NATIONAL QUALITY FORUM

Moderator: Suzanne Theberge
February 1, 2012
2:00 pm CT

Operator: Welcome to the conference. Please note today's call is being recorded. Please stand by.

Reva Winkler: Good afternoon everybody. Welcome to conference call on the Perinatal Steering Committee to review the comments received on the recent recommendations and draft report that was out for public comment several weeks ago.

Just want to advise the Steering Committee members that this is a public call. We do have audience members listening in.

We will provide an opportunity for public comment at the conclusion of the conversation.

Our goal today is to look through the comments that were submitted and discuss them and basically determine whether that feedback causes you to want to reconsider any of your discussion or recommendations on the measures before these go out to voting by the NQF membership.

So with that I'll turn it over to our co-chairs. Has Laura joined us yet? All right hopefully she'll be able to join us shortly. (Carol) I think it's going to be you.

(Carol): That's fine. And we have just have already agreed that I would be the first section anyway so she's got some time.

I just wanted to say that we have a very large agenda so we may want to especially devote our time over the next two hours to new issues that may have been raised that we haven't already discussed.

And also that if there is a critical mass of steering committee members who believe that on the basis of the comments and our current discussion we should revisit our prior position NQF staff will be able to provide us with a mechanism for re-voting soon quickly.

So I'm just going to go through about the first half of this very nice document that (Reva) and Suzanne have prepared for us to summarize the input from both NQF members and others who have provided the 149 comments and then input as well from developers on any of those comments. And Laura Riley will be taking over midstream from me.

So I just - the first sub section is on additional areas for measure development. And we have a list that has emerged from the comments. And I wanted to ask Steering Committee members if they are comfortable with adding all of these to the list that we have generated in our report?

Is someone able to go to that - oh you have ((inaudible))? Thank you.

I wanted to say that it might - yes?

Dr. Rebekah Gee: This is Rebekah Gee I was just really pleased to see the contraceptive use. I think I just want to make sure that this did not include all of our suggestions internally that - is that correct? These are just external suggestions?

(Carol): Yes these are additional...

Dr. Rebekah Gee: Right.

(Carol): ...points that came up.

Nancy Lowe: But (Carol) this is Nancy Lowe. I'm kind of going on with Rebecca's comment. What I didn't see there are some of the issues that we discussed in the email conversations that we had after our in person meeting.

(Carol): For those there's is actually in the draft report a pretty nice list, a pretty lengthy list that gathered those points so these would be additional points.

Nancy Lowe: So in the technical report?

(Carol): Yes there was a report that - the most recent version I believe is the one that went out for public comment. It was called pre-voting review. And it's a draft of our report. And on Page 5, our recommendations for future measure development.

Nancy Lowe: I guess I must not be looking at the right document then because maybe I'm looking at an old version of it because...

(Carol): Right so it wasn't distributed to us recently. It was distributed just about the time when we were getting ready to open it up for public comment.

Nancy Lowe: Okay.

(Carol): So that - I think that that staff did a really good job of collecting our input and listing it there.

Jennifer Bailit: This is Jennifer Bailit. I - one of the comments from the outside commentators is wanting measures of different levels of care including clinicians and clinician groups.

And I think we talked pretty persuasively at the meeting about why presenting data between institutions or between clinicians at lower levels of cases is not methodologically stable or desirable.

So I would just hesitate to have us talk about public reporting of things at the clinician and clinician group level because the methodologies of these measures is just typically not stable enough to create meaningful results.

Elizabeth Drye: This is Elizabeth Drye. I second that thought. But I also am just wondering what it means to put these more generally on a list without any sort of caveats.

So even - so, you know, yes it would be great to have (measuring at that) level but it's really hard to build them.

So if we're putting them on the list ((inaudible)) how we think they should be created and there are no issues I'm just trying to understand what it means to add these to the areas for measurement.

(Carol): I think it would be assume that any measures should come - should strongly - that would be put forth should strongly meet the NQF criteria. And if those could be developed for these various levels that would be appropriate. I think it might be misleading to put it aside as category completely.

Elizabeth Drye: Yes.

(Carol): There's a lot of interest in the external world in those levels.

Elizabeth Drye: Right. And one thing at least in our group we focus on outcomes measures was especially hard to do these, we tend to recommend reporting at the aggregate level but giving information to clinicians and clinician groups for quality and treatment confidentially.

And that's to me a different, you know, that fulfills the need for QI without the (methodologicals) that people get into.

But I just don't know, you know, if you put - my concern is if put a statement in the report like that it doesn't really get into those differences.

(Carol): Right. I think the NQF measures are by definition both for quality improvement and public reporting.

And I feel there's a lot of interest out there among consumers in the public reporting piece as well and being able to have a better basis for selection among facilities, caregivers, et cetera.

Kimberly Gregory: This is Kim Gregory. The last one the composite measures, I see how low birth weight makes it. But I'm a little concerned about expanding it to complex health conditions with special needs when the whole point of this was to focus on child birth and maternity outcomes

(Carol): Right, I think I agree with you Kim. I think the children with special needs could be a little bit outside the scope.

And I was also thinking of whether we want to put forth internal mortality. I just don't think it's amenable to the traditional levels that are considered despite the importance of that issue. I think it could be a little misleading to call for a maternal mortality measure?

Kimberly Gregory: I agree. It's only good for case finding (at best).

Male: Yes I completely agree with that. I mean we never want to downplay the tremendous importance of it but it's of absolutely no use as an ongoing quality control or improvement measure.

(Carol): Okay any other...

Male: I second that.

Mayri Leslie: Yes. (Carol), this is Mayri Leslie.

(Carol): Hi Mayri.

Mayri Leslie: The one question I had is third item measures across the full episode of maternity care.

It just seems really like a broad statement that's not very definitive. And while some of these that got on the list like continue DFED prophylaxis are very specific I thought in the comments there were actually some specific measures having to do with maternity care like VBAC came up more than once, et cetera.

And I wondered why some of those didn't get on the list while others that were very specific did get on the list?

(Carol): Right, so VBAC is well represented in the - a current full draft report.

Mayri Leslie: Got it.

(Carol): And yes, we might want to treat this measure across the full episode of maternity care to become measures of outcomes of the full episode of maternity care.

I don't know if that would help the concerns that were raised initially about that when...

Mayri Leslie: That makes more sense to me.

(Carol): Right. So any other burning questions because I want to try to keep us on track here?

Female: I just want two last comments on this ((inaudible)). I really am not comfortable saying measure at the clinician level. And I think someone else mentioned that as well. And I'd be more comfortable saying clinician groups.

But I know it's a fine point but if it's our recommendation for measures I would not call for measures at the clinician level at this stage.

And the other - just technically as a measure developer. And the other thing I just wanted to hear Rebekah maybe or other OBs talk a little bit more about this phrasing the contraceptive use as a quality measure versus contraceptive access or contraceptive counseling. Because I think there's high variability in populations on at least the contraceptive.

And so I'm a little uncomfortable with that as a recommended quality measure just out-of-the-box, you know, discussion that would go in our report.

(Carol): Yes I mean I think use of the problem I think adherence and then the other notion that it's not here and I think maybe a better way to frame it is the reproductive life plan. There's a lot of work going on now about - you know, measuring reproductive by plan, blessing.

I co-chair the clinical workgroup for the CDC for quick inception and care committee. And, you know, we're sort of early in the movement and so I don't think these tools have been blessed.

But I do think the bigger issue here is has the woman made a reproductive life plan? Has that been part of her counseling session? That's the first piece.

And then the second piece is did she adhere to that and what was the support given to her? And I think another additional piece is did she go to the postpartum visit?

There's a lot of focus on payments reform. North Carolina has changed payment to focus on postpartum visits. And that is another opportunity. So I think there are three pieces -- the plan, the adherence and the postpartum visits.

Sarah Brown: This is Sarah Brown. I want to jump in here. I think there's some additional issues as well. But Suzanne I think you told me in an email that the reason contraception wasn't on this is that there were no measures submitted. Is that sort of where matters stand?

Reva Winkler: Sarah, there were no measures submitted for consideration but that's the point of this section of the report is to identify areas where you feel there should be measures.

Sarah Brown: Well I - this would take a longer bit of time and I know you're very concerned about the agenda. But I think for measures don't you require measures to have evidence of impact or something other than somebody thinking it's a good idea?

Reva Winkler: Absolutely.

Sarah Brown: Yes so for - I mean I love the reproductive life plan, don't misunderstand me. But I think that's still an idea. And I'm not sure there's any evidence showing what its impact is on contraceptive use or prevention of unintended pregnancy.

But anyway, I don't want to get us off on that side - on that tact. I think there are a whole bunch of things we could add. Do you - is it too late to do that?

Reva Winkler: Well why don't we do this. Let's circulate the list that's already in the report that you were - basically created already.

Sarah Brown: Right.

Reva Winkler: These were things that seemed to be new suggestions to add to it. And we'll see how - we'll reformat the two together and ask you to review it and comment on it.

Sarah Brown: Great.

(Carol): Great and we'll need to turn that around pretty quickly I think looking at the timetable.

Sarah Brown: Yes.

Female: I'll get that out by tomorrow morning if not tonight.

(Carol): Okay. So thank you everyone. So let's move on please...

Charles Denk: I'm sorry (Carol), (Carol)?

(Carol): Yes?

Charles Denk: I'm sorry. Hi. This is Chuck Denk from Missouri I was kind of waiting my turn.

I just wanted to ask really quickly what is - for the people who've spoken about, concerns about clinician level measurement what exactly under our purview, you know, is the methodological problem of saying that the measures we've endorsed at a hospital level are also applicable to clinician groups or ACOs. I mean what's the methodological issue other than small sample sizes?

Female: Well I mean you can't do the other. I mean for ACO it's a big population, right? It's got to be a population of thousands and thousands of patients and so that's not an issue.

For individual clinicians who share care of a patient with other providers is an issue of attribution of outcomes or care.

In addition the big driving issue though is the sample size. And so you just don't know if individual physicians have unique, you know, one they're very small populations. So with outcomes you can't make inferences. You just can't public ((inaudible)) random variation in small sample sizes.

And two, they may have unique populations and a lot of our measures we would like to know more about patient preferences on vaccines et cetera, et cetera.

But when you get on to the physician levels those (proturbance) of what a typical population is it gets magnified.

So I haven't seen measures that I really like at the clinician level. And I think, you know, people want to know more about individual clinicians.

But for many types of measures they're just not reliable valid measures at that level. We don't know how to build good ones yet because maybe we will figure it out someday...

(Carol): Well if I understand the PTTI maternity care workgroup is working on this problem. And I hope that they will tackle some of these and identify some common aspects of care where it may be appropriate and then shift to groups where for example the numbers are too small.

But hopefully people will just solve these challenges and problems and create some good measures.

Charles Denk: Okay thanks.

Joanne Armstrong: This is Joanne Armstrong just if I can ask just taking that question a little bit deeper, do we have thresholds of sample size where it might be appropriate not at an individual physician but at a group practice level?

Because as you see more consolidation of the individual practices into groups and in groups into ACOs some of this accountability can be put in a large group practice setting.

So can there be some guidance around sort of sample sizes where these measures would be valid in large group practices?

Female: It's just it's not generic right? You can do it with looking at specific measures. But I - so that's why I'm just uncomfortable making a blanket. We need more of - you could say we need more these measures.

But what I don't want to imply which is what the comment phrase bring the reporting of these measures, the ones that we're approving in this committee down to the group or physician level. It's just going to depend on the measure and so it's...

Joanne Armstrong: Yes.

Female: ...not - so it's encouraging that you're looking at, you know, the things that will work. There will be some that work but it's going to be a smaller subset of measures than you think.

(Carol): Right and fortunately NQF has continuously refined quality criteria to hold the measures up to see if they are going to work, so I think part of it is trusting the process and trusting, you know, developers to do their job and develop strong candidates at that beginning.

Okay so the next section is electronic health records. And a vendor rated the readiness of the recommended measures for incorporating into EHR. That was and NQF thing.

Exercise however, no e-measures were submitted so this is beyond the scope of our work.

And NQF staff commented that in the future they will be requiring e-measure specifications. Does anyone have anything to add to - (the - at) this little summary, the issue?

Okay so the next point is about levels of analysis which we've already covered pretty well. There were several comments recommending that the joint commission measures be considered in terms of their relevance to other appropriate levels and the Joint Commission responded that a facility level is that only one that is relevant to them.

So the action item for us was does - do we wish to request additional levels of analysis for any of these?

And we've also extended this to the requesting that possibly additional levels be targeted in future measures.

And I think it would be helpful in our future measures section to clarify that some of our measure stewards like the Joint Commissioner VON had their own priorities and may not be the ones that as might be expected that would be coming up with some of the alternative levels that may be appropriate.

I think we need to clarify what we've learned here for the broader audience for these. Any comments or questions further about this?

Okay the next point was the issue of just a small number of hospitals that are reporting on a joint commission measure set which is now just about 5% and of course this is beyond the scope of NQF but hopefully this would be a concern of the developer.

And the NQF staff has alerted us to the fact that the National Priority Partnership Maternity Action Team has identified as a priority for their 2012 work working on increasing the rates of reporting of that measure set the we have - we are, you know, in general strongly supporting.

Any comments or questions on that section?

Kimberly Gregory: I'm sorry; this is Kim Gregory. Can - the National Priority, who is that team that you called?

(Carol): Okay so the National Priority Partnership is a group of high level organizations and agencies working on healthcare quality and policy issues that now I think there may be about 40 organizations and agencies involved.

And they have identified a couple priority areas for their work this year. The general idea is that they try to get everyone rowing together focusing on things that are really important.

And they've chosen maternity care as a topical focus this year. And they have a maternity action team, multidisciplinary multi-stakeholder that are just getting underway but have made good progress. And there seems to be a lot of interest just in that group in reaching out to the joint commission and looking at how to solve some of the challenges with better reporting of this measure set.

Kimberly Gregory: Thank you.

(Carol): Sure.

Lee Partridge: (Carol), this is...

(Carol): Yes?

Lee Partridge: ...this is Lee. I think I'm on that action team. And I might add that it's not just joint commission that's involved here.

The Leapfrog Group has also been encouraging reporting of this measure by the hospitals. And they've actually had much better results that their latest report came out this week.

(Carol): Great, thank you Lee. So anything...

Janet Muri: ((inaudible)) this is Janet Muri. I don't know am I allowed to make a comment on the joint commission's number of hospitals that are reporting and some of the roadblocks to reporting?

(Carol): Sure thank you.

Janet Muri: ((inaudible)) we're a vendor for the joint commission.

(Carol): Yes please go ahead.

Janet Muri: Well I just wanted to comment. I think one of the reasons why there's such a poor number of hospitals reporting the perinatal care set is because hospitals are required in order to get their Medicare update their it's a reimbursement issue.

In order to get their Medicare update they have to report four measures sets to CMS.

So what happens is the hospitals that are - obviously most hospitals get reimbursed from Medicare so they want to get that update.

So for them to pick up another measure set like the perinatal care set there's a resource use issue that they have to deal with plus there's no financial incentive.

So I think that's one of the big roadblocks to more hospitals not submitting the perinatal care set.

If a hospital is largely a woman's hospital or has a high volume of perinatal activity and has no opportunity to do the adult measures like the pneumonia measures and the cardiac measures, et cetera, et cetera, those there they have to do the perinatal care set.

But for most hospitals they don't have to. And there's a financial disincentive for them to do it.

So I think part of the advocacy is to deal with CMS and to say is there an opportunity to encourage Medicaid programs to financially reward hospitals that submit the perinatal care set.

(Carol): Right. Well thank you. And I think, you know, the care for mothers and newborns are the most costly Medicaid hospital items. And 23% or so of people discharged from US hospitals are childbearing women and newborns.

So I think we do have a big policy challenge here. And I think it's very appropriate to bring CMS in on this

Janet Muri: Which by the way is one more reason to include contraception.

(Carol): Okay so thank you Janet. Any other comments on that issue?

Okay then next item is target values. And we have some comments that it is difficult to interpret a hospital cesarean or episiotomy results without having target values and with the recognition that some percentage of use of these procedures is warranted. And (Cristiano) replied by reporting that they're down to a 1% episiotomy rate.

So I think that, you know, showed some perspective on that question and where the rates might go. There have been other reports in that range as well and the Joint Commission responded by referencing that it has very precise specifications.

So would we have any insights to put back out there to the people who are interested in this about the question of targets?

I know there are some targets in Healthy People 2020 for the NTSB measure or benchmarking. How would we like to respond to this consent?

Charles Denk: Hi. This is Chuck Denk. I'm pretty sure that if I told you what our, you know, what our obstetricians say in terms of the healthy people 2010 goals for NTSB cesarean rates you would be able to print them in the report anyway.

You know, there - you know, I spent a lot of time working through the hospital association with, you know, with providers and targets make no sense to them. They are so contextually driven, you know, that they appreciate the feedback.

I mean I don't have any problems and I have, you know, like been for years sort of trying to tell them that, you know, that the state for example is not going to set any targets and, you know, we're not holding anybody - we are, you know, I don't know that very many - well nationally we're nowhere near the target for this rate I don't think.

So I don't - and I don't see how NQF really has any special expertise to add to that. But I just want to say that it really makes it a lot harder to work with providers, you know, if we're setting targets.

William Grobman: This is Bill Grobman. I just want to - I just want to modify a little or at least add my 2 cents about was just mentioned which is that I don't think it's the amount of the targets make no sense. I think actually targets make a ton of sense conceptually.

The - what is potentially aggravating to providers is when they are decontextualized targets so that arbitrary numbers are picked without evidence that those targets actually are the right targets so just as an episiotomy for example.

And we can all talk about, I mean our rate at my institution is rather low as well. But the question is we're going to give people a target we need to be able to say to them and we have shown that this is the right number, right?

Like because someone - and when the concept of target came out if it's not supposed to be a zero event then the concept is yes, some number are acceptable because there are conditions for which, you know, it's the right thing to do, that it will actually improve outcomes by doing it.

I mean that's I think the concept. But then we have to know what that is. And so...

Andrea Gelzer: This is Andrea Gelzer and I agree wholeheartedly. I mean there are targets for, you know, an optimal BMI. There are targets for an optimal LDL level.

But we don't have evidence-based targets for most of this stuff so I think there is great value to seeing that comparison.

Matthew Hoffman: So this is Matt Hoffman. This is the measure developer. You know, I think what's been shown is that the rate can be improved upon it. It's really the indiscriminate use of episiotomy that had been (they recur) and continues to recur in many hospitals.

But just like preterm birth before 39 weeks there may be exceptions to the rule. They're relatively small and there is opportunity to gain.

The idea that this is a never event is not necessarily true nor what's reported. But the goal is to move the benchmark so to speak. It is a hazard not having a specific number to attach but I'm not sure we'll ever get to that number.

Laura Riley: So what your - this is Laura Riley. What you're suggesting though really is that you're - you want to look at a trend not necessarily a specific number?

Matthew Hoffman: I think there's two opportunities, one of which is to benchmark against other institutions and also to have a trend that you demonstrate.

You know, there've been multiple institutions have been shown that they've been able to improve their rate through education and reporting that which measures counts nd as people start to pay attention to this one sees fairly dramatic drops in this whether we're speaking of my own institution or others. So there's an opportunity to improve care with this.

But the idea of having a perfect target rate is really not obtainable per se because of the issue distribution and types of patients. There may be times where people feel its use is justified.

(Carol): This is Carol. I wanted to mention too I think we need to look - consider short term and long term for example the Leapfrog Group with this 39 week measure had a previous target of 12%.

We found that a lot of their hospitals were able to get down to 5%. So that's their current target. I think over time as people adjust their expectations and the way they provide care things can change.

So I think we need to offer people things that feel reasonable and that they can get behind in the short term to (reach) ultimately what might be possible.

William Grobman: I mean I - this is Bill. I think again targets are totally - it - generally a good thing if we can provide them.

But I think what like for this rate what would we tell people? If we had something and a care provider came up to us and said so why is that the target what would our answer be?

(Carol): Are you saying - are you asking me the 12% or the 5%?

William Grobman: No I'm asking any number...

(Crosstalk)

William Grobman: I guess I'm - well maybe I'm not a - I mean is where are we at now in this I guess in where we're thinking about this? Because I've heard there are many different concepts. But where Laura, where are we at?

Steven Clarke: Could I...

Laura Riley: We - it sounds like people have an issue with target for all the reasons that have been articulated. I think it's fair to say that as a response.

And we can offer that we would suggest that you use the, you know, sort of your own -I mean that you use benchmarks where they exist for which there is evidence and then use trend internally.

Steven Clarke: This is Steve Clarke. Can I make a comment?

(Carol): Yes.

Steven Clarke: I think it depends. I agree with Bill but it depends on the target. If you take something like the pre-39 week delivery 5% may make great sense because there are multiple institutions big,

small across the country have shown that they can reduce their rate from very high rates to less than 5% and improve outcomes without adding to morbidity.

And so something like that if some were to - one would ask me where would the 5% come from we have an answer.

(Crosstalk)

Steven Clarke: Other targets though as you said Bill are just out of thin air. I mean 15% primary cesarean target or something that just makes people laugh because nobody's ever been able to achieve it and nobody has any evidence to demonstrate what achievement of that rate would do positively or negatively to maternal and newborn morbidity.

So I think we do have - targets are useful but I would emphasize what Bill said, that they're only useful when we do have an answer to that question Bill asked from the medical literature.

And in many cases when we don't have such an answer then it - like coming up with a target kind of casts dispersions on all targets.

William Grobman: Yes I agree -100% with exactly what Steve said.

Elliot Maine: This is Elliot Maine in California, one of - the measured developer for the NTSBC session.

I think the reason we're having this discussion is that most of these measures are pretty young measures as they go. And they haven't had much track record with, you know, hundreds and hundreds of hospitals which is kind of the baseline that you need to have to develop the literature for a measure rather than a study in a hospital.

And I would think that NQF may want to charge the measure developers with coming up - with doing the research and coming up with targets for the next go around. Thanks.

(Carol): Thank you. Well I think the NQF staff is going to have some nice challenge with summarizing what we've been putting forth for this question. Before we move on does anyone else have something to add quickly?

Okay thank you. So now we're going to get into our specific measures. And the first one up is exclusive breast milk feeding, a joint commission measure.

We had ten comments have been generated relatively a lot of interest. We had ten comments suggesting that this measure inappropriately mandates that women breast-feed and eight comments that gave unqualified support for the measure identifying that there are notable opportunities for improvement and expressing the thought that access to support does not interfere with a woman's choice of infant feeding.

And I just wanted to ask (Cecile) a point of clarification that's related to this. Documented reasons are not exclusively breast milk feeding is an exclusion. Does this include mother's informed choice of mixed or formula feeding?

Celeste Milton: Do you mean Celeste at the Joint Commission?

Female: Yes. Yes.

(Carol): I didn't quite hear you but yes I would like - I went back to the Measure Submission Form and I did not say clarification about whether maternal choice is incorporated in the exclusion.

Celeste Milton: It is not.

(Carol): Okay. So all right and overall just as a reminder we voted 20 to 4 to endorse this measure. So would anybody now like to make a comment in light of our prior discussions about this and then the additional comments that were received?

Sarah Brown: This is Sarah. I just want to ask a question. What's the measure say with regard to education and information on alternatives?

Celeste Milton: This is Celeste at the Joint Commission and we did not address that in this measure. It would be a separate measure.

That would be something that we would hope that hospitals would first do that should be the default that they would educate first.

(Pam): (Pam) at the Joint Commissions. And, you know, I'd like to stress that there's nothing in this measure that says that hospitals are to force women to breast-feed.

What it is - what the measure is measuring is how many women exclusively breast-feed during their stay in the hospital?

Numerous pieces of evidence which we enumerated in the measured submission form indicate that education to mom's prior to and at the time of hospitalization can impact on their decision and we certainly support the right of women to make a decision. However the measure itself just looks at how many people exclusively breast-feed.

We are not - we are in no way advocating that -you know, that somebody recently said oh my gosh this is a dictatorial measure.

There's nothing dictatorial about it. It's a measure. And we urge hospitals and we have - if we have a statement to this effect that when we are asked this question we answer that says there is no definitive range that we're expecting.

We don't ever expect 100% performance on this measure but that we would hope that hospitals do all that they can to educate women and incidentally their staff as to the benefits of breast-feeding.

I don't know Elliot did you have any comments on that?

Elliot Maine: Sure. I was - this is Elliot Maine in California, the original measure developer. This is a measure that you do well if you're at 50% or 60%. No one is at 90% on this or even close.

What the focus is is to really make hospitals examine their practices of care within the hospital to see and eliminate those that -actively discourage mothers from exclusively breast-feeding.

There are a lot of hospitals that still give formula freely at nighttime and things like that without even physician ordered.

And so the range is like 20% up to maybe 70%. But most are - there's an awful lot of hospitals in this country that are at a very low rate on this measure. So it's nowhere near trying to force everyone to exclusively breast-feed in the hospital but we're trying to identify places that really have big opportunities to improve.

Nancy Lowe: Yes (Carol) this is...

(Carol): Yes?

Nancy Lowe: This is Nancy Lowe and just a follow-up comment about this one. And first of all in the documents that we have the Joint Commission set a target of 75%.

So there was that target their but the second thing that I wanted to say is that this measure is not really about the mother. It's about the process of care surrounding her in trying to make hospitals accountable for the sabotage of breast-feeding that goes on in many institutions.

Charles Denk: Hi. This is Chuck Denk. I wanted to second just sort of both of those comments by saying New Jersey's had a really disturbing trend since about 1997.

You know, we had maybe three exclusively breast-feeding moms for every one mom that was classified as following a mixed strategy in the hospital where they had both formula and breast-feeding.

And by 2009 we had more women who were mixed breast feeders than exclusive breast feeders.

So, you know, our overall rate of some kind of breast-feeding went up but it actually went - it went up at the expense of exclusive breast-feeding.

So I mean it really is true hospitals, you know, that we can - the population can change its attitude about breast-feeding through all kinds of educational things.

But then the hospital can in fact get in the way by not doing complete rooming in or by, you know, interfering in the first hour with, you know, getting the baby to the breast and there's an opportunity there. And I still think we should endorse the measures the way we - the way it's been presented by the developer.

But there is an opportunity there somewhere to say that nonexclusive breast-feeding in the hospital is the thing that we really want to get after because, you know, if I - if breast-feeding is the choice of the mother and isn't medically contraindicated then we shouldn't be having a lot of mixed strategies, a lot of what's I guess generally called supplementation.

So maybe in another addition of this - we're so far away as Elliot points out from the numbers we would like to have that I don't think this measure does any harm. But as we get closer to that maybe there's an opportunity there to shift the focus a little.

(Carol): And I would also like to say that there were a number of recommendations for new breast-feeding measures in our list so I would ask steering committee members to look at that carefully and see if you have some - want to refine those or identify on the basis of this conversation specific issues that would advance things in the future as well.

Celeste Milton: This is Celeste at the Joint Commission. I just want to clarify that the Joint Commission did not set a target of 75%.

That was actually in the evidence section at the Healthy People 2010 had set a goal of exclusive breast milk feeding during hospitalization at 75%. We simply quoted the literature but we have not set a target range.

(Carol): Thank you.

Nancy Lowe: And then Carol?

(Carol): Yes?

Nancy Lowe: Carol?

(Carol): Yes?

Nancy Lowe: There are notes on Table 2 Page 10 are wrong because that's what's in our rationale.

(Carol): Okay I picked that up too and made the assumption. So could we ask NQF staff to correct that item?

Female: Yes we will.

(Carol): Great. So any other comments or any move to revisit the decision that we made about this measure at our two day meeting?

Jochen Prosit: Yes. This is Jochen Prosit. I've been waiting my turn I guess. I do think it's, you know, I fully support breast-feeding first of all, but I do think it's a little bit disingenuous to say like, you know, that this is all about just removing processes.

Because hospitals of course are going to - of course - there's of course there's going to pressure on them to increase their breast-feeding rates to some - whatever target there may be or compared to their peers.

And, you know, initially they may try to remove all the processes that may stand in the way of that but of course like it's, you know, this was a research like if I was on an IRB and had to think about, you know, whether there might be coercion of mothers, you know, I think there's - I don't think there's - it's an irrelevant concern quite honestly.

Because if these things go into the public domain of course there's going to be competition between the hospitals, of course there's going to be payment decisions of going, you know, might

be made and pressure on the hospitals beyond simply, you know, like saying like oh we just want you to, you know, do a better job at not handing out formula see.

So I feel a little bit conflicted about this. You know, of course I support the breast feeding goal but I, you know, if you truly just wanted to improve the processes I guess we could measure those processes.

But if we - if you measure an outcome that outcome will be pursued by the hospitals in a variety of different ways. This is not entirely predictable by us I think.

Elizabeth Drye: And this is Elizabeth Drye. I agree with that. I think that was really well said. And I've been struggling with how to think about it again, you know, as someone who supports breast-feeding in the hospital.

I think - I'm wondering if we can make a statement in our report somehow to that effect. The way I think about it from a measurement standpoint is, you know, if our concern is a unintended consequences, the mothers are coercively pushed towards exclusive breast-feeding we - I love outcomes measures right? I believe in them. We would try to measure the simultaneously.

We would to - you know, through a consumer assessment health plan survey or something else be asking, you know, did you get the support you need? Was your choice respected?

And so I feel like there's a complementary measurement strategy that would assure we're not overly coercive and, you know, once this is implemented.

But I think it's important technology any measure to kind of put pressure on hospitals and potentially move into payment.

So I was just wondering if in our report we can say we're, you know, we all support the promotion of breast-feeding in the hospital, the removal of barriers, the active, you know, engagement of the staff in ensuring exclusive breast-feeding among mothers who choose that option, the education to, you know, to help them make the best choice but the respect of mothers who choose not to feed.

And I think we can at least add that and the need for measures that assess the decision-making process right?

There are essentially patient survey measures that make sure we're doing - we're respecting patients on the choice.

Male: I think that's a very good idea.

Steven Clarke: Yes this is Steve Clarke again. You know, just as Jochen said if this one's so politically correct it's like saying you're against apple pie and baseball in terms of both scientific validity and coercion of mothers or removal of their choice. It wouldn't even stand chance at being passed or being considered.

So I think we go ahead with is fine. But I have a statements that we can that need - the can emphasize that mothers are not to be coerced and to not to hide this behind some sort of façade that this has the scientific validity of any of the other perinatal NQF measures, that is there happens to be no evidence to demonstrate that over a broad range of population types such as the United States that the hospitals can have a dramatic effect on permanent breast-feeding. This has been shown in small selective groups that - of individuals.

So just keep in mind that this is a PC measure having very little to do with science and really promoting the coercion of mothers which does happen because as Jochen said, hospitals want to have a high score. They are being judged.

Female: Yes, so the flipside is - and I mean I think we're all on the same page. But I think the flipside is is that for some hospitals it does allow you to go to hospital administrators and say you know what, this is important and we're going to be measured on it.

And so we need resources to make sure that nurses and lactation consultants and et cetera, that education actually occurs.

So it can go in both - I mean it can either help you or hurt you obviously. And my sense is is that if hospitals are really cursing women, putting that much pressure on them then I imagine that they're going to see it, you know, bite them in the butt if you will in the HCAP scores or whatever patient satisfaction, you know, tools they're using.

Mayri Leslie: This is Mayri...

(Crosstalk)

Mayri Leslie: Go ahead sorry.

(Carol): No I think maybe - if this can be the last comment just because we have to allow to - get to all the other important topics.

Mayri Leslie: I - just my only comment on this is that perhaps we could say that mothers who identify, they choose breast-feeding then it truly is a process measure if we're interfering at the hospital.

But if when they enter the hospital if they identify it's formula feeding they shouldn't be a part of this cohort.

(Carol): Well that would require a reconfiguration of the measure.

Mayri Leslie: Right.

(Carol): And I think we need to take it as it is right now. But that would be an appropriate thing to recommend for the future and for future breast-feeding measures.

Mayri Leslie: That would like yes, as a comment...

(Carol): Yes.

Mayri Leslie: ...for the future.

(Carol): Okay. So thank you. I feel the need to move on. And the next is a set of three measures on healthcare acquired infections.

We have the VON 304 that applies to very low birthrate infants and then the 478 AHRQ measure and the 1731 Joint Commission Measure that apply to newborns.

And just as a reminder the Joint Commission chose the AHRQ measure for inclusion in its core set after the 2008 report and harmonized with its other measures in its set so now selects set measure using clinical data whereas the AHRQ measure is attractive because it's inexpensive to collect administrative data.

And there were a few comments on this, not as much feedback as we might have received because of the problem of competing and related measures, some supporting it and some expressing inclusion of all three and some expecting concern.

So one of the action items for us is are the measures competing or related. And I think we already have settled in that AHRQ and Joint Commission measures are competing and then the VON measures versus the other two are related.

So does - is there - are there further issues that have arisen that we need to look at? And I'll just remind you that we voted eight yes and no, ten yes and eight no for including both AHRQ and Joint Commission.

And the Joint Commission did make a comment that this could jeopardize the integrity of their full measure set if we did not support that.

And we had a close vote, nine yes and eight no in support of the VON measure. I think we wanted to recognize the importance of these issues as well as respond to the issue of competing and related measures. So I'll open it up for you on after that summary.

Male: Hello.

Laura Riley: This is Laura; just to also remind people that the other thing that we had a serious discussion about was sort of the validity of the data set and whether I think the VON measure at least as a clinical data set and there seemed to be more sentiment to that.

You could more likely make an accurate diagnosis of sepsis from that clinical data set whereas it was significant amount of concern that using the administrative data you may not actually be able to make the diagnosis of say hospital acquired infection in the newborn not knowing whether it

was really hospital acquired versus, you know, it came from the mother's uterus et cetera, just to jog everybody's memory about the discussion.

Scott Berns: Yes Carol this is Scott Berns. I mean we had quite a bit of discussion about those four measures.

And, you know, in my read of the comments I was really struck by I thought the majority of the comments were really around, you know, there are just too - there are too many of these and, you know, what can we do about that?

I was struck by (Deborah Campbell)'s, comment suggesting that 304 may be unnecessary. I think that's what she said.

And no - I know Dr. Prosit had a lot of comments and input on this. I think (Harry) also had some input around the importance of keeping at least one of the VON measures.

But, you know, I'll put it on the table again, you know, it's the balance in my mind as we went through this process between some of the scientific validity of these measures and then, you know, being pragmatic.

And so I think we do need to seriously consider, you know, whether we, you know, eliminate at least one of these.

And just for the purpose of discussion and that risk of rehashing some of the things we already discussed, you know, do we consider taking 304 off the table?

And I understand, you know, what that means in terms of the Vermont Oxford network measure. But I'd just like to put it back out there as a discussion item.

Jochen Prosit: Yes well I guess since you have - this is Jochen Prosit since you addressed me directly. I - well I guess I still have the feeling that I had when we met that, you know, at least from what, Oxford covers about 80% of all of the OBW births in this country and that, you know, we as a sort of scientific steering committee are making a lot of judgments about how people should get access to the data.

Like California has access to the data just because California, you know, their elected officials decided that this is what their population would like to know about.

And so they - the essentially Vermont Oxford data is available to the state there. And but that's not true in other areas.

And I understand that problem but it's I am - I remain concerned that - and I think the comments reflect that that we have many measures and hospitals have to report on these measures and expend moneys to do that for something that is, you know, essentially not really value-added with regard to improving front (right) care.

No I don't think I agree with all of (Debbie Campbell)'s comments regarding the individual measures and the relative benefit of (Clamsey) or (VA), like ventilator associated pneumonia which nobody has been able to really define in neonatology.

And the whole - like we're not really actually measuring (Clamsey) with any of these measures that are on the table.

So I'm - I mean I guess I'm not like the only benefit of not having three or four is that 478 and 1731 are relatively or almost identical.

And but then I guess the question would be well why do we have two of them, you know...

Scott Berns: Well yes, just to try to follow-on to that, you know, it's I understand that. And, you know, but we did have a number of folks that commented, you know, expressing concern about this causing confusion.

Jochen Prosit: Yes.

Scott Berns: And, you know, how much - and, you know, just from a pragmatic standpoint for a minute is that part of our role as a steering committee is to address those, you know - we are addressing those concerns because we're talking about it right now.

But, you know, there's a balance there and so how do you - how do we take account of that?

(Reba): This is (Reba) just to jump in. If you recall the NQF measure evaluation criteria does ask you to look at related and competing measures and compare them. So it absolutely is part of the steering committee role to make that evaluation.

Dr. Rebekah Gee: This is Rebekah. And I just want to say that VON is a very important network, you know, representing over 500 hospitals. Really for a state like Louisiana that's where we've had to go to look at NICU quality metrics.

I think we also have to be realistic in terms of, you know, how many people are already reporting that there may need to be until they - until these NICU measures are mandated and there's a really robust national data system that we may have to have different ways of getting at quality improvement in NICUs.

And I think to ignore the VON, you know, puts it at a disadvantage. In our state we wouldn't -be able to have a NICU QI effort without VON.

Jochen Prosit: Yes and they're really - I mean that's the one organization that kind of closes the loop, you know, in - between measurement and improvement with all of their activities, so it's...

Male: Right so...

Jochen Prosit: ...really like you want - like I guess they don't need necessarily the National Quality Forum's endorsement with, you know, all the members that they have.

But it seems like I'm just - like in this whole process I'm just wary about adding burdens to hospitals that are not going to improve care to the patients.

I think that would be my - I think my primary goal as sort of an evaluator of quality measures is that to me the quality measure exists to improve patient care.

And if it doesn't do that or if it can't really demonstrate that it does that then we don't need it or we don't need a measure that does exactly the same thing as another measure does.

Scott Berns: Yes I think all good points. I just want to say that I think what VON does is incredibly valuable and are critical and certainly capture quite a large number of NICUs across the country.

But for the purposes of moving things along it sounds like we're pretty much (Carolyn) and Laura where we were after our...

Jochen Prosit: Yes.

Scott Berns: ...meeting. So...

Jochen Prosit: Right.

Scott Berns: ...you know, I would just suggest that, you know, yes we recognize that there would be varying comments but I think we're coming to the same conclusion.

Jochen Prosit: Yes. I mean the votes are very close for all of these, you know, so I feel like it's, you know, we're...

Female: Right.

Jochen Prosit: ...like it's quite obvious how we we're struggling with this.

Female: The one thing that we didn't have it's that we - I don't think we still have is a good sense of whether the administrative data set is going to be valid.

Jochen Prosit: Right.

Female: That was the major thing that I think made the vote so close in the first place was how valid is using administrative data states information in trying to reflect whether not it's a health - it's truly a healthcare associated...

(Crosstalk)

Female: ...section.

(Carol): And I actually tried to put in a comment that didn't get picked up asking the Joint Commission the next time around to come back with some testing data showing whether your particular approach leads to better quality data. I think that would be really helpful when this conversation comes up again.

Female: Yes.

Mambarambath Jaleel: This is Jaleel. Well as we discussed I mean we took up about two hours to discuss this on that day and we realized that there was so many difficulties with this.

But one thing which struck me after - from the comments is the comment from epic, one of the EMR vendors saying how difficult it would be to get this information which is on the one measure if you do not have an abstracter sitting there getting all this information because most of that information is clinical information.

(Carol): So when VON resubmits I think they're going to have to deal with that.

Mambarambath Jaleel: Yes.

(Carol): Any - is it fair to say that the comment saying that we are sort of where we were before and we don't need another - to revisit these with voting? Is that still accurate for everybody?

Female: Yes.

Female: Yes.

Male: Yes.

Male: Yes.

Female: Okay.

Male: Yes.

Female: So thank you. So moving on to the incidence of episiotomy, we had two comments in support of it. And one comment in support of this measure and one, and asking for an exclusion relating to the need for shortening a second stage.

And we had a developer response first of that is that is a - that exclusion is not consistent with the ACOG guidelines and second that it would propose data collection challenges and make that a more burdensome measure to collect.

So those are the only new issues that came up. And we voted 19 yes and one no previously. Are there any comments in response to the issues that have arisen?

(Carol): I think it would be probably fair to say that we still are supportive of that measure and we can move on to 475 which is Hep C vaccine among all live ((inaudible)) prior to discharge.

We had three favorable comments and one requesting that parental refusals be measured separately as a component of the numerator.

And the developer response was that their testing revealed that hospitals had difficulty incorporating parental refusals and they were anticipating that coding for vaccination refusal will be standard and people will get up to speed the process with the introduction of ICD 10.

And as a reminder we voted yes 22 no three on this measure previously. So are there any comments, further comments about this that members would like to make?

Okay so I will take that as statement that we do not wish to reconsider our recommendation. The next one is 476, appropriate use of (antenatal) steroids.

And we had one comment in support of this measure but encouraging aligning with the relative ACOG committee opinion in terms of gestational age definition.

And the developer responded by saying we've already made this change and put it in the specifications manual.

And we had one comment that identified the need for a specific list of exclusions. And the Joint Commission responded by saying that their specifications are intended for trained abstractors.

And I was guessing that that meant that the abstractors know what the exclusion are. Would that be correct?

That was just Celeste. I'm sorry I got your name wrong before or (Ann).

Celeste Milton: That's okay that's fine. And this is Celeste...

(Carol): Yes.

Celeste Milton: ...of the Joint Commission. And actually the way that - I'm trying to recall exactly how we worded it but yes trained abstractors would be reviewing the record.

They would be looking for clinician documentation of either the reason or an implied reason. We do have notes for abstraction that allow them to look for a reason.

And it's usually going to be in conjunction with a statement about the steroids and the fact that they didn't get the full course because or it could be an implied reason that they got the first dose and then the delivery occurred prior to the repeat dose.

So that would be an implied reason that could be used or they documented that the fetus had anomalies incompatible with life. Once again you wouldn't be giving steroids to the mother for that reason.

(Carol): Okay. So maybe...

Celeste Milton: There are no...

(Carol): ...I'm sorry go ahead.

Celeste Milton: There are no like ICD9 codes things that you would - diagnoses that you would look for like the...

(Carol): Right.

Celeste Milton: ...kind of was suggesting. There just isn't a distinct list.

This is going to be clinician documentation, opportunity for improvement if they're not documenting and linking, linking it to the event.

(Carol): Okay. So thank you. I think what we can do is in our documents clarify better what is intended by exclusions there.

And as a reminder we voted 25 to support this and zero to reject it. So I'll just open this up for any further discussions that anyone wants to have or comments.

Okay so I think we will probably continue then with that recommendation. And I'm going to switch over to Laura now for 477.

Laura Riley: So 477 is the - under 1500 grant infant not delivering in the appropriate level hospital.

There were a couple of comments on this one requesting expanding the exclusion criteria. And at this point the comment had been forwarded to the developer. I didn't see the response, did I miss it or...

Elliot Maine: Hi. This is Elliot. I did send that back last week.

Laura Riley: Okay.

Elliot Maine: As I recall the issue raised where there are of course some mothers who come in and deliver -- that's always the case -- and a few that are in rural areas that just can't make it to a Level III center.

It is not expected again that this is a zero measure, a zero rate to be expected. It is of interest in when we've looked at hospital levels numbers here.

Most of the hospitals that have high rates are actually in urban areas. We don't have problems with the far reaches of California which has a lot of rural, extremely rural spaces. Those others get out just fine with of course the rare exception.

So and it's as we're doing the follow-up quality work the quality indicators that were used to as a sub indicator on this is how long the mother was at the hospital before she delivered her baby.

And a lot of these mothers were there 12, 24 hours before delivery. So there's real opportunity to improve but it's never going to be zero because of the reasons that were stated.

It is just hard to collect those reasons without chart review. This is meant to be a very simple administrative data collected measure and it has very little burden.

(Carol): Right, did anybody from the committee want to reconsider our recommendation given...

William Grobman: This is Bill. I completely support what Elliot said. There's no reason to think that one is going to be a problem if this was supposed to be zero. But given that it's going to be comparative there's one hospital that has like a wildly high number. It's going to be hard to believe that because all their mom's happen to come in super late.

Female: Right.

William Callaghan: And this is Bill Callaghan. I absolutely agree with that.

Dr. Rebekah Gee: Rebekah I agree. Rebekah.

Mambarambath Jaleel: Jaleel I agree.

Female: Okay.

Mambarambath Jaleel: This is about examining practices and looking for opportunities for improvement.

Laura Riley: Perfect. So moving on to 483 this is the proportion of infants 22 to 29 weeks gestation who were screened for retinopathy of prematurity.

There was some comments about the burden of looking for what's in this particular population what's almost a zero number.

So I mean I think again this may be an opportunity for some hospitals and not for others but that's just my own thought about that comment. Do others have questions or concerns about this?

Male: Yes I wasn't quite sure what they meant with the added healthcare burden?

Laura Riley: I think that this was the - they didn't have any babies between - they didn't have any retinopathy in babies between 22 and 29 weeks or not enough babies in that timeframe.

And so the sense was is that that's an awful lot of work for something that isn't a very common occurrence. I think...

Male: Okay.

Teri Kiehn: No I - this is Teri Kiehn. Actually that was one of our providers that commented on that because we've actually some internal data that will soon be published showing that actually 28 weeks the cut off.

So we do not screen to 29 weeks and so we would look really bad on that obviously. But perhaps the developers can consider this again once the data is published.

Male: Yes I would wait for the data to be published because we don't - I mean this has been submitted for publication and doesn't necessarily mean that is published.

Female: Right.

Male: And the AB recommendations currently are to do this screening. And even the ophthalmology Association also recommends the screen the same way. So I would wait until the publication comes out.

Laura Riley: Right. Anybody else on the committee have any comments? Can we leave our recommendations as they stood?

Okay 1746 was inter-partum antibiotic prophylaxis for group B strep. Most of the comments were about the specifications and also mentioned the difficulty that they'll be with sort of the data elements that go into calculating the measure.

And the developer did respond with some details of the specifications, didn't really change things all that much but does anybody else have any comments or concerns about that measure as we voted for it?

No? Okay so moving on to a different set, these are measures that we did not endorse that generated quite a few comments.

The first was the birth dose of hepatitis B vaccine and hepatitis B immunoglobulin for newborns of hepatitis B surface antigen positive mothers.

And so (Reba) may have to help me out here. I can't remember exactly how we voted but this one was a little bit of a tricky one because I think we felt as though it wasn't, the magnitude of the problem wasn't so great yet.

(Reba): So I can just jump in Laura that we - it did not pass the important criteria...

Laura Riley: Right.

(Reba): ...so we stopped right there in our previous vote.

Laura Riley: And I think important piece of it was the magnitude right?

Female: Yes they summary of your evaluation is on page - begins on Page 25 of the memo. And the vote on the importance, measure and report was yes six, no 20.

And the issues I think that were raised at the time were around the fact that this is very regional. There's some areas with greater populations of at risk individuals compared to others.

That given the committee had recommended the other measure of Hep B vaccine the marginal additional value of this measure would only capture the (H big) part of it and the impact was felt to be somewhat small.

Dr. Rebekah Gee: Yes. And this is Rebekah. This was my measure, was assigned it. And the other issue is we just don't know the extent of this. I mean the number of women that are positive fall through the cracks versus the burden of collecting this did not seem in terms of relevance and importance also did not seem to meet the criteria.

Laura Riley: Other comments? After sort of considering those things do you do people feel that we have to - that we should reconsider this recommendation that we made previously?

Kathy Harriman: Kathy Harriman from the Counseling Department of Public Health. Are we allowed to comment? We were given the call in information because we had been an original sponsor of that measure.

Laura Riley: Sure.

Kathy Harriman: And I guess what we'd like to say is that clearly the issue of infants being missed, of infants of infected mothers being missed is kind of where the rubber meets the road with the whole perinatal hepatitis B prevention program that the CDC established 20 years ago.

And in fact the recommendation to give hepatitis B vaccine to all infants universally is really to prevent any infants who slip through the cracks from not being vaccinated.

So in a sense perhaps those two measures are sort of competing against each other. Where it sound like you endorse the measure for the universal birth dose is that correct?

Laura Riley: Yes.

Kathy Harriman: So I mean the whole point of the universal birth dose to, you know, pick up any infants who somehow fall through all the cracks and safeguards that are now, you know, part of this program and the bottom line is that we don't want any infants to be missed. So it - I mean I guess...

Female: Thanks. Thank you.

Kathy Harriman: ((inaudible)) I don't know if I make any sense. But I guess what I'm trying to say perhaps the second measure might be more important than the first measure because really the bottom line is that infants of infected mothers are not missed. And that's really why we have the universal birth...

Trudy Murphy: Trudy Murphy from Measure 0747...

Female: Zero, seven.

Trudy Murphy: ...475. And I would have to agree with what Dr. Harriman has said. However I would add that you have to know that the woman is positive to make sure the infant is not missed.

And what the zero birth dose measure, the 0475 does is it includes infants whose mothers might have been missed in the screening process. Thank you.

(Graham Centro): This is (Graham Centro). I'm actually the developer of this measure. And I apologize. I wasn't able - I was overseas actually hoping to prevent perinatal transmission of Hep B in Asian countries when you had the last conference call.

But like, you know, (Angie) I think this is a very important measure and the first universal birth dose is almost supplemental to this measure because you have, you know, CDC estimates about 24,000 births to mothers who have current Hep B.

And this population if they are not appropriately prophylaxis, you know, as many as 9100 will get chronically infected and 2300 will eventually die, not in the pediatric lifespan but later in life from liver cancer and liver disease.

So as the 2010 Institute of Medicine Report found is we have great national guidelines but for God knows what reasons people are not implementing them. So this is why I introduced this measure in 2008 to address the gaps.

And if you actually read all these comments from health perinatal nurse coordinators around the country from Michigan, Idaho, Los Angeles, you know, they all, you know, talk about the importance of this measure because, you know, I, you know, I'm a surgeon. I'm actually a liver transplant surgeon, a liver cancer surgeon.

Why I'm so passionate about this is because I don't want to see anyone else that's, you know, coming to see me from a totally preventable problem just because of failure to implement evidence-based recommendations.

And so if you look at this I think the coordinator from Los Angeles sum it up really well.

On more than one occasion when articulating ACIP recommendations the hospitals and healthcare providers they advise us if ACI - if the ACIP recommendations are not in the law they are not going to implement.

But when they hear the National Quality Forum endorses this practice they are willing to listen.

Sometimes we feel like we are in a battle field when advocating for this vulnerable population. And we need all the ammunition we can get to ensure all infants receiving appropriate post-exposure prophylaxis in a timely manner.

So, you know, I - actually I'm on the Institute of Medicine for Population Health. And, you know, if you look at the evidence base for this I mean it's undeniable.

And the California, the reason we actually asked California is to sort of provide the data is really to show NQF this is doable.

But we also show you that the data from the rest of the country which I - we - I think Suzanne circulated to all of you this is not a geographic problem. Twenty-four percent of all the births now are from mothers who are foreign born. And so this problem is happening all across the country.

So if you look at the list I provided you can see that in 2008 data from Georgia show that 403 mothers were - who gave birth were hepatitis B surface antigen positive.

And 12% - 18% of them of the babies did not get Hep B birth dose and Hep (Big) on the first calendar day so that means 72 of those babies were vulnerable from becoming chronically infected.

So I really urge the committees to look at the evidence base and the feasibility to improve, you know, the health care of all these to improve the healthcare and prevent perinatal transmission.

I mean this is the whole reason why USPTSF, you know, recommends, you know, all pregnant women to be tested for Hep B.

And the premise is that they would be given timely Hep (Big) and Hep B vaccine. So I think not endorsing it I, you know, I feel is really tragic and just because...

Laura Riley: Well thank you. I mean I don't mean to be rude and cut you off it's just that we have a few more to go through.

I think at this point I hear you and what you've presented to us is absolutely compelling. I think at this point though I need to hear from the steering committee sort of where we stand in terms of looking at this again.

Mambarambath Jaleel: This is Jaleel. This is one of the measures which I struggle with. And I did mention this in one of the post meeting emails that I sent off because this is an easily preventable disease.

I agree that the gap in performance is very minimal. But if we don't keep this is a measure we - there is a potential slipping down on this.

Yet the burden of collecting this information is going to be there but it's an easily preventable disease. So I think we should reconsider this.

Laura Riley: Other - other steering committee members?

Elizabeth Gee: This is Elizabeth Gee. I hear they're very compelling evidence based. And I think we all understand and accept that and ((inaudible)).

But to me it's an issue of, you know, whether the case for using this is as a quality measure is important and whether the performance gap is broad enough after -- I think about in in a marginal way -- after implementation of a Hep B vaccine requirement measure that, you know, you really - it's really on the same scale as the other kinds of measures that we're looking at.

The - we can't implement a quality measure for every evidence-based medicine guideline. We just can't.

That would not - it's not quality measure that it compares performance across hospitals in this case. And so it's - I just don't think quality measurement using - endorsing this as a quality measure and requiring nationwide is the right approach, the most efficient or effective approach to ensuring that these babies after we implement a Hep B not only evidence-based guideline, but measurement, the ones that ((inaudible)) at the margin that are going to be missed don't get missed.

I think that targeted effort in populations where, you know, that's more likely to happen are going to be - it's just going to be more cost effective.

So I just even though it's very important it's terrible to not prevent a preventable disease I don't think proving this as a quality measure is the right way to fix that problem relative to other things we can do with quality measurements.

Laura Riley: Others ((inaudible)).

Female: I would support Elizabeth on that one.

(Bill): This is (Bill). I would support Elizabeth and wherever just spoke before me.

Female: Yes.

Female: Rebekah I would support it. I don't think it means that we shouldn't value it but I'm not sure that this is a way to prevent the preventable in this case given the rarity.

I think never event, other payment reforms could be explored. But I think the difficulty is that the population and the national scope of what we're trying to do not maybe matching up.

Laura Riley: Okay. Others?

Teri Kiehn: This is Teri...

Mayri Leslie: I agree. This is Mayri.

Teri Kiehn: This is Teri. I agree also.

Laura Riley: Okay.

Female: This is ((inaudible)). I also agree.

Laura Riley: Okay, excellent.

Male: Could I just add one word? You know, if you actually - we've been studying this problem with CDC for the last four years in Santa Clara County.

And all the hospitals embrace it once we brought this to them because they see this as a QA problem.

They know that if any child who actually went home without getting H (Big) is a liability. And it's reportable, you know, if the child get infected because they did not implement this prophylaxis they are going to be reported to the Joint Commission. So I don't see any issue with this.

The federal government CDC has been funding state perinatal coordinators just to make sure they comply, all the hospitals comply with this.

They are use - CDC's using their money resources to collect that data. So it's no sweat on the hospital. So I don't really understand what you folks are talking about?

Male: I think what we're saying and actually what you were just saying to me makes the argument for why it doesn't need to be a quality measure.

Because you've already stated the hospitals are collecting the information, that they're highly motivated to not of this happen, that it happens on a rare basis.

When it does happen it's a liability concern so then hospitals are already well aware...

Male: The hospitals are not. It's the federal government funded program who are going into the hospital to do child reviews to order them, to check on them because the hospitals are not doing them. So I really don't see how - I don't understand it.

Laura Riley: So I think at this point (Reba) maybe we can just confirm the vote by email after the call...

(Reba): Okay.

Laura Riley: ...because it's really hard for me to sort of gather all the voices and know that I'm hearing the right ones so is that fair?

(Reba): We can do that.

Laura Riley: Okay excellent. I think that that's probably the best way of handling it. So can we go on to the next - I just clicked off my email I can't believe I did that.

Okay the next one is 502 which was the pregnancy test for female abdominal pain patients. And I think people will recall that we spent a tremendous amount of time on this measure.

The developer is requesting that we take another look, reconsider our recommendations based on the fact that we did - this is a tricky one.

We did vote to pass all for the criteria but we had significant concerns about the quality of the data and the liability which I think is what led us to the vote that we got giving it more thought do people on the committee want to reconsider?

(Reba): This is (Reba). At the minimum I really need to have the committee at least weigh in on their rationale in direct response to the fact that yes you voted that the measure did pass all the criteria but then you did not vote to recommend it.

So we really need to be able to explain that more thoroughly if indeed that's the case.

Jennifer Bailit: Hi. This is Jennifer. I mean I think I can kind of summarize what some of the concerns were which one of which is the clinical nuance of this is far more granular that we want to try to be able to collect about when it's appropriate and when it's not appropriate.

And so because that data burden becomes very great very quickly with exceptions I think it's a medically feasible measure.

Laura Riley: Other comments?

I guess the question remains I ask you to take a look at your - the summary of your evaluation on - it starts on Page 26. Because it's sounding like Jennifer from your comments that would really applied to the scientific acceptability, reliability of allegedly aspect of the measure perhaps yet the

committee voted fairly significantly that it did meet the criteria so that's we're really trying to reconcile here.

Jennifer Bailit: Yes.

Sarah Brown: (Reba), this is Sarah. The data weaknesses that have been discussed in a variety of settings are - do you think that they're higher here than the vast majority of recommended measures? Do you think this is an outlier?

(Reba): I would ask other members of the committee to respond to that.

Laura Riley: This is Laura. I mean I think that that was part of a major part of the conversation is that there was concern that even the data that was presented by the developers was internally inconsistent and vastly different. And I think that that was part of our consternation at the time.

Female: Then why was it passed do you know? What's - what carried the day? I wasn't able to be at that meeting.

Laura Riley: I don't really remember.

Female: Is this the one where AETNA was going to go and do another data run to see with the actual frequency of this was?

Female: This is the discussion that (Janet Evans) presented and she brought her own data.

Female: Right. And then we had a follow-up discussion with the medical director from AETNA who said oh, if you can give me the facts I'll - I will run it against our database to see actually how many

times does this actually happen that the patient either isn't tested and is pregnant or vice versa blah, blah, blah.

So I'm not sure it if that follow-up the people - the measure developers were going to work with her on that.

Kimberly Gregory: This is Kim. Is it possible to see that maybe this is one we should see the minutes of our discussion about?

Kate Chenok: Yes because this is Kate. This was a really close one as I recall and (Janet) did a great job of - is she on this call now?

Female: No she's not. And Kim the summary of your discussion begins on Page 26.

Kimberly Gregory: Yes I see it but it's not - well it's - I remember it being how do I say, I guess I'm not - I'll look at it some more but it's not coming across clearly why we voted one way despite what a paper says.

Kate Chenok: Well honestly I think -- this is Kate -- it was very much at the end of the day and people were exhausted and a lot of people were very surprised that it wasn't approved.

Jennifer Bailit: This is Jennifer. I seem to also remember there was discussion about what really was the outcome that we were concerned about at - the deaths from atopic pregnancies is falling, how many of these are really being missed, what was the consequence of that?

If they weren't - then if these were patients who were already known to be pregnant, you know, how did this all fall out?

But it seemed to me that the atopic pregnancy disease burden was also part of the issue.

Sarah Brown: This is Sarah...

Female: But...

(Crosstalk)

Female: ...also the part - just the relationship of the process of screening to the outcome or outcomes was not as clear as we - it would make us comfortable.

Charles Denk: This is Chuck Denk. My recollection was that this was a clinical guideline that was endorsed by the American College of Emergency Physicians. Is that correct? Does anybody remember?

Kate Chenok: Yes I remember that. This is Kate. I remember that also.

Charles Denk: So I'm pretty sure is one of the people who voted to endorse it even at the end because I thought we were - a lot of the discussion was just started second guessing whether that was really a good standard of care because of the rarity of capturing the sort of things that were captured.

But I thought that if that was - if it was endorsed by the society then a good measure of it was, you know, our responsibility.

(Reba): Yes Chuck this is (Reba). I would say that you - that needs to be evaluated in light of actual evidence the published literature that would support that recommendation.

Female: I'm also struck by - I - had I been there I would have just had some questions about the feasibility of getting good data here.

The exclusions require a bit of questioning. So filling out the measure constructing it has several layers here with I think a high probability of missing data or error.

Nancy Lowe: And this is Nancy. I think when I go back and look at our notes what I see is a lot of voting in the middle and low range and I...

Female: No.

Nancy Lowe: I think that's why at the end of the day the vote went a little bit on the negative - enough on the negative side that we didn't endorse it as I remember because when you look at that pattern of voting high, moderate, and low it's not that we didn't think it was important but we just weren't convinced that it was quality measure where there was enough of a gap to endorse it as I recall.

Jochen Prosit: Yes this is Jochen Prosit. I kind of have the same kind of recollection that there was a lot of question about the true evidence on the line the - this measure.

Female: We did have the discussion about atopic was high on the list. We didn't really have great data. And the other one that sort of was thrown out there as a reason that, you know, the test should be done was the whole issue of unnecessary x-rays, et cetera, but...

Jochen Prosit: Yes.

Female: ...you know, there’s really from an obstetrical standpoint there’s very little sort of...

Jochen Prosit: Right I recall you saying that then I think too yes.

Female: ...did discuss that. And I think that that was part of the sort of reluctance to that along with, you know, all feasible was this going to be. I think that that's where we got into this situation that we're in.

Female: Did so...

Jochen Prosit: I think the rationale was not so bad. Is there limited data on impact on relationship to outcomes and need more studies to like on the benefit of the measure? I guess that's - those are not - I think those things are kind of coming back no, if I hear what people are saying?

Emily Graham: Hello?

Female: Is someone trying to call in talk in? No okay.

Emily Graham: Yes hi. Hello can you hear me?

Female: Yes.

Jochen Prosit: Yes.

Emily Graham: Okay I'm sorry. This is Emily Graham with ASEP. Is it possible for me to make a comment now or should I just postpone until you open the line for public comment?

Female: You're the developer of the measure.

Female: Go ahead please.

Emily Graham: Okay thank you so much. My recollection of the discussion was exactly as you all describe, but I think at the end of the day what we as a measure developer are confused about is how is it that we were able to move through the process and receive a favorable enough vote to get to where we did but then at the end of the day the measure does not get recommended?

It just sends a concerning message to us about where the bar is supposed to be set and what we're supposed to be meeting.

If we met all of your criteria and you approved is how is it that we would be denied endorsement or recommendation for endorsement at that late stage?

And the other point I wanted to make is that following the vote you are all correct that there was a gap because I think it was it was not expected that we would fail.

And conversations afterwards with Dr. (Young) who presented the measure I do recall that she had a conversation with some of the insurers and they had a dialogue about, you know, ways that they could follow-up.

But ASEP did not actually, you know, have any dialogue with the insurers about doing any additional study although I'm sure we would be happy to do that. So nobody reached out from the insurer group to ASEP about it.

Female: Okay.

(Joanna Ocean): Well this is (Joanna Ocean) from AETNA. I think the reverse is true. There wasn't a follow-up around what is the data question and what those specs would look like.

(Reba): Laura, this is (Reba). I think the question is the disconnect between the reasons and the concerns and issues raised in the discussion and the vote on importance and perhaps of scientific acceptability and perhaps on feasibility...

Laura Riley: Right.

(Reba): ...certainly raised those issues. The question I guess I would ask the committee is given this conversation, given those issues we can provide you the transcript of the discussion previously.

There is a disconnect between your votes and your discussions. And perhaps certainly for the record would you want to relook at that again and revote it?

Laura Riley: Yes. This is from Laura. I think that that's what we should do because I think there's enough sort of concern on the phone that people don't remember the conversation.

This conversation may have jogged some memory. And I think that it is only fair to the developers to revote.

Female: Well I think it is fair to say that. We clearly - there was a lot of - it wasn't a straightforward vote until I think that that reflects the discrepancy pretty well but it wasn't straightforward.

Scott Berns: Yes this is Scott Berns. I think it is a good idea that we go back Laura. You know, but I do want to echo I think Nancy's comment which was if you really look back at the scoring throughout the, you know, all the different, you know, right across from Impact through feasibility we really were pretty spread out there, you know. And there were quite a number of sort of moderate lows and so we just, you know...

Male: Hello?

Scott Berns: ...((inaudible)) so I concur with you coming back.

Female: Okay. (Reba) can you...

(Reba): Yes.

Female: ...add that to our to do list?

(Reba): Yes absolutely. What we will do is be sure that you have at your fingertips the submission form. We'll pull out the transcripts so you'll have exactly everything that was said at the time. And you have the votes from the workgroup on the sub criteria.

What we will do is send you out a link to a Survey Monkey tool that you've used before to go ahead and revote on your assessment of the four main criteria -- importance to measure and report, scientific acceptability, usability, feasibility and then recommendation for endorsement.

Female: Okay.

(Reba): Okay. And we'd ask you if we can since we really do have most people on the phone we're going to send it out as soon as possible and we hope that we can do this in a fairly quick turnaround time.

Jochen Prosit: Should we...

Female: So...

Jochen Prosit: ...await the - so this is Jochen Prosit. Should we await the additional data that, you know, people felt like were kind of lacking until the last meeting since we don't really have it, but if, you know, if the health plans were willing to undertake or help with that analysis?

Barbara Kelly: Yes this is Barb Kelly. And I recall having concerns about not enough data on a topic. And the data was around PT with the early pregnancy and it was felt that that wasn't a valid endpoint, you know, injury, so I do think we need more data around it. I think that was really the sticking point.

Female: Unfortunately we really don't have the time to be able to wait for something that would have to be sort of ((inaudible)) from scratch.

If it were something that could just be retrieved, you know, like for us tomorrow to provide to you that would be one thing. But it sounds like it's a much more complicated process than that.

(Carol): So (Reba) this is (Carol) and my recollection is that we did not have, you know, resoundingly strong votes for the individual criteria.

And then additional data were presented before our overall vote which made us feel less comfortable with the strength of the evidence.

And so if you could provide us with the transcript for that discussion that would be very helpful I think.

(Reba): We'll provide you with the transcript for the entire discussion of this measure.

(Carol): Okay thanks.

(Reba): Yes. The recording is posted and the transcript is posted but we'll take that and excerpt this particular discussion point for you in a separate document.

(Carol): Thank you.

Female: Okay and then the last one is admission to the NQU at term. And I don't know that there's a lot to say about this one really (Reba).

There was two comments submitted suggesting that this is a component of the adverse outcomes index measure.

And there was also voicing concerns over potential overuse of NQU facilities and the need to measure and monitor that the quality and appropriateness of those admissions.

And you see here the note from the NQF staff that responded and to recommend this measure as a standalone measure was not really part of our purview so...

(Reba): I would just - I think that the measure developers indicated in interest and perhaps further of developing this measure as a standalone measure because there is interest in it.

But certainly it would have to be respond to some of the concerns that you raised particularly around lack of risk adjustment perhaps but also be tested for reliability and validity as a standalone measure rather than just part of the adverse outcome index.

Female: Okay.

(Carol): So this is (Carol) and I also would like to say that I think this raises concerns about related and competing measures.

I don't know if Elliot is still on the phone but healthy term newborns is a currently endorsed NQF measure that focuses on a population that should be low risk. So it solves the problem of no need for risk adjustment.

And the idea is whether the newborns that should not - we would not expect to have experienced complications, certain procedures and NICU admissions did in fact do so.

So I think that we may already have a great one on the books that can be used that encompasses this concept.

Janet Muri: Hi. This is Janet Muri. I don't know if Dr. (Mann) or Dr. (Pratt) are on the line. This came up - we knew obviously that the AOI was not going forward as an endorsed measure, composite measure.

But we were asked to consider whether or not it should be a standalone measure and basically said, you know, I think it's maybe worth considering I think in order to respond to some of the comments that came up during the meeting.

The issue for us was - one of the issues was how do you clarify that you're only getting to the NICU level of care?

There are hospitals that say they have NICU beds but whether or not they are - everybody's defining that exactly the same way, one of the ways - the way we get at the definition of a NICU level bed which is defined as a Level IV bed using the uniform billing revenue codes is 174 so that is the level of care where there's continuous nursing and continuous support for severely ill infants.

So if a term baby excluding the exclusions that we included in our submitted documents is admitted to the Level IV bed there is concern that the hospital is over utilizing that level of care for reasons that are not clinically valid.

The other issue that came up was I guess the question was whether or not this is a process measure. Yes it is a process measure.

Hospitals I think make decisions or policies based on, you know, this is a process in that the baby was admitted or not admitted.

So but I think that in terms of risk adjustment there are exclusions for this measure. I think you could broaden those exclusions. But really I don't think that it needs risk adjustment. That was one of the other issues so I don't know if anyone has any questions about the definition of how you get to a baby being - and it being in a NICU level bed.

I'm not familiar with the other measure that was referenced so I don't know how they're competing.

Female: Okay. It's number 716 if you wanted to look it up.

Jochen Prosit: Yes, this is Jochen Prosit. I guess I was a little bit struck about this - with this measure regarding the, you know, the structural differences that exist across NICUs.

So they're saying, you know, there'll be some NICUs that have a transitional area and other NICUs that don't. Like some of that may be dictated maybe by hospital policies although in other places it may not be or may be dictated by staff availability or structural abilities within the hospital.

So I felt - I know what the measure, I understand well what the measure wants to achieve. I'm a little bit concerned that there might be some real kind of like structural impediments and different policies that you know, for instance measure in ways that are not easily generalizable.

Female: I think that's why.

Mambarambath Jaleel: Yes this is Jaleel here. I second that what, you know, Jochen said. There is so much variability in here.

I can understand the possibility of overutilization. But there is so much variability in staffing, in expertise, in so many other factors that last thing I would warrant is to deny a baby a higher level of care just because there is concern of overutilization.

Female: I think that's exactly why you want to use the Administrative Uniform Billing revenue code data to define a NICU level because within the nursery area there are about three or four different levels of billing revenue codes.

So we're not talking about an observation bed. We're not talking about a rehab bed or a step-down bed or even an intermediate bed.

We're not talking about those codes; those revenue codes are distinct for those types of beds. And they relate to the level of staffing just as you're saying, the level of staffing and the level of intervention.

What we're talking about is the highest level. We're talking about revenue code 174 which is that highest level of care that is reserved for seriously ill infants and high degree of staffing, one on one staffing for those kids, so we...

Mambarambath Jaleel: I think the gray area where the overutilization can happen is in the lower acuity area. If a baby requires intensive monitoring and the higher level of care that you have mentioning. I think the chances of having a baby over there, it's not as great as some of the other lower acuity areas is what I would guess.

Jochen Prosit: Yes, you'd have to be intubated to get to that...

Mambarambath Jaleel: Incubated...

Jochen Prosit: ...code right?

Mambarambath Jaleel: ...yes. I mean that's...

Jochen Prosit: I would be - I mean I would be surprised if there's a lot of hospitals that just, you know, utilized like intubated babies just to get that higher code.

Mambarambath Jaleel: That revenue, yes right.

Jochen Prosit: You know, babies that - but I think the majority of these babies maybe that you would find in this area's to me would be like to rule out sepsis baby...

Mambarambath Jaleel: Hypoglycemia, hypothermia...

Jochen Prosit: Yes.

Mambarambath th Jaleel: ...and things like that which would not just come into the highly intensive care area.

Jochen Prosit: And maybe I'm misunderstanding the purpose of the measure.

Female: Well I think you're right. I think that's where there's a great deal of overutilization and where hospitals have a lot of leeway. You know if all C-section babies and ((inaudible)) in a observation bed for a day or something. You know, there really is that overutilization.

I think what we're trying to do at this - with this measure is just to get those - at those cases where there's overutilization at the highest level which are really is a - and they don't necessarily have to be intubated or have some surgical intervention or procedural intervention, a procedure intervention.

So I think we're just trying to get at that highest level because understand it's very difficult to discriminate with some of the hospitals.

Jochen Prosit: Yes. So I would be - I would - I guess I'm not terribly aware at least of the supporting literature for that level of care and overutilization or concerns.

And I guess (Reba) maybe there were - or Laura I'm not quite clear like what are I guess the action item for this measure is for us at this point.

Are we discussing whether we would like revote on this measure, individual measure or...

Laura Riley: It wasn't submitted as an individual measure.

Jochen Prosit: Right, it was only part...

Laura Riley: I don't think that there's - (Reba), correct me if I'm wrong. I don't think that there's anything for us to do now presently.

(Reba): Yes.

Laura Riley: Well I think that it's more be aware that the comment is there. I think that perhaps the Steering Committee might, you know, your discussions suggest that perhaps there might be a use fullness of a measure of NICU admission that perhaps needs a little further development, better specification as well as testing for reliability and validity for that particular use as a stand-alone measure.

And if that's the case I think the recommendation to the developer is to pursue further development in a measure and to bring it back to us when we have the next opportunity to see perinatal measures if indeed that's what the steering committee would want to do.

Lee Partridge: Yes and (Reba) this is Lee. I think also pick up on Jochen's comment about the evidence base for overuse at the level we're talking about here. We're probably more interested about the potential of overuse at why at a lower level bed's labeled NICUs.

Jochen Prosit: Right and like if there's - I mean I might be wrong. Maybe I'm just too naive about this. But it would seem like it would be awfully hard to...

Mambarambath Jaleel: Justify.

Jochen Prosit: Yes, to justify like intubate a baby or do a bunch of procedures in a baby that really doesn't need it. I mean I can sort of see the gaining around like the minor things.

But like I would, you know, but I'll be happy to reeducate about this if you could point us to some literature on overuse on this like high level of care.

Female: Okay.

Jochen Prosit: And these are full-term baby. You know, these are, you know, high - so this would be high care to full-term babies, yes.

Female: Right.

Jochen Prosit: Is anybody or the steering committee aware of literature in that area?

Joanne Armstrong: This is Joanne. And I'm sorry I - I'm not aware of the literature but there is certainly a pervasive belief ((inaudible)) that it occurs. So, you know, clearly you need the literature to understand it.

Jochen Prosit: And at the high end of care.

Female: Both, yes.

Female: We have a - we had a multi-hospital collaborative that used the AOI. And this particular adverse event within the (ten) was the one that moved the greatest.

So we had hospitals seeing a notable drop in their NICU usage. So that makes a (huge) drop.

There was a - there were a lot of cases being admitted to the special care nursery and being charged at that highest level. But they had to reconsider.

Jochen Prosit: It might be worthwhile looking at it. For me it feels that it is highly unlikely. But if that's what you have seen I think it might be worthwhile looking at developing measures like this.

Female: Okay.

Female: Okay, can we move on? Do we open this now for public comment?

Female: Yes. Now, particularly now that we're pretty much at our time yes (Cathy), operator could you please open the lines to see if anyone who's been patiently listening would like to offer a comment?

Operator: And the lines have been opened at this time.

Female: Is there anyone who'd like to make comment?

Female: And I'm not hearing anything.

Female: They all hung up.

Female: Yes okay. So I think - hello?

Emily Graham: I'm sorry this is Emily Graham with ((inaudible)). I think because of the earlier dialogue and conversation I'll hold all of my public comments because I kind of already made it.

Female: Great, thank you. Is there someone else?

Dr. Patrick Romano: This is Dr. Patrick Romano. I was just checking I may have missed the discussion of the AHRQ indicator. But I was just checking if there were any questions for me?

Female: Oh, on the infection measure. I don't believe there was anything outstanding for you Patrick.

Dr. Patrick Romano: Okay thank you very much.

Kim Moore: Hello? Hello?

Female: Yes?

Female: Yes we can hear you.

Kim Moore: Yes hi. This is Kim Moore. I'm calling from Los Angeles County Perinatal Hepatitis B Prevention Program. And I just have question on I favor and support Measure 0479.

And when you said of the comment regional this is why it was denied because it's a regional problem or one of the comments, one of - I think on your committee, one of your committee members?

Female: Yes?

Kim Moore: Could you explain that when you say regional?

Female: Does the committee member who mentioned that want to explain? I don't really remember who that was honestly.

Kim Moore: Okay because yes we have a lot of problems trying to get the hospitals to follow the ACIP recommendations.

And as I said, any support we can get back up it's greatly appreciated. It's a major problem and it's really sad to, you know, see children who will develop liver cancer when it can be prevented. And that's my comment.

Female: Okay we appreciate that.

Kim Moore: Thank you.

Female: Are there other comments? So (Reba), can we go on to the next steps?

(Reba): What we will do is tonight and first thing tomorrow morning well put together a follow-up set of documents for the steering committee to review.

Now my list contains the summary of the additional areas for measure development, the discussion that started off this call and then there was, and we want to clarify the committee's stance on that reconsideration on the Measure 479. And then the committee is going to revote on all of the criteria for Measure 502.

So we will be sending that information out to you very quickly and ask you to please respond in a timely fashion so that we'll be able to have - pull this information together and take it to the NQF membership for a vote in about two weeks.

Female: Okay.

Female: Okey-dokey.

Female: Does anybody on the committee have any other burning questions or concerns that we need to relate to (Reba) before she does all of that?

Female: No.

Female: All set?

Female: Yes.

Male: All set.

Female: Okay.

Female: Thank you to everybody on the committee. Thank you all for the time this afternoon and your participation. And you will definitely be hearing from us.

Male: Okay.

Female: Thank you. Good night everybody.

Female: Thanks.

END