance to review the comments on this measure, the public comments?

Female: Yes.

Female: I actually have not seen the public comment yet. Do we have time to just review it quickly?

Female: Can you post it?

Kimberly Gregory: Does the staff have that available or do you want me to – see if I can pull it up here.

Suzanne Theberge: Yes. Nadine, can you pull up the memo?

Tracy Flanagan: It's included in the invite for anybody who has Lotus Notes or something equivalent. The comments are summarized in the invite attachments.

Kimberly Gregory: So, basically, they sort of reinforced our discussions which were – that it would be great to have quality content – to have content issues or available. But that – since that isn't available yet, that this was the next best thing and it sort of kept the measure in everyone's eyesight, I guess, I want to say. That it was being actively used at the plan level and that ACOG endorsed the concept but that even they thought that we might want to make the timing of the visits sooner. And I guess they addressed that in their – the dates that they mentioned was 21 days to 56 days. So it made it between three and six weeks, so it does allow for an earlier visit. And then, I guess one other comment said to split it into two rates, and they felt that since there were two measures that was already two rates.

And I have (found that) the final comment is that they were 10 comments, and six of the comments were in support of the measure. And then I address the three – the rationale behind the three that didn't support it. So, on that note, are there any comments from the committee? Or are you either in favor of somebody want to take the (pro provision) of why we should endorse it or try to move it forward?

Tracy Flanagan: This is Tracy Flanagan. I want to – before we go into discussion, I want a point of clarification from NQF on this. Do we have the capability to recommend splitting? That's one question. And then the second question is, there was a lot of discussion in the room which I didn't hear summarized today on the interval that, you know, what if it was from one week to eight weeks as opposed to three to eight weeks? And would that satisfy people? And that was kind of touched on in the comments. So, I guess these – the second question is, can we – in addition, can we split them? Secondly, can we recommend a recommendation of a larger interval?

(Crosstalk)

Karen Shea: The second part of that question is, can we – if they – if we agree there should be a larger interval, can we both pass it with the larger interval? Do we …

Reva Winkler: No.

Karen Shea: … have the authority?

Reva Winkler: No, you don't.

Karen Shea: Yes. I …

Reva Winkler: No, this is Reva. You don't. You're – the measure is put in front of you. Is – do we have anyone from NCQA on the line who could respond to the comments?

(Christine): Yes, Reva, this is (Christine). Hi, can you hear me?

Reva Winkler: Thank you, (Christine).

(Christine): Oh, great, OK. Hi, it's (Christine) from NCQA. And, you know, I think that this came up in public comment as well. I know that there are some disagreements around the timing, and really there is variation across the different recommendations from different organization. And when you look across the guidelines, you see that most organizations are typically recommending a four- to six-week postpartum visit unless there are, you know, complications during delivery that would require somebody to come in sooner.

So, given that, our advisory panels, when they looked at this measure, recommended the three to eight-week time frame as something that is appropriate for delivering postpartum care. And, really, when it comes down to the intent of the measure, they are seeing this at the time to be providing comprehensive postpartum care services. And, really, (with that) specific issue of the wound check and coming in earlier for that came up as a discussion point. And the panels did not want to count the quick room checks as postpartum care. And that is why they did not set the time as being a week post-delivery. Because, really, the hope is to be able capture that time when a

woman can come in for comprehensive care and really hope that the measure would serve as a motivation to health plan to be getting women back in even if they had come in for (inaudible) check to be doing the physical that they would be able to do a little bit later after delivery. And that's really the reasoning and rationale for the timing.

Karen Shea: So, could you tell us what the important content of that visit is in terms of what the intent of the measure is with that narrow time frame?

(Christine): Right. Well, the intent – so, you know, this is the intent that we hope will happen at the visit. But the measure does not specify when it needs to happen, just to be clear. But, you know, for example, the American College of Obstetricians and Gynecologists says that a postpartum visit should include, you know, a physical check, social, and anticipatory guidance on things like birth spacing and contraception, maternal depression screening, other psychological well-being issues, counseling on how one is coping with an infant or a newborn. And so – and any other postpartum concerns, physically or mentally that woman may have.

And so that's the recommendation and it really was felt that the post-delivery wound check where they're just really checking to see that your stitches are OK and wasn't going to really going to satisfy that. And so, purposely, (based it out), you know, a little bit further past the delivery date.

Karen Shea: And in fact, this is Karen Shea, that post-op check is included in the delivery charge. And it's not supposed to be coded as a postpartum visit.

(Christine): Right, exactly.

Karen Shea: And the intent of the postpartum visit clearly is the timing for depression screening and a discussion around contraception and, you know, implanting contraception at the, you know, the three to six-week or three to eight-week time frame.

(Christine): Right.

Female: I think the bigger issue here, though, is that for different populations, the timing may be very different on when it's most appropriate. You know, if you have patients in rural areas would start to come in, you know, maybe doing it at the time of delivery and then, you know, a follow-up phone call. I mean I think there are all kinds of various things here, and we really don't know empirically what's best. And so, to sort of, you know, pick out of the air timing on this just doesn't make sense. I mean I think we need more empirical evidence about what should be and what it does before we actually recommend it as a measure.

(Crosstalk)

Cindy Pellegrini: Well, this is Cindy Pellegrini. Can I make a quick comment here?

This is actually, I think, going to the heart of an ongoing debate in preventive care in general. And I certainly saw this in my last job when I worked for the American Academy of Pediatrics, where so much of the childhood periodicity schedule is based on expert opinion, right? There's evidence-based recommendations and there are evidence-informed recommendations. And sometimes that evidence, when it's evidence-informed, is expert opinion.

And there was a lot of hand-wringing and unhappiness about those facts, but there was also a recognition that it was highly unlikely that anyone was going to step up and start doing, you know, randomized controlled trials of what was the best periodicity schedule and exactly which anticipatory guidance should be offered at each visit, you know, and how all that was going to be timed.

So, I think what we may need to look at here is this idea that, "OK, this is not an evidence-based recommendation." But I think we can say it's an evidence-informed one if we are willing to accept the expertise of the expert bodies that issue these recommendations in the form they are now and understanding that they do evolve over time. So I am much more comfortable, I guess, in some people in moving this forward fully recognizing its shortcomings and its flaws. But also acknowledging that to have no measure at all on prenatal and postpartum care would be a huge gap, and I think a disservice to the field.

Female: OK. So, I was one of the ones that voted against because I'm a medical director at a health plan that has every year been penalized because we go short of the 90 percentile. And, again, I think the measures need to be more customized according to your patient population. And if anything, you know, I think the time period should be widened as opposed to shortening it. And I think that that would make it more reasonable especially since you don't have any content-specific, you know, criteria for what should happen and when.

As a neonatologist, I would say that if there is a problem with the mother and baby bonding, especially if there's a risk for child abuse, three weeks is too late, you know, that an earlier exam would be reasonable. And for all the things that you mentioned that, you know, are important in a postpartum exam, two weeks would work as well as three weeks. And so, I would argue for an earlier, you know, to have – if you had a measure, to widen it, to make it, you know, to make it easier for the health plans to be compliant.

The way it is now is just absolutely too narrow. And I think, you know, the data that was presented at the earlier meeting was that after five years, the needle had not been moved in terms of increasing the rates. And I think it's – you know, the big problem is the validity and the usability.

Jennifer Bailit: This is Jennifer Bailit. I just want to say that I think, you know, it so much depends on what we think our standard should be for measuring something. I have no problem with recommending people should get some postpartum care as a general statement. To your point, that's evidence-informed but not evidence based.

But to measure people, penalize people on it when they may be doing some creative things to try to work with their special population, I think a short side that there are unintended consequences of measuring things. And that we really need to hold ourselves to a higher standard than evidence-informed for these kinds of measurements.

Female: I agree with that, totally, yes.

Tracy Flanagan: This is Tracy Flanagan. I actually want to just add to that last, the last two comments. You know, we did very well on this. We do hit 90 percent and we

basically put also to system things in place to be successful. But when I look at – you know, I get a report on what the reason for the fallout and it's usually because somebody came in four days before or four days afterwards, which to me is just kind of ridiculous because we're doing the same thing. And in, you know, the – addressing the issue of the one-week visit incision check, I would argue that there's something in between one and three weeks. Sometimes people come in because they're having a question postpartum, and you end up doing routine visit because they live far away, it's more convenient. So, just because it's happening before three weeks doesn't mean it's not as comprehensive. And same thing, the same comment after the eight-week time. So I would favor a widening of this interval but really support a postpartum visit.

Juliet Nevins: This is Dr. Nevins. If I may ask a question to the developer. If this does not pass, if it's voted against today, how long would this gap with respect to not having this measure? Would it be a year or two before the comments that are offered today sort of can be taken into the development process? I mean how long would we go without a measure if this one does not pass before you could come back with one that has taken into account all the comments put forth today?

(Christine): Well, this is (Christine). So, this measure is in our HEDIS health plan measure set. And so, you know, if it doesn't pass NQF, it will remain in HEDIS. So, the measure days, you know, the extent to which it gets used in programs, I think, is up to the individual program.

So, we actually recently looked at this measure and that is where we did address a lot of these questions around the timing. And you know, NCQA uses a consensus process with experts and multiple stakeholders much like the National Quality Forum process here.

And you know, our own panels and public comments and, you know, our technical panels, our coding panels, have reviewed this measure. And so, this measure did pass that consensus process. As I noted, many of these issues came up, they were discussed and consensus was reached on how to specify the measure.

And so, I would say that I – you know, we can take these comments into account and we are definitely very happy to hear many different opinions around how a measure should be specified.

You know, to the point about specifying a measure so that it – the right measure for every different population, you know, this is a health plan level measure and so the way that we tend to look at it is that, is it specified in a way where it can be applied pretty fairly across health plans, and are there health plans that would have, you know, that – is this specified in a way that would really unfairly bias a specific kind of plan, because you really cannot make a measure that is going to be perfect for everybody. And what this measure intends us to do is to say that a woman get a postpartum visit. And did a woman get a prenatal care visit in a timely manner. And I – it goes as far as it can go in terms of the timeliness.

There are going to be lots of special circumstances, but at a health plan level, it's probably not going to affect the (plannable) results, you know, too differently across plans.

We hear this a lot about, OK, well, someone came in three days after the threshold, but the reality is we have to set the threshold somewhere and, you know, the point of the measure is to really provide a motivator for health plans to be reaching out to their members to encourage them to come in for a postpartum care visit.

This measure fits in our access and availability of care domain. And so, you know, we really view it as a measure that's getting an access and (agreed) to tell us a little bit about whether a health plan is getting those timely visits or not.

Female: OK, so – sorry.

(Christine): So, I'm sorry, yes. So, really the issue is, it's going to stay in HEDIS. We'll take this into consideration. If it doesn't receive endorsement, it all remain in HEDIS and we can think about what we might do. But we also want to focus on developing measures that get us a content of prenatal and postpartum care,

so whether or not we really put a lot of resources in changing this particular measure, I couldn't give a timing on that.

Kimberly Gregory: So this is Kim. One question that follow up on that is if the – since the measure is being measured anyway, is there any opportunity to sort of track the fallout, I mean, like if you change from – if you do some type of sensitivity analysis so that if you change it from two weeks to eight weeks, does that improve the – did the event occur or not, met (the) number.

(Christine): We don't – we would not track that, no.

Kimberly Gregory: Could you find a partner who could? We're just sort of asking – in other words, how are you validating they're now – right now, you're validating the visit based on what people tell you. And so, as a measure developer, do you have a partner that could sort of help improve the validity of the measure?

(Christine): Oh, I think that the issue is that we would have to accept it, a one-week timeframe is valid and the …

Kimberly Gregory: I said two weeks, but …

(Crosstalk)

(Christine): The difficulty is, as we said, it's a little bit more around – it's an evidence-informed timing. So, you know, I think if we could get somebody to test that if we had the resources, we wanted to pour into finding the answer to that question. I'm not sure we would do that right now in terms of our priorities.

Kimberly Gregory: OK.

(Crosstalk)

(Christine): And we would not be …

(Crosstalk)

Female: I would like to offer that – and that you really look at the Medicaid population. You know, I think that this measure is extremely burdensome for that population for a lots of reasons.

And when I was in Texas, this measure was offered as a – as part of the incentive program. And we voted against that, we, the medical directors, just because we know about the issue. So, we continue to measure but we – you know, we didn't – we would not allow to be penalized because of it.

In Maryland, we are, we are penalized for it. And the Medicaid population, which is getting close to 50 percent of the population in general, I think it's a burden that's very onerous on the health plan.

Kimberly Gregory: OK, are there any other …

Naomi Schapiro: So I have a …

Female: This is …

Naomi Schapiro: Yes, I have some …

Kimberly Gregory: Go ahead.

Naomi Schapiro: OK, this is Naomi Schapiro. And I have some questions, sort of looking at it the other way. So, if we – so I have two questions. So one is, if we were to approve it, when could – and given that there's some problems around the validity and some of the issues around health plans, when could it come up for review or revision.

And related to that, if we happen to not – if we don't approve it, which we didn't last time, how does that affect its status as a HEDIS measure?

And my motivation for asking is, I hear what the problems with the health plans, but, you know, I work with a lot of patients and families who are undocumented. And so they have insurance, women, when they get pregnant, they have insurance only while they're pregnant. And for the delivery of the baby and then they lose it after.

And there's a, you know, movement in California that maybe extend that insurance to all undocumented adults. But, you know, it's hard to know how things are going in this country, and there's a lot of anti-immigrant sentiment floating around right now. So I am concern that if this measure goes away, then, you know, women would get cut off from their insurance the minute they deliver. And you know, not have the incentive into their postpartum visit.

So I worry about the care on that side for people who are flipping in and out of insurance coverage.

So that's kind of, you know, why I might have a tendency to approve it even if I understand that it's burdensome for the health plan, and understand that the evidence for it happening at a particular time is weak, but I – so I'm just – I'm concerned.

Maybe we'll get care and the baby …

(Crosstalk)

Naomi Schapiro: … we'll get care for the baby, but not the mom.

Karen Shea: Right. And hi, this is Karen. I want to say and I want to tag on to what you just said. And we really are in a bit of a dilemma right now and I think that we're all saying we need a meaningful prenatal and postpartum measure.

And what I see is that, what we measure, we – and reward that clearly drives what the health plan invest in, it drives our activity, it drives the allocation of resources.

And as has been mentioned, many of the health plans are very, very invested in this measure because it's one in which we are penalized for. However, in the absence of this particular measure, my concern is that that investment in that population, the pregnant women population, would be reallocated to measures that were tied to, you know, performance outcome and if prenatal and postpartum care was not tied to a performance outcome, there would be no investment.

And so, I think as far as I'm concerned, I'm really tied – torn between, you know, a measure that isn't ideal but it's a measure in which we are rewarded against that then drives, you know, my company's investment improving prenatal and postpartum care. I very much like to see this improved, but it seems that it's in front of us now, it's all that we have to vote on. Yes …

Kimberly Gregory: So can I clarify? This is Dr. Kim Gregory. One of the questions on the floor for the developer is, if it's not approved and it stays a HEDIS measure, does it stay a HEDIS measure or if HEDIS measure is tied to NQF endorsement?

(Christine): HEDIS measures are not tied to NQF endorsement.

Kimberly Gregory: OK.

Female: So …

Female: This is …

Female: … mentioned this before, so, would you – if it's not endorsed, would you go back and consider widening the timeframe?

I mean, just – I mean – yes, so, you know, you don't really have a lot of validity for the current timeframe and we're all saying, you know, if we need to measure it, but it's just too narrow. I mean, it seems like, to fix this problem is to widen the timeframe.

Karen Shea: I just want to say one other thing, and this is Karen, that even though the measure will – that NQF endorsement is not tied to NCQA accreditation, or, I mean, tied to the fact that it will be a measure that's continued to be used a HEDIS. State Medicaid agencies will still look at the NQF endorsement or not endorsement of the measure, regardless of whether NCQA endorses it and still hold us accountable.

Cindy Pellegrini: So (Christine), give us an idea of a – it's my recollection here that the NCQA process for updating a measure is neither quick nor easy that there's a lengthy process and that the entire measure would have to be reopened in all of its

details, it's not like you can go in and surgically change one number very easily or something like that.

(Christine), if you all decided tomorrow that this was an urgent meeting and you had to revamp this measure, what would you estimate the average timeframe would be for going through that whole process and rolling out a new measure, a revised measure?

(Christine): So I think that was Cindy, right? You're correct, I think you've seen the process. You're right, we'd have to open the measure, (inaudible) significant change. And it would (claim) with the HEDIS cycle. It's something where we would have to start working and put it up for public comment for HEDIS, and then take it through our consensus process and it probably wouldn't come out until 2018 or so.

And I have to be clear and say that because this did go through our process recently, it's probably not going to get opened up again.

I think that a better use of our resources will be to start looking at better measures that could eventually replace this measure and look at content. And you know, maternal depression screening and things like that.

In the meantime, this is a measure that (inaudible) access and it does serve as an incentive for plans to get women back in for their postpartum care. You know, someone asked about how the rates would change. Well, clearly, if we widen it, the rates will improve. They'll look better. But, is the point to make the rates look better for the plans or the point to just say, you know, guidelines are suggesting these, so you're evidence informed so this is the timeframe in which we would like to see women come back for a postpartum visit …

Female: Yes.

(Christine): … that's really where we are.

Female: Yes, we'll talk about that, you know, internally and with the health plan. And you know, our goal is to get the women back for prenatal care. And it's our position that we can deliver a comprehensive prenatal postpartum exam at two

weeks as – and do it easier and get more women in, than we can at three to six.

Kimberly Gregory: OK …

Diana Jolles: This is Diana …

Female: Still a good care. You know, it remains to be a good care.

Kimberly Gregory: All right, Diana.

Diana Jolles: Yes.

Kimberly Gregory: OK, go for it.

Diana Jolles: Thank you. I just wanted to make two comments in reflecting upon all of the comments that have been made, which have echoed some of our previous discussions about preference-sensitive variation.

According to the measure developer, the variation on performance of this current measure based on HEDIS data is significant. So, a range of 67 percent to 95 percent performance on the prenatal portion, a range of 46 percent to 88 percent on the postpartum portion, among Medicaid clients, 49 percent to 72 percent performance on postpartum compliance. Those variations proved that this is a valid measure.

We need to fix these issues with perfecting the measure, but I can promise that if only 59 percent of clients are coming into their postpartum visits, the quality of the visit for all the people who didn't come is poor. Their access to LARC is poor. All of these issues. So, our measure profile is anemic with regard to life course health and health promotion.

These things are systems driven. Until we get to the point where we fix our systems where everyone has access, where presumptive eligibility isn't affecting people's entry to prenatal care, where silly things like not having a simple postpartum visit when you leave your birthing facility. Those are little fixes that make it so that people do attend care.

So, I think that we need to be careful about stating that it's population driven or preference driven by certain populations when certain systems have found the populations most resistant to getting to care are the most likely to access care when it's culturally appropriate, when it's accessible, when organizational barriers have been removed. So, I'm in full support of this measure.

Female: I just want to say that if the data at least anecdotally we're hearing is that the people who missed these are missing about two or three days. I just want you to tell me that somebody who gets a postpartum visit four days later than the measure says is getting substandard care.

Diana Jolles: But that's not the majority of the …

Female: We have no idea. We don't know.

(Crosstalk)

Female: Yes.

Diana Jolles: Well, I – well, my experience …

Female: Again, you're …

(Crosstalk)

Diana Jolles: … in a variety of health systems is that the majority of people missing are really missing, especially with the postpartum. But this is just based on clinical experience for 16 years. So I'm not saying it's in randomized controlled trials, but this is a real issue. People aren't getting into timely access to prenatal care still because of organizational, institutional, regional and health policy-driven issues.

Female: OK, I mean …

Female: OK.

(Crosstalk)

Female: … comes back to how you define adequate or a standard prenatal care, postpartum care.

And if you can't say for sure that three weeks is a good care but 58 days is poor care, you know, unless you can say that, you know, with some reasonable backup, then – you know, then, you know, we're all talking in theory.

Kimberly Gregory: OK, so this is …

(Crosstalk)

Juliet Nevins: … ask another question, if I could ask a quick question. It's Juliet.

Kimberly Gregory: OK, Juliet, and then I'm going to say, unless someone is going to bring up a new topic pertinent to this topic, this is the last one.

Juliet Nevins: OK, question …

Kimberly Gregory: OK.

Juliet Nevins: … because I'm try – I want to make sure I understand, and please forgive my naivety, the importance of this vote. Because, I, like someone else who has spoken, I work for health plan but I'm also an OB-GYN and I work for a set of really qualified health center, where these postpartum visits is an issue, and I work with a population whom I care very deeply for.

So, this is not going to be fixed as the developer mentioned, they have their own consensus, they're not going back to the table to redraw this measure, right? That has been established. And this measure will still be a part of the health effectiveness data information for HEDIS, even if we vote against it, is that correct?

Kimberly Gregory: That is correct.

Juliet Nevins: So, that means that if – you know, from what I understand, HEDIS is really what it's all about, because this measure affects predominantly the Medicaid population, and the population is like the one that I work with.

So, health care plans will still be held accountable, and hospitals and providers will still need to allocate the resources to reach these patients, is that correct? Because it's still a measure – there's still be measures on it, whether or not we build on it or not.

(Suzanne): And we'll be using HEDIS, this is (Suzanne). The same to keep on mind is whether or not it gets used in other programs, that may or may not look at endorsement at something that is favorable. OK.

Juliet Nevins: OK. Thank you.

Kimberly Gregory: OK. So I want to be cognizant of the time, and I think that this was a very robust and healthy discussion, and refreshed a lot of people's memories, I'm sure.

And then I'm going to ask Reva, how do we vote or what would be the next step to facilitate the vote.

Reva Winkler: Well, essentially, we'll bring up the voting slide for the committee to vote on and we'll take the vote and see what the results are. And we'll need to vote on both validity and vote on the overall recommendation.

Kimberly Gregory: And it's an oral vote?

Reva Winkler: No, no, no, it's – the reason you were given your computer prompts specifically was so that you can vote online.

Kimberly Gregory: OK.

Reva Winkler: Suzanne?

Suzanne Theberge: Yes. So, Nadine is pulling up the voting slides now. So I think we can advance to the next slide that has the validity vote. And then, this is not the voting slides yet. But on the next slide, you will have the option to select which option you want high, moderate, low or insufficient. And the system will calculate.

Nadine or (Kendra), is there anything else that committee members need to know before we start the voting?

Female: No, I think you are correct, Suzanne, once that does appear, a box will appear next to the answer and just click on the box next to the answer of your choice. Currently, we have 22 voting members on the web.

(Crosstalk)

Female: What do each of these mean, how do we either know it's going to pass or fail the validity test?

Suzanne Theberge: It's the same consensus standard as the in-person meeting, greater than 60 percent is pass, 40 to 60, inclusive of both 40 and 60 is consensus not reached, and below 40 is not recommended.

Female: So, that low – is that low and insufficient?

Suzanne Theberge: That's correct.

Female: OK.

Suzanne Theberge: Yes, low and insufficient.

Female: So do we – go ahead.

Female: So do we just use our clicker and click on the number or?

Suzanne Theberge: Just pick a box.

Female: OK.

Suzanne Theberge: Only committee members should have this box option to vote.

Female: So after you make your choice, does it – is the computer – the computer then take that into consideration or is there a send button or an enter button right here …

Female: Yes, yes, is there a submit?

Female: You should see a little check kind of appear once you click in that box and then that will …

Female: Yes.

Female: … cast your vote for you. So you should not need to hit submit or anything, just click the box.

Female: OK.

Kimberly Gregory: And there are how many voting people?

Female: I have 22 voting members online.

Kimberly Gregory: So again, I just want to confirm that I'm voting under another – under assumed name, so are you getting two votes under the same assumed name.

Female: It will pull out in that report, but, yes, correct, you are correct.

Female: OK, so …

(Crosstalk)

Female: With our names and the web address to login on.

Suzanne Theberge: Yes. So it looks to me like we are sure – OK, let's say, we – like we've got everybody, no, we've got 20 – sorry, 21 votes and we're expecting 22. Has anyone not voted?

Female: I don't know if my vote is counting, because I checked the box, but then on the other screen, we each have our name in a webpage that we're supposed to log in to. Are we supposed to go to that webpage to vote?

Kimberly Gregory: Yes.

Suzanne Theberge: Yes.

Female: OK.

Kimberly Gregory: If you're on that – if you go to that webpage, you see what everybody else sees, but you get the one where you can vote.

Female: OK. So, I haven't voted, but I – can I just tell you my vote?

Suzanne Theberge: Yes. Yes, that's OK.

Female: OK, it's four, insufficient.

Suzanne Theberge: OK. So, I believe that makes us continue at consensus not reached, because that would be 11 moderate, seven low and four insufficient. So I believe we are still in the consensus not reached.

And so, we will continue – correct, Reva, we will continue and vote again on the recommendation for endorsement.

Kimberly Gregory: I thought if it didn't pass this, then we couldn't vote on that.

Suzanne Theberge: Reva?

Reva Winkler: Kim, I mean, you're right, it is a must-pass criteria. I think because the committee can't come to conclusion, we're going to be taking it further on to CSAC. So, we still would like to know if, when you factor in that vote on validity, how it affects your overall sense of the measure?

Kimberly Gregory: OK, great. OK.

Suzanne Theberge: All right. So …

Kimberly Gregory: So …

Suzanne Theberge: … let's vote.

Kimberly Gregory: … let's vote on whether or not based on the discussion and the prior vote, the committee's overall – no, your vote as a committee member, the suitability for endorsement of this measure. Well.

Suzanne Theberge: So we're at 16 votes, or 18. 20.

Sheila, do you wish to vote verbally?

Sheila Owens-Collins: Yes, I – yes, I said no.

Suzanne Theberge: OK. So, I think that still has us at consensus not reached.

Oh, 10 versus 12. So, this measure will continue on as consensus not reached. We will take it to the NQF membership and the membership will weigh in. And then, the Consensus Standards Approval Committee, the CSAC, will make a decision on endorsement.

Kimberly Gregory: OK. Well, that was healthy discussion.

I think we are now moving to Carol.

Carol Sakala: Yes, and I'll try to pick up a little time here. Thanks to the NQF staff for sorting out several cross-cutting themes that emerged from the various comments that were received.

One of those themes related to the three measures on newborn blood stream infection that we similarly struggled with because we felt as if we needed to weed some out, but we had trouble doing that. So we passed all three with a request to the developers to come together to help reduce the burden of reporting over the next 18 months and come back to us with a single measure and supporting documentation for considering this, where we would pick it up in an off-cycle review.

The good news is they have agreed to do this. And I would like to ask if anyone has any concerns with providing our proposed committee response to be, we agree that harmonization of these three measures is important to reduce the burden of reporting. The developers have been directed to work together over the next 18 months to arrive at a single measure with supporting data to be presented to the committee during an off-cycle review.

Are there any concerns about that response?

Great. So the next one is the whole issue of women's choice and this arose across the breastfeeding measure which some people discussed, there's two measures because we now have an eMeasure version, and the three contraceptive measures. And the committee discussed this in both cases. In the end, 91 percent of us supported the – for 90 percent supported the breastfeeding measures and the contraception measures were supported by 80 percent to 89 percent of members.

The developers have clarified that 100 percent would be an inappropriate rate and that good performance would be well below this, with some important variations across this that needs various group of measures.

The contraception measures are new and that developer has clarified that they have established processes for carefully monitoring the experience as this measures go into use, and also that they have issued a contract with UCSF to develop a measure of experience of receiving contraceptive care. So that down the road, this could be considered a paired measure with the contraceptive measures or a balancing measure to identify and check any misuse.

So many contraception comments mentioned this issue of coercion and the importance of choice, but there were a large number of comments, actually about 25 in each case and only one of those commenters actually proposed holding back endorsement until the new measure is available.

And on the breastfeeding measures, the developer commented that rates for communities, such as traditional breastfed at lower rates, vary widely across hospitals suggesting the importance of appropriate system support. And further, the Joint Commission does not establish benchmarks for its measures.

So, I would like to ask you if you feel comfortable with the proposed committee response that reads, the committee agrees that patient choice and the need for person-centered decision making is paramount. Comments regarding specific measures have been referred to the developers for a response. Thank you for your comment.

OK. Now, for the third subject, measure gaps, I would like to ask you to look at pages five and six of this briefing document because the list is too long for us to read them out now. I will tell you that we had a brief discussion at the end of our meeting and some members had to leave at that point. We created an initial list of measure gaps that were in the draft report and then we had submitted comments proposing additional gap areas.

So the question for the committee is whether members are comfortable adding this list to the report and also whether you're comfortable with the proposed response to those who proposed new measures.

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

J. Matthew Austin: So, Carol …

Carol Sakala: So …

J. Matthew Austin: Matt Austin.

Carol Sakala: Yes.

J. Matthew Austin: Real quick. The second to last sentence about comments regarding specific measures, because these are sort of future thoughts, is there really a developer at this point?

Carol Sakala: So, I would defer to NQF staff about the actual meaning of that.

J. Matthew Austin: I mean, it's just similar phrase to what we've used in the other ones which I think was appropriate. But given that these are non-proposed or non-developed measures …

Female: You could edit this by saying prior perinatal measure developers.

Carol Sakala: And it's also possible that this refers to proposed modifications to existing measures that could not be addressed in real time in our work. But, does anyone from NQF have a comment about that?

Suzanne Theberge: So, the list that we have put together was just sort of everything that people suggested in the comment as a gap area for measure development in the future. It's not a binding list on anyone. It's just a list of suggestions. And you know, if there's anything you disagree with, we're happy to remove it or revise – revise that with.

Carol Sakala: So, Suzanne, I think the question is whether we could remove the sentence comments regarding specific measures have been referred to the developers for a response because that …

Suzanne Theberge: Sure.

Carol Sakala: … maybe less suitable here.

Suzanne Theberge: Yes. Yes, we can remove that.

(Crosstalk)

J. Matthew Austin: … alternative, I just – to me, it's a little funny because these aren't necessarily existing measures. I'm not sure who the developers could be.

Suzanne Theberge: Right. You know, I think where that come from, is that a number of these were included in other comments. You know, I like this measure but we also need this measure.

J. Matthew Austin: OK.

Suzanne Theberge: So that's kind of what that's getting at, but we can definitely remove that particular line.

Carol Sakala: OK. So does – do we have any questions, concerns or proposals relating to this list and the proposed response which now would fall down to two short sentences?

Great. So thanks, I think we did take up a little time.

We've allocated 70 minutes in the agenda. It's going to have to be quicker now to discuss our response to comments on specific measures other than the one we first took up. It will be in order of their NQF number. And we also do intend any other issues that the committee may wish to address and Kim will take us through the first few.

Nancy Lowe: Carol?

Carol Sakala: Yes.

Nancy Lowe: This is Nancy Lowe. I hate to do this, but I do want to make one comment. Because when you were going through the themes, I had trouble orienting myself back in the report where I had underlined stuff. And I do want to make one comment about the three neonatal measures.

I was really struck by the Joint Commission's response. We have done extensive work and these measures have been harmonized to the extent possible at this time. Would seem in conflict with the idea that they're going to get together and come back to us, the three of them. I just wanted to make sure that we all noted that. I was not convinced that the Joint Commission was onboard with getting back together.

Carol Sakala: So, thanks, Nancy. And do we have a Joint Commission representative at this time who could speak to that because we did hear from one of the developers that they had separately agreed to work together. So, that's a good point to clarify.

Ann Watt: Thanks for the opportunity to comment. This is Ann Watt from the Joint Commission.

As we discussed at the time of the Standing Committee meeting, the Joint Commission and AHRQ has spent a long time working to harmonize our neonatal bloodstream infection measures. And I do, in fact, feel that we have probably come as far as we can go. I think that where the issue came up at the Standing Committee meeting was the Vermont Oxford Network, which we

had not – the Joint Commission had not spoken with and I'm not aware if the other developer had, but we have agreed to do that and in fact we will.

Nancy Lowe: Thank you.

Kimberly Gregory: OK. So we are turning your attention to measure 0033, which is the Chlamydia Screening. And the comments related to that or the summary of the comments related to that can be found on page six of the summary document sent out to us, and there were six comments relatively supportive. I think the main issue addressed was changing the age criteria for screening. And the committee proposed response is thank you for your comment.

And the action item for us to consider is – actually, I'm sorry, the developer responded to the comment by referencing the CDC as well as the task force. And the question in front of the committee is, in light of the public comments and the developer's comment, do we want to reconsider our recommendations, and specifically, do we want to address the age comment.

Sarah McNeil: This is Sarah McNeil. The reason why we were comfortable supporting this measure is because the data are only good for the groups that are – that were proposed to look at. So, I would argue that we shouldn't be because we don't have evidence to support the benefit of screening for males or screening for a different age range, we should keep it as is.

Kimberly Gregory: OK. Committee, do you …

Naomi Schapiro: So …

Kimberly Gregory: … are you …

(Crosstalk)

Naomi Schapiro: So I just have one comment. I mean, I'm OK with the ages. This is Naomi Schapiro and I work with teenagers. I'm comfortable with the ages.

I think the issue about not screening males, I can sort of understand that on a kind of nationwide public health look. But, when you're actually straining in a clinic, you know, I'm in a school-based health center, and if we don't screen

the guys, we don't stop transmission because women don't necessarily do partner – give partner treatments even though we offer it.

So, they feel uncomfortable because they know what the result of not recommending that we screen men is that people – that a lot of the insurances don't pay for screening young men for chlamydia. And so the clinic has to eat the cost or not do it. So that – you know, I've always had a hard time with that recommendation. We actually do screen young men in our clinic.

So – and I don't know – you know, I know partly because we don't do it, we don't have the evidence for it. I understand that, you know, some of the worse effect with chlamydia are on women, it's not an equal opportunity infection but …

Kimberly Gregory: But do – we don't have authority to change the measures.

Naomi Schapiro: Yes.

Kimberly Gregory: So, I think that what's in front of us is only what we can vote on and the issue is …

Naomi Schapiro: Yes.

Kimberly Gregory: … do you want to – do we want to take away our support of the measure because it doesn't address men. All right.

Naomi Schapiro: I mean, I don't think so. I don't think so but maybe a – you know, maybe a comment could acknowledge that some work needs to be done in this area.

(Crosstalk)

Kimberly Gregory: … that we add that as a gap measure when – you know.

Naomi Schapiro: Yes, yes.

Kimberly Gregory: And I think that that might be a way to address it.

Female: I think that's kind of – I mean, I think there is a basic principle involved, the screening that you have to screen the population, who's got the adverse outcome. And that's women with chlamydial downstream effects. So I completely get the public health point, but there's also the, you know, you only screen for diseases that you can treat and have effects in that population. So, just another thought.

Kimberly Gregory: OK. So I'm going to assume the silence means that we're going to let our recommendation stand, and that we accept the NQF response as our comment.

Female: Yes.

Kimberly Gregory: And then I'm going to move to elective delivery which we approved that 100 percent pass, and the eMeasure at 88 percent pass. And the public comment wanted additional emphasis placed on gestational age.

And the developer responded – well, actually, they wanted additional exclusions and gestational age. And the developer responded saying that there have been numerous ICD-10 codes added. There have been clarification related to ruptured membranes. And they reinforced that 100 percent is not the goal here. And felt that the requirement for gestational age was burdensome.

So, NQF staff, on our behalf, recommended the comment, the thank you for your comment and on putting force to you right now is based on this combined information. Do we risk to reconsideration our recommendation on these measures?

Male: No.

Kimberly Gregory: All right, I will take that as a consensus, and move to episiotomy, which can be found at middle of page eight. And there were four comments. Everybody was in support of the endorsement. Someone wanted us to add fetal distress as an exclusion criteria. The developers felt that this was not necessary and could lead to the risk of over coding for fetal distress. So again, the proposed committee response is thank you for your comment. And this was an FYI only.

And then I get to take a break and defer back to Carol.

Carol Sakala: OK, thanks, Kim.

Now, we have reached 0471, PC-02 Cesarean Birth. And 96 percent of our members voted to pass this measure and continue endorsement of it. It received 17 comments and there were theories that had unqualified support, we can leave those aside.

Some raised concerns mostly about risk adjustment and then there were some that were focused on the CDC target rate. And that was a little bit of a sidetrack because the measure developer does not set a benchmark. And – however, some of those suggest that that maybe shouldn't be used for such a purpose if it were not – that are risk adjusted. So, that is relevant to the general topic of risk adjustment.

There was another comment that NQF staff have been involved in the Leapfrog Group and concerns about that. However, the NQF Council, I am told, does not view that as a concern because Leapfrog Group is involved with implementation and it's not a measure developer. So, provision of technical assistance to Leapfrog is fine within their ethical standards.

So the main matter for our consideration is risk adjustment, and I would propose that we hear from the developer before opening this up to committee discussion and would first like to offer two possible framing comments.

One that said it could be important to point out in our response that we are recommending continued endorsement, our report is now called unexpected complications in term newborns, which is a balancing measure that could provide a signal about any overzealous and harmful excessive cesarean reduction.

And I also wanted to suggest that I think this is relevant for some of the other comments that will follow on other measures. That performance measurement needs to balance fairness to those being measured and fairness to those collecting and reporting results, and resource use issues and not

wanting to alienate people from the measure, performance measurement enterprise. So specification will often take it to account high impact matters rather than every possible consideration.

So Dr. (Maine) showed us a PowerPoint at our meeting. And since that day, it's been posted on SharePoint and it's called C.S. Age BMI Brief. Just as a discussion was that hospital level (NTSB) rates are not clearly related to high BMI and high age with the conclusion that there seems to be considerable role for how such women are cared for. And that the evidence does not currently support adjustment on the variables and BMI is a challenge in any case just because of the frequent lack of access to height information.

However, it has come to our attention that the Joint Commission had not updated its documentation to reflect removal of age standardization from the measure specification, and it has done so now. And we would like to ask (Susan Yandro) from the Joint Commission to speak to the changes that are made – have been made and also (Eliot Maine), I believe, is available. And then we can open this up for committee discussion.

(Susan Yandro): Thank you. Yes, hi, this is (Susan Yandro).

After we had submitted the form for consideration to the NQF, we had a – and before the Standing Committee meeting occurred, we had a meeting with our technical advisory panel. We reviewed analysis that our staff did on data that we received at the Joint Commission. And what this data showed us was that the age is only a re-predictor of outcomes and that age stratification could potentially affect the rates for the hospitals with small sample sizes.

And our technical advisory panel also reviewed several recent studies that also supported the removal of the age standardization from the measure. Therefore, the Joint Commission did remove the age stratification in all risk adjustment from the measure as of July 1st of 2016. And it has been pointed out, this has been removed from the testing submission form and this note has been updated as well.

We also removed the exclusions, the denominator exclusion, for clinical trials, both having to do with reducing the burden of data collection for hospitals, in addition. Thank you.

Carol Sakala: Thank you. (Eliot Maine), if you're on, do you have any comments to add to that?

(Eliot Maine): You know, the main thing that we wanted to point out is the removal of maternal age from the specifications, and if there are any other questions, I'm happy to respond as we go along. But we wanted to be circumspect in our discussions at this point.

Carol Sakala: Thank you.

So, the important thing here is that the NQF documentation is aligned with the actual measure. And we now are interested in whether anyone has any questions or comments. And feels that there is a need any reason to revisit the support that we previously gave to this measure.

So, this may mean that we can move on to Hep B Vaccine if there are no comments. It sounds as if you're willing to support our previous recommendation, and we will ask the NQF staff to work up a small response reflecting what has transpired and what we have heard.

Reva Winkler: Carol, this is Reva.

I just want to really get a confirmation from the committee that in their evaluation of the measure, they were thinking about the changes that have been made to remove the age adjustment. And that that was factored into the evaluation and their votes on the measure.

I would really – I want to be sure the committee is very clear that the measure they have voted on evaluated is the measure that has been changed from the prior, and that now no longer contains any of the risk adjustment or age adjustment.

Female: Yes.

Male: Yes.

Female: Yes.

Male: Yes.

Female: Yes.

Female: Yes.

Male: Yes.

Carol Sakala: Great, thank you.

So, moving onto 0475, Hep B Vaccine, 100 percent of our committee members voted to pass this measure. The developer responded to several comments as follows. First, they would be open to excluding the people who are transferred out from the facility from the denominator but as this is so low, it's been likely not consequential.

Also, issues were raised that some people do delay for getting the vaccine at a later point in time. But the developer says this is also such a low number that likely it has no material impact on measure result.

And also, there's a recommendation that the measure should be modified to require that parents receive educational material. And the developer responded that this is required by law already.

So, on the basis of that response are proposed committee response is nearly thank you for your comment. Does anyone feel that these issues raise anything new for us or require further discussion?

Female: No.

Carol Sakala: Thank you.

Male: No.

Carol Sakala: OK. So, the next measure is 0476, which is PC-03 Antenatal Steroids. Again, 100 percent of our committee members voted to pass this measure. And one of the five comments raised several concerns, for example, about staff and facility preparedness to implement the measure.

The developer responded that these issues are beyond the scope of the measure and would require other types of measures. And the proposed response from us is thank you for your comment.

And again, we ask whether anyone feels that the issues that were raised for antenatal steroids want further discussion or reconsideration of our recommendation.

Male: No.

Carol Sakala: Thank you.

So then we have the pair of 0480 and 2380, PC-05 Exclusive Breast Milk Feeding paper and electronic version. We supported those at the rate of 91 percent and 90 percent of our members.

The paper is a continued endorsement. The electronic is a new endorsement. 13 comments were received, most were supportive. The main issue was maternal choice which we discussed earlier.

But there also the potential for additional exclusion and the need for measures along the document breastfeeding over a longer term and after hospital discharge. So the developer responded that the threshold would be well below 100 percent to account for a maternal choice and also some exclusions that apply to a small proportion of women.

Developer noted that the Joint Commission has no way of tracking breastfeeding after hospital discharge. But, breastfeeding at hospital discharge is an important precursor to being professional recommendations for the duration of both exclusive and any breastfeeding.

And our proposed response here is thank you for your comment. And wondering if anyone has anything else to add to this discussion or our recommendation on these measures.

John Keats: So this is John Keats. Can I just ask a question as a relatively new member of the committee? What other responses are sometimes sent rather than just thank you for your comment?

Carol Sakala: Well, I think that they will hear the – see the developer's response. So, I think thank you for your comment would indicate that the committee feels that beyond the issues the developer has addressed, there's no other issues that we might take up.

We might add, for example, we concur, that it would be wonderful to have measures of breastfeeding after hospital discharge and encourage the development of such measures, but it's beyond the scope of the current discussion. We could add that to our gap list, maybe it is on the gap list already, I think maybe it is.

So that's the kind of thing that, you know, they think that go beyond the developer's comment.

Suzanne Theberge: If the committee elected to change their decision on any particular measure after this, reviewing the comments received, then there would be a more in-depth response from the committee summarizing what made them change the recommendation and what the votes were.

Carol Sakala: OK.

John Keats: OK. Thank you.

Carol Sakala: So I think we'll move onto 1382, Percentage of low birth weight babies, this was another one where we had 100 percent support. There were four comments, two were fully supportive.

One recommended replacing low birth weight with gestational age. And the other said that there have been no improvements overtime with this measure.

Interestingly, the developer says, "I agree gestational age is now a better measure of outcome and should replace this measure."

However, we did not have any gestational age measure to consider. This is all that we have.

So, we wonder if any members of the committee have any comments on this situation and whether there's any need to reconsider our recommendation at this point in time.

Sheila Owens-Collins: Hi, this is Sheila Owens-Collins. I probably made the gestational age comment.

Just so I can understand what the response is, are they saying that they will not do it or they can't do it now, but is a possibility that they can do it going forward, or that's just not on the table?

Carol Sakala: I think no commitment was made about measure development, that's a major, you know, that's a major commitment, and I would expect to say we're working on it or intended to work on if they would have said so. So, right now, there are maybe nothing known in the pipeline along that direction.

Sheila Owens-Collins: OK.

Mambarambath Jaleel: Hi, this is Jaleel. Is it possible to add this to the gap measures?

Carol Sakala: It is possible. And I'm not sure if it's on the list, but is there – is anyone have any concerns with adding that if it is not on the list?

Female: That’s a good idea.

Carol Sakala: Great. Thank you, Jaleel.

J. Matthew Austin: Yes. So, this is Matt Austin. I mean, I guess the one, I don't know, fully committed to this idea, but it's – even the measure developer is saying there's a better way of measuring this construct. Why would we move forward with a less good version?

Carol Sakala: Because – yes, it's all that we have right now. And maybe – especially knowing that there's nothing in the pipeline, or not having evidence that there is anything in the pipeline, we might not want to put this aside.

Female: And it almost sounds like from the developer's response that they …

(Off-Mic)

Carol Sakala: I'm sorry, could you say that a little louder please?

Female: Yes. So, it just kind of sounds like from the developer's response that they would put this back in for a review when it comes up again.

Carol Sakala: Do we have a developer on the phone for this measure who could speak to intentions or any knowledge of other work on a gestational age measure?

Kimberly Gregory: Would it be possible that they could do some concurrent validation and bring it back in 18 months or three years?

J. Matthew Austin: Yes. Kim, this is Matt. Yes. I mean, could we do some sort of like one year or two-year endorsement of it while they work on gestational age or something?

Reva Winkler: Yes, this is Reva.

No, it's kind of an all or none right now. I think I would interpret that as saying the developer, you know, agrees that there is a gestational age and is telling us that that data is now available. And certainly, I think that we could ask them to keep us posted as they consider possibility of a different way of looking at this measure. But I think this measure is pretty much what's being used at the time and in the foreseeable future.

J. Matthew Austin: OK. This is Matt. I'm comfortable with keeping our recommendation. I just wanted to have a real conversation about it.

Carol Sakala: Thank you. Any other comments about this measure? Or a recommendation?

OK. Thanks. So, I think we're going to go back to Kim for the final series of measures. Making good progress, thank you.

Kimberly Gregory: Thank you, Carol. So, the next measure, 1391, is easy. It's Frequency of Ongoing Pregnancy Care. We did not pass it and it has been withdrawn by the developer. So, there's really nothing to discuss there. And that is what's stated as our response.

2902, or actually, there are three contraception measures. No, I'm missing one. 2893, NICU all-cause admission.

Again, this was not endorsed at the last meeting, and it received one comment supporting the measure, but no additional data.

And so, the proposed action for us is – I mean, I'm going to assume that since we didn't endorse it, that we do not want to revisit it. And then I'm going to move to the three contraception measures.

And the first two, 2902 and 2903, both of them received over 20 comments. All of them were supportive.

The biggest issues were discussed by Carol earlier, and that's with regard to the issue of patient choice and some concern that it wasn't quite a plan level measure, but the developers responded in both instances. And I'm going to put to the group, do we want to revisit our recommendation?

Actually, there's no committee action required. So, I'm going to move to 2904 because this is the one we might want to discuss a little bit. And this is access to long-acting contraception.

And again, there were 24 comments and they were almost all supportive. But the biggest concern was the fact that some insurance and health systems actually restrict access to LARC.

And commenters both agreed and disagreed that this is a measure of access. And there was also a concern about appropriate counseling.

So, the developer response with the same information as – in the prior to the main one is that they have elicited a patient and reported outcome measure with under development regarding the experience of contraception. And they made the comment that they didn't want to imply one LARC method was preferred over the other.

However, there may be benefits to looking at the methods separately in the future with regard to IUDs and implants. And they deferred to their working group to consider developing another measure.

So we need to actually come up with a suggestion for our response to this and decide if we want to revisit our recommendation.

I'm tempted to assume that we don't want to revisit our recommendations. And I think that the proposed committee response would be to take some – an obstruction of the developer's response, and emphasize the patient-reported outcome measure that's under development.

Does anyone else have any other thoughts?

J. Matthew Austin: That sounds good to me. Thank you.

Female: Yes, that sounds good to me as well.

Female: Me, too.

Kimberly Gregory: So, Nadine, you want to take us into next steps?

Suzanne Theberge: OK, this is Suzanne, I will actually take that part.

So, the first thing we'll have to do is open the lines for public comments. Or actually, before we open the lines for public comment, I just want to make sure that no one else from the committee has anything they want to discuss, or there any other comments that were raised and issue that you feel like we haven't adequately addressed?

OK. Hearing none from the committee, now, we will open the line for public comments.

Operator, can you open those lines?

Operator: Yes, ma'am. At this time, if you would like to make a comment, please press star then the number one.

And you have a question from the line of Gustavo San Roman.

Gustavo San Roman: Yes, good afternoon. This is Gustavo San Roman and I've made many comments over the course of these projects.

A last-minute change made today to section 2b4 of the submission from measure number 471, now claims that age is only a weak predictor of outcome. Despite the change of the section 2b4 made today, the submission still has the same exact data as submitted in February, which was with risk adjustment in sections 1b2, 1c15, 2a2.3, 2b2, 2b5.3. These sections include the sections on validity as well as the reference articles supporting the submission with this risk adjustment.

Several of the reference articles contradict the claim that age is a weak predictor of outcome. And even the one published article by (Caseras) that is now officially referenced in section 2b4.2 shows cesarean birth rate of 21.7 percent for women under 30, 29.8 percent for women between 30 and 44, and 41 percent for women over the age of 35.

There is no data provided for this measure without risk adjustment for performance scores in section 1b2, nor is there any data without risk adjustment provided to validate this measure in section 2b2.

The only published article reference to support the validity of the material change to this measure actually contradicts the claim that age is a weak predictor of outcome.

According to the National Vital Statistics report published annually since 1997, women that have a maternal age of over 30 have not been able to achieve a cesarean birth rate lower than 23.9 percent since first recorded in 1997.

And non-Hispanic black mothers have not achieved this goal since the year 2000. 20 years of published studies confirm that age is a significant factor in the rate of cesarean birth for (NTSB) women, yet not one member of this committee questions the claim that age is only a weak predictor of outcome.

Every committee member claimed that they voted on the measure with the risk adjustment removed, even though there are no performance scores or validity data submitted without risk adjustment. You should all be ashamed that Math and Science were ignored today. And when this measure causes a disaster that is coming, hopefully, you will provide some explanation for your silence. God help us all.

Suzanne Theberge: Thank you. Do we have other public comments, please?

Operator: At this time, there are no public comments.

Suzanne Theberge: Nadine, have we received any comments via the chat box?

OK. I don't think we have any other public comments. Thank you.

So now, we will move in to the next steps. So next slide, please.

So, the project team will be working on writing up the final answers and revising the reports that we put out for comment to include this new information. We will be doing that over the next week. We'll red line your report and then it will go out for NQF membership vote.

And actually, next slide, please, Nadine.

The NQF membership is asked to vote and weigh in on the set of recommended measures as well as the measure that did now achieve consensus. And we will take that information at the two-week period from August 4th through August 18th. And then we will take all of your discussions and decisions and that membership recommendation, we will take that to the CSAC on September 13th at their conference call event.

The committee co-chairs will be representing the committee, along with the project team. We invite you all to attend, but you are certainly not required

and if – that you're – if you're interested, you are welcome to listen in to the CSAC discussion.

And we will let you know both the results of the NQF member voting as well as the votes of the CSAC review. CSAC will vote on their recommendations after that call and we should have those recommendations by late September, and then the NQF Board will make the final decision on ratification for the set of measures on October 27th.

Following the Board's decision, the measures are officially endorsed, all of the endorsed measures will go out for appeals, and that's a 30-day period that opens on October 31st. And we open and we'll let you know how that goes and then once appeals closes, if anything comes in, we will adjudicate the appeals that were received and then put out a final report.

At this point, the bulk of the committee's work has really been completed, we will definitely be keeping you posted as we move forward through the process. And we'll let you know each step as it comes up. But you are basically finished your work at this time. So, on behalf of the project team, I'd like to thank you so much for your time and effort on this committee. We very much appreciate it and we know it's a big ask and a big time commitment. So, thank you.

I will pause here and see if there are any final questions, or see if my NQF colleagues want to add anything before we close the call.

Kimberly Gregory: This is Kim. Can you just clarify for us when you say the NQF membership, like who is that?

Suzanne Theberge: Sure. NQF is a member organization. We have over 400 organizations or members of NQF. We have eight stakeholder groups ranging from health professional to consumers and purchasers, to folks who actually work in the measure development. We put all of our measures that are recommended by the committees or that don't achieve consensus, they all go out to the NQF membership voting.

It's a pretty wide variety of organizations. I know many of you are affiliated with the organizations that are NQF members.

Kimberly Gregory: OK. And so they actually vote again, do they vote for the slate or do they vote for the individual measures?

Suzanne Theberge: They vote for the individual measures, you know, they have the same recommend or they agree with the committee's recommendation or they disagree with the committee's recommendation to recommend each measures. So they vote on individual measures, it is one vote per organization and we have …

Kimberly Gregory: OK.

Suzanne Theberge: … yes, one contact study to organization who does submit those votes.

Kimberly Gregory: Great, thank you.

Suzanne Theberge: You're welcome. Any other questions about the voting process or anything else?

Female: Suzanne, we missed the public comment from For dialing let's got public comment from (Sean Kerrigan), he did not get a chance to comment.

Suzanne Theberge: Oh, OK. Is he on the line or via chat?

Operator: (Sean Kerrigan)'s line is open.

Suzanne Theberge: OK, (Sean), please go ahead and comment.

(Sean Kerrigan): Hi, sorry, I though I was chatting and on the vote.

Just to go back to the trends, I would like to mention on behalf of ACOG that patient choice is very important but also optimal care is very important. We don't judge immunization, people sometimes disagree with immunization. And we don't hold immunization to that – the level that we are – we seem to occasionally want to do for breastfeeding and contraception, so just want to remind you of that.

Per Dr. San Roman's comments, we would like to make a recommendation for the committee to consider including risk adjustment methodologies by age and BMI to the measure gap list.

And let's see, oh, and your evaluation of 1517, Prenatal & Postpartum Care. I believe that the – most of the directed – the vote against the validity is directed at the sub-measure of postpartum care.

We are making the recommendation for the committee to consider voting on the sub-measure separately and we believe that there would be a different validity vote for timeliness of prenatal care versus postpartum care, and leave that for the committee to decide what to do.

Nancy Lowe: I don't know what the NQF staff would say. This is Nancy Lowe. But I think that's up to the developer. I mean, it was submitted as one measure with two sub-measures and I think it would be much cleaner if it were indeed two separate measures.

Suzanne Theberge: We do ask that the committee vote on the measures as submitted and, you know, we often have committees want to vote on a different measure. We understand that interest, but we do ask that you vote on what was submitted.

(Sean Kerrigan): I realized that, but I do want to bring up that the last time that this committee met, when we evaluated composite measure, composite measure, sub-measures were evaluated individually.

Suzanne Theberge: Reva, do you have anything to add?

Reva Winkler: No, I don't have anything to add.

(Sean Kerrigan): And the example I can give you is the Adverse Outcomes Index that was evaluated three years ago from NPIC, the National Perinatal Information Center.

Suzanne Theberge: I believe the difference there is that it was actually submitted as a set of composite, a set of – a composite with a set of component where this was just

submitted as one measure, not in the same fashion. Am I remembering that correctly, Reva?

Reva Winkler: That's what I remember.

Suzanne Theberge: That this – yes, this – I don't think this was actually submitted as a composite this time.

(Sean Kerrigan): That's OK, we tried.

Suzanne Theberge: We can – you know, we can certainly – I think there was some discussion about adding that to the list as gap and, you know, we can make sure that's on there.

Are there any other pubic comments that didn't make it through the first time or any other committee questions or comments?

Operator: And at this time, there are no public comments.

Suzanne Theberge: Thank you.

If there are no other questions or concerns, thank you so much for your time this afternoon. We really appreciate it and we will keep you informed as to the progress of the project and each step as it opens. We'll be sharing with you our revised report by the end of next week, so look for that in your e-mail.

Female: OK.

Suzanne Theberge: On behalf of NQF and the project team, thank you so much.

Female: Yes, hi. Could you answer – I know you said it before, of course, there'll be a lot of people that are waiting for this. What's the timeframe for the final answer for the postpartum measure? And what are the next steps.

Suzanne Theberge: I'm sorry, I'm not understanding the question.

Female: OK. There a lot of people that are interested in the postpartum measure, and so I just wanted to be able to tell them what the timeframe is and the next steps for that measure.

Suzanne Theberge: Oh, I'm sorry. OK. Well, the next step, it will go out for NQF member vote that opens open next week, first day, August 4th, that's a two-week period. The NQF membership vote results can be available on August 19th. And then the CSAC will make their decision in mid-September, but we're not going to have a final decision of endorsement or non-endorsement on any of these measures until the Board officially ratifies them at the end of October.

But the CSAC will make a recommendation in mid-September, the NQF membership will make a recommendation in mid-August. So there's still several more steps in the process before there are any decisions made.

Female: OK, thanks a lot.

Suzanne Theberge: You're welcome. OK. Anything else?

If you do think of something, please don't hesitate to e-mail or call the NQF staff, we're always happy to discuss our process or answer any questions that you may have.

So, with that, I think we can wrap up the call. Thank you so much for your time today.

Female: Thank you.

Male: Thank you.

Male: Thanks all. Bye.

Male: Thank you.

END