

NATIONAL QUALITY FORUM

**Moderator: Reva Winkler
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12:00 pm CT**

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

Reva Winkler: Good afternoon everybody. This is Reva Winkler from the National Quality Forum. Here with me at NQF is Suzanne Theberge and Gene Cunningham of the Project Staff and Heidi Bossley as Vice President of Performance Measures.

We welcome you all to this first work group Meeting for our Perinatal Endorsement Maintenance Project.

We think we've got most of the Steering Committee members here and we're going to want to do introductions and disclosures.

But also any of the other Steering Committee members who are not on this work group may wish to listen in, and certainly welcome. We'd like to also have you just introduce yourselves as we go through.

So let's start with just going through the list. First one is Laura Riley.

Laura, would you just introduce yourself and...

Laura Riley: Yes.

Reva Winkler: ...make any statements around disclosures?

Laura Riley: Okay. This is Laura Riley. I'm a Maternal Field Medicine Specialist at Mass General. And I'm a long time participant in this process with ACOG. And I'm also on the Society of Maternal Fetal Medicine Specialists and I don't have any specific disclosures.

Reva Winkler: Right. In terms of disclosures we're looking for any interest - any involvement in measure development or anything that might give you a bias towards the evaluation of the measure so that's the kind of thing we're looking for from folks.

All right, Barbara Kelly. Barbara, (are you on)?

Barbara Kelly: I'm here. I'm a Family Physician with the University of Colorado. This is my first experience with this group and I have no disclosures.

Reva Winkler: Okay. Thank you very much. Lee Partridge.

Lee Partridge: This is Lee Partridge. I'm a - hi. I'm a Senior Health Policy Advisor with the National Partnership for Women and Families, a National Consumer Advocacy Organization and I have served on a number of NQF and NCQA Committees and including the Perinatal Committee that preceded this work three years ago with Laura Riley.

Reva Winkler: Great. Thank you, Lee. Is Sharon Sutherland with us?

Sharon Sutherland: Yes I am.

Reva Winkler: Great, hi Sharon. Do you think you could introduce yourself and make any statements around disclosures of interest please?

Sharon Sutherland: Yes. I am with the Cleveland Clinic. I'm a Staff OB-GYN and I'm the Quality Improvement Officer for Women's Health Institute which covers OB-GYN services at Cleveland Clinic facilities and I have no disclosures.

Reva Winkler: Great. Thank you. Kathleen Simpson. Kathleen?

Kathleen Simpson: Yes. I'm a Perinatal Clinical Specialist at Mercy Hospital in St. Louis. I did participate on the original committee with Dr. Riley's partners and I was also on the Joint Commission Technical Advisory Panel that selected the subset of measures.

I have no other disclosures.

Reva Winkler: Thank you Kathleen. Janet Young.

Janet Young: Hi. I'm Janet Young. I'm an Emergency Physician at Virginia Tech Carilion School of Medicine. I am the Forensic Nurse Examiner Medical Director here and this is the first time I've represented ACEP and my first time working with the NQF. And I have no disclosures to state.

Reva Winkler: All right. Is Sarah Brown with us yet?

Sarah said she'd be a little bit late. We'll capture her when she joins us.

Are there any other Steering Committee members on the call listening in?

Okay, some of them have indicated they might join us. We also have with us several measure developers for the measures that we are going to be discussing.

And I think we'll introduce you as we discuss each measure.

Sarah Brown: Hello?

Reva Winkler: Yes, hello?

Sarah Brown: This is Sarah.

Reva Winkler: Oh great, hi Sarah. Thanks, glad you could join us. Could you introduce yourself and make any statements of disclosure of interest please?

Sarah Brown: My name is Sarah Brown. I'm the CEO of the National Campaign to Prevent Teen and Unplanned Pregnancy.

Reva Winkler: Okay, any disclosures?

Sarah Brown: About what?

Reva Winkler: Any conflicts with the measures or any financial interest with the measures?

Sarah Brown: None at all.

Reva Winkler: Okay, thank you very much. All right, so that means we've got everybody from the work group.

Before - what we're going to do today is discuss five measures that have been submitted for evaluation. Four of these measures are measures that have been previously endorsed by NQF and are undergoing their maintenance review. One measure is a new submission that has not been evaluated previously.

On the webinar we are showing the measure submission forms as we discuss the measures.

Just to let you know. NQF is having some technical issues with limited bandwidth these days so there is a bit of a lag.

If you have your own version of the submission form it might be easier for you to use that and feel free to do so.

The other bit of information is the results of the initial preliminary evaluations that the work group has done via the survey monkey tool. And the summary results were sent to you earlier today. If you haven't had a chance to look at them, that's fine. I've got a copy sitting right in front of me and we'll talk about them as we go through the measures and the different criteria.

So just to let you know what our intention is today is we do want to get through all five measures which means we've got to spend about 20 minutes per measure. This is meant to do a couple of things.

It's to help us look - help you all become familiar with the NQF criteria, to become familiar with the measures, to share the experience of a preliminary evaluation of the six of you and how you're viewing the measures, find out where you're agreeing, where you're not agreeing, have an opportunity to discuss and bring those issues out.

The measure developers are available to answer your questions if perhaps you need issues clarified or further explained.

And so this is a chance to just kind of come together around the information on these measures in anticipation of the final evaluation and recommendations to be made at our in-person meeting on November 29th and 30th.

So and I think that given this is a first experience for many of you, I'm going to kind of lead you through it with some questions to help sort of get you started in your discussion. I think all members of the work group should feel very comfortable to jump in and add to the discussion.

We have assigned a measure, a lead discussant, for each measure not to put anybody on the spot but to sort of share the load.

In this case we don't - we have more work group members than we do measures but we will hope that the other folks will jump in and join in the conversation.

So that's our plan for today. Does anybody have any questions about what we're going to be doing or any questions about the materials we're going to be referring to?

Okay Suzanne.

Barbara Kelly: Sorry, Barb Kelly. I'm trying to get it up online so I can see what you're doing. Are you showing things online?

Suzanne Theberge: On the webinar, you should see the agenda.

Barbara Kelly: Okay. And where is - I can't find the email that's got the link in it.

Suzanne Theberge: The webinar...

Female: ((inaudible)).

Suzanne Theberge: ...is myeventpartner.com/qualityforum202. It's right at the top of the agenda. It's also on the work group...

Barbara Kelly: Okay.

Suzanne Theberge: ...file.

Barbara Kelly: I'll try to type it in. Thank you.

Suzanne Theberge: Okay.

Sarah Brown: I'm sorry. Can you repeat that again? We're supposed to be on a webinar format now?

Reva Winkler: Well you could be. You either - you can either view the submission form on a webinar or you can view it yourself. We're going to be using the measure submission form.

Female: And where do I find those submission forms again because I don't see it in my webinar?

Suzanne Theberge: I'm only showing the agenda at the moment. The submission forms are all on the SharePoint and I'll pull them up as we go. So once we get to a measure I'll pull up the form. Right now it's just the agenda.

Female: Thank you.

Reva Winkler: Is everybody else okay? All right.

Operator: And if you've got a question or comment over the telephone, please press star 1. The participants' lines are muted.

Reva Winkler: Okay, thank you. Okay, let's move onto the first measure then.

The first measure is measure 502. This is a measure. The title is Pregnancy Test for Female Abdominal Pain Patients. This was brought to us from the American College of Emergency Physicians.

It is the percentage of female patients age 14 to 50 who present to the Emergency Department with a chief complaint of abdominal pain for whom a pregnancy test is ordered.

So I believe this measure received time limited endorsement in 2008. And so this is the first review since that time. A time limited endorsement meant that the measure passed all of the criteria except for the testing for reliability and validity.

So on this follow-up maintenance review we will expect to see testing information and results.

So I believe Janet you were the lead discussant for this, correct?

Janet Young: Yes

Reva Winkler: Okay. So have you had a chance to read through? And I do have ratings on this from all six of the work group members.

So why don't we start talking about your thoughts on the importance criteria. The first one of course is impact. The second is opportunity for improvement. And the third one is evidence for the measure process.

Janet Young: Okay. So when I initially saw this quality measure, I thought wow. This is pretty much a no-brainer. I'm not exactly sure why we're reevaluating it. But we'll look at it again.

And so I did a fairly large analysis of the literature going back to actually the 1980s when urine pregnancy tests and Rapid pregnancy testing started. American Journal of OB-GYNs actually published their first data in '78.

So as far as impact abdominal pain is the third most common chief complaint for presentation to both urgent and emergency care. So it has a very large number of patients and a substantial impact on patient population especially those who don't present to their primary care office for either planned prenatal care or follow-up prenatal care.

So from an impact perspective it's actually quite a large group of patients.

Reva Winkler: Great, super; any other comments from other work group members?

Okay, why don't you talk - why don't you look at opportunity for improvement, 1(b).

Janet Young: 1(b) for opportunity for improvement, I don't know actually what's being reported right now in terms of how many patients are actually getting pregnancy screening for chief complaint of abdominal pain so this is one of the holes in my own knowledge.

And I don't know if the original submission from ACEP actually addressed performance and how that has been reported on either a hospital or clinic basis. Maybe you can fill me in on that.

Reva Winkler: Yes. Anybody else from the work group want to jump in?

The submission form does discuss a published - a paper published by (Sure) that looked at a national database of U.S. emergency departments as well as a chart review of four Northeastern academic emergency departments.

And there was a bit of a discrepancy in the national database. The performance was about 67%. In the chart review it was - it ranged from 89% to 95% I believe when I read the article.

Janet Young: Okay. And that article was by (Sure). Okay, so just based on the information that you're giving me with a 67% from a national database to a 90 something percent local ED chart review, I certainly think that there's potential for improvement but I think that we need to get more data for this particular criteria.

Reva Winkler: Okay. Janet, are you looking at the measure evaluation form?

Janet Young: I am looking at the - what you have on the webinar right now.

Reva Winkler: Go down to the bottom of Page 2.

Janet Young: Bottom of Page 2. Okay, yes.

Reva Winkler: Okay. So there's a description of the study. Also because this does seem to be a significant one, I found - I pulled that study and I posted it to SharePoint.

Janet Young: Thank you.

Female: Excuse me. If I - is there any way that - where do we go on SharePoint to go back to the original statement of...

Janet Young: I could not find that information at all.

Female: Pardon me?

Janet Young: On the SharePoint. I could not find the original submission.

Female: Yes. Where's the original statement of this measure?

Suzanne Theberge: The originally endorsed measure or the - just the measure - the submission that we're looking at right now?

Female: The measure we're looking at right now. How do we get to that?

Suzanne Theberge: It's on the - if you go to the SharePoint site. And then you go to measure share document, it's under work group One.

Female: Okay, wait a second.

Suzanne Theberge: And it's also in the All Measure Folder as well.

Female: Agenda work group One.

Suzanne Theberge: You should also see the measure forms in that folder.

Female: Well listed are the work group, TB work group One Results and Agenda work group One, then 1769 adverse outcomes so.

Suzanne Theberge: It should be in there. Its number 502.

Female: Okay, got it.

Suzanne Theberge: Great.

Reva Winkler: Okay.

Suzanne Theberge: And right now we're looking at the bottom of Page 2.

Reva Winkler: Okay. So Janet did you - can you see the data on the bottom of Page 2?

Janet Young: I can, on the webinar, yes.

Reva Winkler: Yes. Okay.

Suzanne Theberge: Let me make it a little bigger here.

Reva Winkler: So we'll make it as big as we can.

Female: I'm really sorry. I still can't pull it up. I see the document. I'm clicking on it and it won't come up.

Suzanne Theberge: There's a - there's - the title is listed twice. You want to click on the one that's on the left hand side. It should be - if you can't get it now maybe we can talk you through it after since we have a limited time for each measure.

Female: Okay.

Janet Young: Actually after this meeting if somebody could just send it to me in a separate document so I can dump it into a file folder that would be great.

Female: We can't look at it online now. Is that what you're saying?

Reva Winkler: No. You are looking at it online.

Female: No. I'm on SharePoint and it says 502 Pregnancy Test for Female Abdominal Pain. There's a Word document. I come to the left of it and a box to check, but it was...

Suzanne Theberge: Oh no, don't check the box. Just click on the title and that should ask you if you want to open it.

Female: It asks me that, I say yes, and then it doesn't open it. Never mind. I - never mind.

Suzanne Theberge: Okay.

Female: Just...

Reva Winkler: Can you see it on the webinar?

Lee Partridge: This is Lee. I couldn't get it on the webinar so I'm looking at it on SharePoint.

Reva Winkler: Okay.

Lee Partridge: Am I...

Sarah Brown: I can't on SharePoint so I don't know.

Lee Partridge: Am I sharing with anybody else? Could we all access it on SharePoint?

Suzanne Theberge: No. It should - you should all be able to open it at once. Yes, Gene's going to send an email to the work group members with the measure forms right now so just give it a couple minutes. It'll be in your inbox shortly.

Sarah Brown: All right, and just as a suggestion it seems to me every time we're having a call that would be a very easy thing to do is just send the phone number again and the documents you - that we're going to be discussing in their own self contained email.

Suzanne Theberge: Well we're trying to keep everything on SharePoint just to - we had a lot of trouble in the past of people not getting our emails because we have too many attachments. I can definitely send the numbers and the web login information every time before the call but...

Sarah Brown: I understand that. But you have to - I'm now on SharePoint trying to open it.

Suzanne Theberge: Yes.

Reva Winkler: Oh we know. Sarah you're right. We can - we'll try multiple ways until we get some of the technical issues ironed out.

Okay. So Janet you're able to look at the measure evaluation form, correct?

Janet Young: I am. I'm actually looking at the bottom of Page 2 on the webinar.

Reva Winkler: Right.

Janet Young: 502.

Reva Winkler: Right, okay.

Janet Young: With the article on (Sure).

Reva Winkler: Right, so...

Janet Young: So based on that data, and again I haven't done a new data review so as of today. But I will by the next time we talk.

Reva Winkler: Yes.

Janet Young: With 67% of EDs checking pregnancy tests for female abdominal pain presentations. I think there's a very large, a large improvement possibility.

And I think based on women with ectopic pregnancy, we certainly have an excellent opportunity for improvement.

Reva Winkler: Okay.

Female: Reva do you want us to tell me...

Reva Winkler: Absolutely.

Female: Okay.

Reva Winkler: If you'd like to - other members of the work group, this is the purpose of this.

Female: I made a note to myself on this one that the developer recommended additional study before widespread implementation of this measure.

And I think that I gather that stems from the fact that of the two studies, the differences were so significant and based on that I found that I was questioning whether or not this was a measure that was ready for being continued in essence because it was time limited originally.

Reva Winkler: Do we have the measure developers with us?

Emily Graham: Hey Emily Graham is here. I'm not sure if Jay Schuur is on the line or not.

Reva Winkler: Okay, Emily. And do you have any comments in response?

Emily Graham: Honestly I wish that Dr. Schuur was on the line so he could speak to this from a clinician perspective. I'm filling in as staff so.

Reva Winkler: Okay.

Jeremiah Schuur: I'm on the line now. They had muted me.

Reva Winkler: Okay.

Emily Graham: Okay, great.

Jeremiah Schuur: Jay Schuur. I'm an Emergency Physician and was involved with the team that developed this and did one of the validation studies. We cited two pieces of evidence in our measure reapplication.

The first was our study. And that looked at two things. It looked at national database, the NHAMCS which is what showed 67%.

But then we also did a chart review at four hospitals. And we found a much smaller gap with about - around 90% of appropriate patients getting a pregnancy test.

A second validation study was done by Dr. (Graff) at a community hospital in Connecticut. And they found a significant gap in improvement after they implemented a QI project.

And so we think there is a gap associated with it. That's why we reapplied for the measure.

I guess in general the American College of Emergency Physicians feels that, you know, measures should be well tested and so I think at this point it's been tested in four or five different EDs but has not had a large national test.

Reva Winkler: Okay.

Female: Okay.

Sarah Brown: This is Sarah. This is one of my principal concerns about it. And Reva maybe you can help us. In general is this amount of data considered adequate for a measure?

I thought it was inadequate but I may be wrong.

Reva Winkler: I think that's a judgment call for the committee. We don't have any absolute thresholds.

So does anybody else have anything they want to add about opportunity for improvement? We certainly have some data.

In terms of the pre-ratings, it's kind of across the board. Of the six work group members two rated it high, two rated it medium, and two rated it low.

So I think there - this is an area I think of some concern. There doesn't seem to be lots of data or the discrepancy between the national study and the four community hospital study does pose some questions about the significance of the opportunity for improvement, so I think this is one area. And that's one factor in the importance criteria.

Why don't we move onto the third one which is the evidence?

And in this case we're looking for the evidence that ordering a pregnancy test can affect the patient outcomes. So what is the relationship between ordering a pregnancy test and patient outcome?

Janet, did you want to start us off?

Janet Young: I can start us there actually and then I would love to have your ((inaudible)). This was for me the kind of the crux of why we're looking at the measure outcomes and I believe this was at - this is in Page 4. Can we go to the next page on the webinar?

Reva Winkler: Yes, got to next, yes.

Suzanne Theberge: All right it should be showing up now.

Janet Young: Sorry, I'm - this would be - this is measure 1(c), correct?

Reva Winkler: Yes, measure 502, 502.

Janet Young: Yes. No, no, I'm just (looking) for the subset.

Female: Oh.

Reva Winkler: Oh.

Suzanne Theberge: 1(c)(1).

Reva Winkler: 1(c)(1), yes.

Janet Young: Thank you. By ordering a pregnancy test are we improving patient outcomes?

And I think that there's been some very - there's historic literature that in patients who get pregnancy tests for acute evaluation of abdominal pain we rule in or rule out a gynecologic emergency relatively quickly or we investigate further if there's a positive pregnancy test.

And I'm not sure right now based on the - again the literature review that I've done that I have the specific studies that tell us that there's an improved outcome. I know that the - there's no NHAMCs or (NCs) the national database information on that and maybe Dr. Schuur can speak to that point about a specific study that has determined a co-work group of patients who've gotten abdominal pain workups without a pregnancy test versus those who have and what those outcomes are.

But the standard of care certainly has been at least in the emergency medicine and urgent care literature to provide a pregnancy test for any patient who's presented with acute abdominal pain.

And I'll leave it there because I would like to hear...

Female: Okay.

Janet Young: ...a lot further feedback.

Reva Winkler: Dr. Schuur, did you want to comment?

Jeremiah Schuur: Sure. I would agree with the comment that this is considered standard of care. And so there have not been, you know, any prospective trials looking at different evaluation strategies with or without pregnancy tests.

The concern and the reason why the measure was developed initially came from risk management experience that emergency physicians and insurers that they work with have that missed or delayed diagnosis of ectopic pregnancy is a significant cause of adverse events and risk management events.

Reva Winkler: Right, okay.

Sharon Sutherland: This is Dr. Sutherland. I guess the best corollary I can think of is the pre-op HCG. In other words we do it routinely before we take a patient to surgery and we're not going to structure a study in which we start operating on women without knowing if they're pregnant or not.

So I think, you know, we have to realize that there might be apposite of evidence because it's not ethical to consider structuring a study like that.

Reva Winkler: Okay. Any other comments from any other work group members?

Sarah Brown: Can I...

Reva Winkler: ((inaudible)).

Sarah Brown: Can I ask a question? This is Sarah.

Reva Winkler: Sure.

Sarah Brown: What's the schedule for reexamining existing measures? Is it every four...

Reva Winkler: Three years.

Sarah Brown: Three years. So presumably three years ago whoever the Selection Committee members were a process, all these issues have been resolved to their satisfaction. Is that right?

Reva Winkler: Well I think that time - it kind of worked in multiple dimensions. And the criteria that we're now looking at measures, I think have - are more specific particularly around evidence what with the work of the Evidence Task Force last year.

So we're being a little bit more focused on the evidence and the relationship to outcomes than perhaps they were three years ago.

Sarah Brown: Well you know what I'm wondering is, you know, I think one of the things here is that we're kind of feeling we don't have adequate data or may not.

But what I'm wondering is maybe three years ago a boatload of information was looked at and reviewed. And the fact that there's only one or two more since then may or may not make much of a difference if the original bibliography was really large and intense.

Jeremiah Schuur: I can comment at least for this measure. That was not the case. There really is very little published about this. And the studies that we cite are - were done in response to this measure to try to develop some evidence around it.

The only prior study we found in the United States was actually a study by Dr. (Burstin) in the late 90s and that was cited in the original application.

Female: Right.

Sarah Brown: So that means maybe that the standards of evidence have gotten tougher now.

Reva Winkler: Well from NQF's perspective they become more explicit in terms of the fact we're looking at the body of evidence, we're looking at the quantity, quality and consistency.

So there is more - there is a sharper focus.

Sarah Brown: Right.

Reva Winkler: On outlining the evidence. Yes.

Kathleen Simpson: This is Kathleen. I was on the committee last time. I don't recall this measure.

Was it in another group like (different) measure?

Reva Winkler: It was in another project.

Kathleen Simpson: Oh okay.

Reva Winkler: It was an Emergency Room project, but one thing I'll note in looking at the evaluations that the work group did beforehand, three of the members have rated the evidence as low.

Would any - either of the three of you like to comment on that?

Sarah Brown: Well I'm one of them. It's not so much low meaning low in quality. It's just there's not very much.

Reva Winkler: Okay. So low in quantity.

Sarah Brown: Yes. Well yes, I probably screwed it up. But I just would have the general feeling that in order to approve a measure that, you know, is going to take people time to, you know, fill out and think about and disseminate and respond to in an orderly way that we probably would want a deeper bench. That's why I'm asking sort of what the expectation is.

Janet Young: Sorry. This is Dr. Young again. When I was doing my (confren) database review and my (pubmed) review most of the data around pregnancy test especially Rapid pregnancy testing is from the mid-80s.

And I have not been able to weigh through in the last seven days since I've only been able to work on this for seven days. To weigh through all of that information.

And there may actually be some better data out there. I can't speak to that yet and I do need more time. This was just a very compressed time format for me.

Reva Winkler: Okay.

Janet Young: So I'll be able to speak to that a little bit further in the next couple of days.

Reva Winkler: All right, any other thoughts from those of you who had rated this low?

One question I would ask is this - the specification for this is that the pregnancy test is ordered.

Why would it not be the pregnancy test was performed?

Female: Good point.

Female: I guess ((inaudible)) the data source.

(Crosstalk)

Female: Sorry Doctor. Go ahead and answer.

Jeremiah Schuur: So initially the measure was developed I think with the physician quality reporting initiative in mind and there was a concern around whether or not the - if the physician was - if this is to measure physician behavior then it should be based on ordering of the test.

This was something we had a heated debate over it. And I think we'd be amendable to editing it if that was the only issue.

Kathleen Simpson: This is Kathleen. I do have a question about that especially on this end, another measure. Is it looking for performance of the whole team, looking at performance of physicians, looking at performance of the hospital, which is supposed to be the focus?

Reva Winkler: The submission says that the level of analysis can be either individual or group clinicians or a facility, so there are several levels, potential levels of analysis for this one.

But I guess in response to Dr. Schuur's comment and I will just disclose the fact that I was a practicing OB-GYN for 20 years and I was frequently that ED doc.

You know isn't it part of the doctor's performance to not only order the test but look at the results and incorporate that into the evaluation decision making process in taking care of the patient?

Jeremiah Schuur: I agree with that. I think when this measure was developed it was developed mainly with a PQRS system in mind. And that was the position that the American College of Emergency Physicians wanted to put in the measure.

But I think we'd be amendable to changing that because I think that's a very reasonable point of view.

Reva Winkler: Okay. When you did your study what - how did you collect the data? Was it the presence of a pregnancy test result or was it the order on the order sheet?

Jeremiah Schuur: In the study that I did we looked at both and there were no cases where a pregnancy test was ordered and not performed.

Reva Winkler: Okay.

Jeremiah Schuur: So that was not - the results were the same for that.

Reva Winkler: Okay. So you looked at both though.

Jeremiah Schuur: We did look at both.

Reva Winkler: Yes. Any other comments from the work group members because essentially your preliminary review of this measure three of you said yes it meets the important criteria and three of you said no.

So this is an area where we've got a definite discrepancy in thinking. So how can we help answer whatever questions you have or whatever concerns?

Sarah Brown: Lee? Is Lee Partridge on the phone?

Lee Partridge: Yes.

Sarah Brown: Lee this is Sarah. Why did you think that - forget about the evidence level. Why did you think that this issue of pregnancy testing was not so important?

Lee Partridge: Oh I don't have a problem with the importance. I had a problem with whether or not there was a real gap.

Reva Winkler: Okay.

Sarah Brown: Okay.

Lee Partridge: I mean it is standard of care. That's obviously - it should happen. The question was is it happening? Is it - if the results - if you had new data that said the result across the country was that 95% of the time, all the hospitals were doing it, then I wouldn't recommend that they'd be endorsed simply because, you know, it's standard of care that's being adhered to.

Reva Winkler: But you're feeling that there is enough data to know that?

Lee Partridge: Yes.

Reva Winkler: Okay. Okay, any other thoughts on the importance criteria from folks?

Are there any additional questions or anything we can find out?

Don't think we can create more data unfortunately.

All right, then let's look at the next criteria which is scientific acceptability. The first issue was around the specifications of the measure.

Janet, do you have any thoughts about how this measure is specified, the numerator, the denominator or any exclusions?

Janet Young: No. Actually I thought that the numerator being all patients, all female patients with abdominal pain. I'm sorry. I'm having to work off a piece of handwritten paper for the moment.

Is that for - yes, all women. But your numerator would be - sorry, number of patients who have a pregnancy test and ordered in the ED. And I guess we talked about ordered versus performed and the denominator being all women from childbearing ages, specifically 14 to 50. And having done an OB-GYN residency I can tell you that we've delivered women before the age of 14.

So a denominator can be childbearing age and that may be something that's a little bit different regionally.

The target population I think is appropriate. Again the denominator time window, I've delivered 11 year-olds so I know that we can change that age or at least discuss changing that age.

And I think that the exclusion criteria was appropriate because a lot of patients and there's actually very good data out there to support that. If patients think they're not pregnant about 98% of them truly aren't pregnant.

And that's actually there's been several studies and literature that has supported that.

So I think for in terms of reliability and the numerators and denominators I think that's reasonable.

However the pregnancy test, I actually went back to the original data on the pregnancy test, sensitivity and specificity. And we all pretty much accept at least for clinical practice that it's got a very high specificity, a true negative as a true negative.

But we also know that the sensitivity for true positive is a little bit lower especially in Rapid testing, urine, point of care testing which is predominantly what we do when we take care of patients. Almost always we try a serum, sorry, a urine screen first and then we confirm with urine or with serum, pardon, if we have a positive or a questionable pregnancy test.

So sensitivity and specificity of the test itself and of course there's 8 million vendors out there, it's pretty well accepted though sensitivity is less than specificity in this particular test.

And I wanted to bring both of those discussions to the forefront. The age range, childbearing age range and the test itself, the sensitivity and specificity of itself.

Reva Winkler: Okay.

Janet Young: I'd love to hear your comments.

Reva Winkler: Yes. Any thoughts from the other work group members?

Barbara Kelly: This is Dr. Kelly. I would agree with the age change, maybe down to age 10. I don't know what the data would show. But again I would agree that that would be a window we might be missing.

And I also agree with the comment made that we don't know that this is going to have a huge impact out there as it is standard of care.

And I did look for that in the data. I really could not figure it out. The only piece I saw was the fact that 56% of ectopic's were missed or around that number. And so I thought well that was a reasonable reason to at least consider implementing this nationwide is the fact that we were missing so many.

Reva Winkler: Other thoughts from work group members?

Okay, on the preliminary review all of you rated the measure as passing the scientific acceptability criteria.

Can I get a comment from Dr. Schuur about the age?

Jeremiah Schuur: So I think we had this discussion. And clearly we're in agreement about that childbearing age can start younger. This was a question of sort of at what age for a measure point of view, people thought it would be worth the sensitivity and specificity, how many of these patients are you going to - is that the age range where you want to measure?

And you can look at that two ways; you could say you're going to be measuring lots of patients in whom this may not be applicable.

But that also may be an age group where there's a greater risk because providers aren't thinking actively about pregnancy.

So we decided 14 but I think if there was a strong reason to change it it would be reasonable to do. It would really be an expert consensus. We couldn't - didn't have a specific piece of evidence to choose one age over another.

Reva Winkler: Okay, any other thoughts from the committee on scientific acceptability? Any other questions you'd like to have addressed?

Female: If it's considered standard of care for ER do they actually have anything in your guidelines that would say what the age is that you should start because it would be helpful to have the measure follow the national guidelines?

Jeremiah Schuur: So there's an outdated guideline that was put together and I don't actually - don't have it committed to memory. It was - it's a guideline by the American College of Emergency Physicians on evaluation of abdominal pain that has never been reviewed because they've switched the way they write guidelines now.

And I'm not sure if it has an exact age in it. But if it did it probably was also based on expert consensus.

Lee Partridge: Sarah this is Lee. Am I right? The age of puberty is dropping in this country?

Sarah Brown: Well a little bit. But it's still I think it's 12.7. Am I right? I think that's the most recent number.

Female: So that would be 12.7 years?

Sarah Brown: Yes. I live in the district. And we hear routinely about deliveries to girls who are 10 and 11.

Female: 11, yes.

Sarah Brown: So that's average.

Female: I guess I would recommend looking to see if there are any guidelines within the pediatric societies as well because again if you were looking to set a number to kind of tag it to something else it seems reasonable.

Sarah Brown: Okay. See what we can find.

Reva Winkler: Anything else on scientific acceptability?

Then let's move onto usability. The work group members generally rated this moderate to high. There was one for low.

Janet, your thoughts on usability of the results of this measure to various audiences?

Janet Young: Sure. So I was looking at it from the terms of a consumer looking at their local hospital to see how their local hospital stacked up because often times that's what I hear from our more sophisticated consumers is that oh well your hospital has XYZ percent success or infection rate.

And so I look at it from and through the lens of how you look at your community resources. And often times that's consumers and the patients.

And I thought that maybe we'd be able to understand this pretty darn well because this pregnancy test is a ubiquitous part of female reproductive life.

So I thought that that was a very - or at least meaningful for the patients and consumers.

Getting back to that standard of care issue I would be really anxious to know if, you know, the local hospital recorded an 86% rate of getting pregnancy tests with abdominal pain presentation. I think that would be quite disconcerting to me so again that's just a hypothetical.

But I think for meaningful and useful and understandable for most consumers I think that would - it is reasonable.

Reva Winkler: Great. Any other thoughts from the work group?

Kathleen Simpson: Yes. This is Kathleen. I was wondering is there anywhere you'd find out the percentage of people who do have electronic medical records because otherwise this would require a chart review and this isn't just for this measure but is there any idea about that, like what the burden is.

Jeremiah Schuur: So currently about somewhere between 30% and 50% of Emergency Departments. And that data is based on a national survey. It's about two years old. Thirty to 50% had what you think of is a pretty comprehensive electronic medical record system. Higher percentages had different components of that, order entry.

Kathleen Simpson: So there's a burden of looking this up for something that's already a standard of care.

That is, you know, a consideration. I think that's a big task.

Reva Winkler: I think we've moved into the feasibility.

Janet Young: Let's just keep (segway). That's a great segue. Let's just keep going (right over).

Reva Winkler: Yes. Any other issues around the feasibility?

Sarah Brown: This is Sarah. Can I ask a question again, back - sort of basic question?

Most of the measures we looked at in this set had a mixed report on whether the measure currently is or could easily be incorporated in an electronic medical record.

Why are you asking this in the sense that, you know, some people do these things electronically and some don't. I mean...

Female: Right.

Sarah Brown: ...how important is this to you all in your thinking?

Reva Winkler: Well I think we certainly - NQF's position is that we really do want to see progress towards measurement using electronic sources.

And so measures that are much farther along in that pathway are probably, you know, should earn a few extra points as opposed to those that aren't really thinking about the fact that electronic sources are really going to be critical for ongoing feasibility of measurement.

So but again none of these are absolute. But they are factors to kind of weigh-in with all the other aspects of the measure.

Sarah Brown: So if a measure - let's just take an outlier. If a measure isn't in any electronic system but we still think it's important, that trumps - the importance trumps EMR.

Reva Winkler: Yes. I think that certainly the importance is a must have criteria. The other is not so much so.

But you do have to look at the totality of all the criteria.

Sarah Brown: Thanks.

Kathleen Simpson: Well for example, you know, they said about ten minutes per chart. Well there's a lot of patients that go to the ED that are women between 14 and 50, so that would be a significant amount of charts to be looking through say on a paper chart.

Sarah Brown: Yes.

Kathleen Simpson: Since this is already - again this is already a standard of care. So you want to have a measure that's not only important but, you know, it's going to help with the quality of projects, close a significant gap, etcetera. And this is a lot of time per record to find this out.

Sharon Sutherland: This is Dr. Sutherland. And just want to talk to this EHR issue. If we were to do this effectively in an electronic record, this is not a routine data element. So you would have to do a custom build and you would want to do a documentation questionnaire for all of those exclusions.

So you would have to go through does she have a hysterectomy, yes or no. Do you already know that she's pregnant, yes or no.

In other words if you wanted to do a very clean collection you would have to do a custom build. That would be my opinion based on my knowledge of this.

Kathleen Simpson: And this is Kathleen again. The custom build is difficult.

Sharon Sutherland: Yes, it's expensive.

Kathleen Simpson: It's not an easy thing. You know I have a - I work with a big system with 28 hospitals and do a custom build, we have to get all 28 to agree. Then we have to get the cash to do it. I mean it's just it's no small matter.

Sarah Brown: Yes.

Reva Winkler: Okay.

Lee Partridge: This is Lee again. Is this a measure in which you would accept a sampling methodology?

Jeremiah Schuur: Yes.

Lee Partridge: It doesn't help. I mean it might help a little. Not a lot but I...

Sharon Sutherland: I think it did say 25 charts as one of those samples taken.

Jeremiah Schuur: Yes, I think that's right.

Reva Winkler: Okay. Anything else about this? We've spent a good amount of time on this measure hopefully to kind of get a sense of the criteria.

But the issues you've raised are all very pertinent issues. If there's additional information we can obtain for you or if the developers would like to respond to some of these issues in more detail prior to our November meeting, those avenues are available.

Jeremiah Schuur: (All right).

Reva Winkler: Does anybody have anything more to say on this particular measure? The actual final evaluation and final recommendation will occur at our November meeting. So we have certainly raised some important issues.

Okay.

Barbara Kelly: I guess I - sorry. This is Dr. Kelly. I just have one. I'm sorry. And we sort of addressed it. I mean this is standard of care. And the outcome really was inappropriate imaging for pregnant women. Is that correct?

Janet Young: I think it was rated missed ectopic Dr. Schuur?

Jeremiah Schuur: So that was the - that's the main goal of this measure. In his evaluation study Dr. (Graff) also looked at patients who received imaging prior to knowing whether or not they were pregnant as a potential adverse event and...

Barbara Kelly: So - go ahead sorry.

Jeremiah Schuur: ...so that's a secondary piece of evidence for the measure.

Barbara Kelly: So, this is Dr. Kelly again. Can you - I didn't see, I mean I saw where half of ectopic's were missed in one study. But I guess I'm still looking at the significance of this in terms of missing ectopic. Because to me, I think the CT imaging dropped from 3% to less than 1%. And I didn't think that was a huge outcome making me want to implement this nationwide. But missed ectopic's could be.

Jeremiah Schuur: Right. So ectopic's and missed ectopic's are a relatively rare event. So they did not have - there were not enough in Dr. (Graff)'s study to make a comment about the change in the number of missed ectopic's.

The appropriate testing did increase after - it was low initially and it improved after the QI Program.

Reva Winkler: Any other thoughts on this measure before we move onto another one?

Okay, everybody ready to shift gears maybe a little bit?

The next measure is measure 582, diabetes in pregnancy, avoidance of oral hypoglycemic agents. This is brought to us from Resolution Health. This measure identifies pregnant women with diabetes who are not taking an oral hypoglycemic agent.

Who is assigned to this measure?

Barbara Kelly: That would be me, Dr. Kelly.

Reva Winkler: Great, Barbara, super. Do you want to start talking about your thoughts on the importance criteria?

Barbara Kelly: Well I cannot get into the webinar so I'm...

Reva Winkler: Okay.

Barbara Kelly: ...using paper.

Reva Winkler: All right. I'm sorry.

Barbara Kelly: So actually do think that there's a lot of data on importance. And I may have to look at the rankings but I think most of us probably ranked it high in importance.

Now if people can pull that up.

Reva Winkler: Yes. Of the four of the work group members submitted ratings and there were two that were high, one is low and one was...

Barbara Kelly: Oh.

Reva Winkler: ...insufficient data.

Barbara Kelly: Oh okay, all right.

Reva Winkler: (For instance).

Barbara Kelly: So we have some disagreement on that I guess.

Reva Winkler: Yes. There is a little bit of disagreement on it. Ultimately putting together all of them, there is - this is an area for discussion, the importance criteria.

So in terms of impact, what are your thoughts on impact?

Barbara Kelly: Well this was one of the studies - this was supported by studies that actually showed a significant impact. I'm trying to back it up with - I'm looking through papers here. I apologize.

Reva Winkler: Would it be better to go to the 1(b) opportunity for improvement?

Barbara Kelly: Well let me see if I can figure out impact here. Sorry. I do apologize. I just can't get onto your webinar. I guess I'll talk to your IT people.

Reva Winkler: Okay. Sorry Barbara.

Barbara Kelly: That's okay. So it seems to me that the impact was recently supported with the data presented. So I did not actually understand and maybe someone could explain to me 1(b)(2) which was the summary of data demonstrating the performance gap.

Reva Winkler: Okay.

Barbara Kelly: But...

Reva Winkler: Allen, are you on the line?

Allen Leavens: Sorry. Yes, I'm here.

Reva Winkler: Okay, great. Did you want to explain the data you submitted under performance gap, the list of numbers?

Allen Leavens: Sure. So the way we apply these measures is we have a number of clients. You know and basically the plans are - have different members of each of the populations, so what you see here is just the numerator and denominator with the a compliance rate for each of those plans.

So clearly the groups with the smaller numbers are less meaningful but it just gives you an idea of the range of compliance among the different populations.

Lee Partridge: So this is Lee. So I'm looking at it, Barbara. And I have the same problem that you have because it's a list of numbers and what - each set of numbers represents a different health plan score. Is that right?

Allen Leavens: Right.

Barbara Kelly: And as I looked at that I thought is this a true performance gap because we've got a lot of 100 percent's. Now they were low numbers but the range was 81% to 100% and I just though I don't know if we're going to do much better with this.

Reva Winkler: Any other thoughts from the work group members?

Three of you rated it as medium or moderate rather and one insufficient.

Female: I guess it would be interesting to know whether or not there are particular characteristics of any of these plans. For example is there some possibility that the one that scored 81.95% which actually has the largest number, so had to do different - from a different segment of the

population or within a different location where perhaps less access to endocrinologists was - I'm just curious if we've got a disparity question here.

Allen Leavens: Yes this is Allen. Certainly that's possible that's the case that we didn't have the detail level data to answer those type of questions.

Reva Winkler: Is something - is that something you could get Allen?

Allen Leavens: I can talk to our analysts and see if we can, you know, try to dig into that a little deeper. In terms of specialty distribution I guess - is that - would that be sort of the first thing we've got to look at?

Reva Winkler: Well actually population would be pretty critical too. If you had a high incidence of either Hispanic or Africa-American population in that - the plans with the lower score for example.

Allen Leavens: Yes. We were a little challenged with getting ethnicity data. But we - and I can certainly I guess check with our analysts and see what kind of data we can get.

Reva Winkler: Okay. So Barbara, what do you think about 1(c) the evidence criteria?

Barbara Kelly: I thought the evidence was strong. And I do believe its standard. It's actually standard of care. So I rated it as high.

Reva Winkler: Thoughts from anybody else in the work group?

Laura Riley: So this is Laura. I actually don't think the evidence is all that great. I mean I think that there's a lot of evidence that suggests that insulin is the way to go. But I think there's more and more data suggesting that for some patients oral hypoglycemic's are appropriate use in pregnancy.

And I think even in the - if you scroll down somewhere in here I read. It's also in the ACOG guidelines that it says the use of oral agents for control of Type 2 Diabetes during pregnancy should be limited and individualized until data regarding safety and efficacy of these drugs become available.

So it's not suggesting that it doesn't necessarily work. And it gives you leeway in terms of whether or not to use it.

And I think there are many people who stay on their oral hypoglycemic because that's about all the patients going to do.

So I'm not convinced that the evidence is absolute at all.

Kathleen Simpson: Well this is Kathleen. I agree with Dr. Riley. I rated it as low because in reading the ACOG Practice Bulletin and the other opinion I thought that there was a big gap in the evidence and I did not think that there was a strong evidence base to support this. I think the evidence is evolving.

Laura Riley: Exactly. That's sort of how I thought about it is it's not there yet.

Sharon Sutherland: And this is Sharon. I pulled a citation because I felt this is an area I didn't know much about. So if you look out on the Excel file at 1(c) there's some information there. It was a citation that looked at just this issue of using the oral hypoglycemic agents in pregnancy.

So based on what I felt I agree with the other two.

Sarah Brown: This is Sarah. I am the one in the group that didn't vote on this because I didn't understand what the measure even was. Could one of you - I won't take anytime.

Just one of you in 25 words or less tell me what this is about.

Laura Riley: So essentially what - this is Laura. Essentially what this is suggesting is that if you have Type 2 Diabetes basically prior to pregnancy and then you enter pregnancy once you become pregnant this is suggesting that all of those patients should be taken off of their oral hypoglycemic's and placed on insulin during pregnancy.

And that certainly has been where, you know, historically exactly what has been done. But I'd say more recently with, you know, newer oral hypoglycemic's as well as many more patients with Type 2 Diabetes there has been greater use of oral hypoglycemic's during pregnancy.

But as you can imagine with pregnancy it takes a fairly long period of time to get the safety data that, you know, might make this normal clinical practice.

So at the end of the day the question of whether some Type 2 Diabetics can stay on oral hypoglycemic's and still have reasonable glucose control and not having any adverse outcomes for themselves or their babies, I think is a bit of an unanswered question at this time.

Sarah Brown: Well based on what you said it says in the brief description of measure, it says this measure identifies pregnant women with diabetes who are not taking an oral hypoglycemic agent. Based on what you just said it sounds like what the measure is, is identifying pregnant women with diabetes who are using insulin, not are not taking. Because not taking can mean either that they're doing nothing at all or that they're doing insulin.

So it's not specific enough.

Allen Leavens: All right, this is Allen if I may comment. We - so this is designed as a, or we call it a quality profiling measure. So we designed it so that higher compliance rate is the target. So exactly as you're saying. We're trying to identify women who are pregnant and have diabetes who are not taking agents, so a higher - so it's basically if they're all doing as we would want then the compliance would be 100%.

Sarah Brown: But I thought the issue was not whether or not they're doing something but whether they're doing oral or oral hypoglycemic agents or insulin. It's not just that they're doing something. I thought the focus was on what they're doing.

Allen Leavens: Well if they have diabetes and they're able to be controlled without taking insulin and oral or oral agents, then they would still be compliant. It's just a matter if they're - they have diabetes and the pregnant woman is taking oral agents that would make them noncompliant.

Sarah Brown: But how do you - where are you separating out the women who have diabetes who are taking neither oral hypoglycemic agents or insulin and basically are uncontrolled or unmanaged appropriately?

In other words they're taking nothing because they've just never taken anything or they've never been properly diagnosed. Where do you separate those out from either the numerator or the denominator?

Allen Leavens: Well we're not getting at issues of control, this measure because it will require, you know, lab data and this was, you know, it wasn't designed as level three measures just using administrative data.

Laura Riley: But I - okay so now even I'm confused. So it sounds to me - am I not reading this correctly?

It sounds to me like what you're saying would be a success, turn it a different way, would be a woman who had been on oral hypoglycemic's or not I guess prior to pregnancy. She gets pregnant and now she's goes on insulin.

Isn't that the success? Isn't that who you're trying to increase the number of?

Allen Leavens: That would certainly fall into the positive compliance rate, correct.

Laura Riley: Right. So a woman who was on oral hypoglycemic's prior to pregnancy, gets pregnant and stays on her oral hypoglycemic is not compliant according to the way this is written.

Allen Leavens: Right.

Laura Riley: Even if she's in good control.

Allen Leavens: Correct.

Laura Riley: That's what I have an issue with.

Sarah Brown: Right. Well that's another aspect of this same thing. I mean there's three conditions.

Having diabetes and not having it controlled, being on nothing, before pregnancy, during pregnancy, whatever.

Then there's what you just outlined which is sort of they were on oral and now they're on insulin.

And then there's one where maybe they were always on insulin.

But these different - there's three or four different sequences of prior status and then pregnancy status with regard to treatment, none and then the two options.

And I don't - I just don't see how they're all covered in this measure.

Laura Riley: I don't think they are all covered in this measure.

Sarah Brown: Right.

Laura Riley: And I'm suspecting that I mean the measurer can tell us. But that wasn't your intent was it?

Allen Leavens: Right. I mean again if we had lab data and we could or, you know, administrative data and that qualified whether it was controlled or not controlled which, you know, inconsistent compliance, then we would certainly want to segment that out.

But we didn't have that ability based on this administrative data.

Laura Riley: So because you couldn't do that then what you're doing is almost a proxy to that is basically saying insulin is better than an oral hypoglycemic so you want to increase the number of people on insulin.

Allen Leavens: Right.

Laura Riley: Correct?

Allen Leavens: Correct.

Laura Riley: But see, that's my point. That's a judgment call that I don't know that we have the data that supports that necessarily. We have historical practice that supports that. But we don't know that in - that right now with all the oral hypoglycemic's that are on the market that that's the case.

I guess I'm having an issue with whether or not, I mean it sounds to me like it would be punitive if in fact a provider or a patient decided to stay on an oral hypoglycemic even if her sugar was well controlled. That doesn't seem right.

Allen Leavens: Well...

Laura Riley: And I don't know whether there's data to support that change.

Allen Leavens: Right. I mean there was the two pieces. One part is the control which in general we would hope that insulin provides better control but also the issue of we're still determining whether there's safety with oral agents.

And so until that data is available to be conservative and switch (to control).

Laura Riley: See I think that there's a problem with that. Because I think that it's not - it would be in contrast to the statements that are - to the guidelines out there.

And as we just talked about with the last measure it's nice to have guidelines that go along with the measure. This is one where the guidelines are telling you you could potentially do something different. And it's okay. Yet here you would be penalized for it. And that doesn't sound good I don't think.

Sarah Brown: Can I ask it a different way? What happens with this measure when a bunch of women and an aggregate measure even in an individual case pops up who is pregnant with diabetes and

not taking an oral hypoglycemic agent and for whatever reason we think that she wasn't taking anything before pregnancy either?

Allen Leavens: She would still get pulled into the measure with a denominator for being having diabetes and being pregnant. But would be compliant because she's not taking an oral agent.

Sarah Brown: So that's my problem. But she's obviously not compliant. There's an example of somebody who maybe in very - who may really need help. They have uncontrolled, undiagnosed, whatever, unmanaged diabetes.

And this measure puts them into a category of a success in essence.

Laura Riley: That is so true.

Allen Leavens: Right. And it's a very valid question.

Female: (All right).

Barbara Kelly: This is Dr. Kelly. I have traditionally changed my diabetics in the situation to insulin. Can one of the obstetricians and gynecologists tell us how many doctors are choosing to use these agents? The oral.

Laura Riley: Well I - I mean I do. I use oral. I mean if a patient of mine comes in and she's well controlled and she's already on something and her sugars are low, I see no reason to change her to insulin.

You know and obviously that's someone who's checking their sugar four times a day and they have good hemoglobin A1cs. You're hard pressed to now have them sticking themselves.

And there are some patients who just aren't going to do it. And I'd rather them take something than nothing.

Sarah Brown: Right.

Laura Riley: So sometimes it's a judgment call obviously.

Sarah Brown: Yes. And when there's that much judgment I'm just wondering how it works as one of these aggregate measures.

Barbara Kelly: Well I guess I'm changing my mind from my a lot of evidence to not so much evidence.

Reva Winkler: Okay.

Barbara Kelly: Because, you know...

Female: It may (come)...

Barbara Kelly: ...it's a standard of care that's reasonable and possible like the patient you just described would, you know, would be - to me that sounds fairly reasonable. And I don't think this measure is addressing that.

Reva Winkler: Okay. All right, I think we need to kind of move on a little bit but we certainly highlighted the issues around the evidence supporting this measure.

Sarah Brown: But Reva, I think, I mean it's partly evidence but I think the - at least my question is about the measure. Not the...

Reva Winkler: Okay.

Sarah Brown: ...evidence behind it. I still don't really understand the measure itself.

Reva Winkler: Okay. Well do you want to have any - do you want to talk about the scientific acceptability of the measure, the way the measure is specified and its reliability and validity?

Barbara Kelly: I'm not - well this is Dr. Kelly again. I guess I'm not sure. I - going back on the - I'm not sure this an appropriate measure now. Now I'm changing my mind, I'm flip flopping. I'm not sure if we need to discuss the rest of it. But what do the others say?

Laura Riley: This is Laura Riley. I agree with Dr. Kelly. I'm not sure that there's a whole lot else to discuss. I have an issue with sort of the upfront piece of this. So it's hard to keep going.

Reva Winkler: All right.

Laura Riley: It's not going to get any better.

Kathleen Simpson: I agree. This is Kathleen.

Female: I agree.

Janet Young: This is Dr. Young. Based on the information that I'm hearing it sounds like there had been some question about safety and efficacy of oral agents in the past. But the data has slowly come along that says this might not be as unsafe as we thought.

And while we still might not have that data there's no compelling reason to push patients over into self injecting with insulin if they are well controlled. That's sort of the - what I'm hearing. Is that correct?

Laura Riley: I think that that is what's happening in practice. Not in droves but I think, you know, yes. People are making judgment calls based on a whole bunch of things and not just automatically switching people to insulin.

Reva Winkler: All right. Well since time is flying and it sounds like you had a good discussion on that.

Let's move onto the next measure, 476. This is antenatal steroids. Now this measure was endorsed during the last Prenatal Project.

And the stewardship of this measure is now in the hands of the Joint Commission. So this measure assesses patients at risk of preterm delivery at 24 and zero to 32 and zero weeks gestation receiving antenatal steroids prior to delivering preterm newborn.

Who is this?

Laura Riley: It's me. It's Laura.

Reva Winkler: Well great Laura.

Laura Riley: So we talked about this a lot three years ago. And I think it's still a good measure.

I think the things that concerned us before were how complicated it was going to be to get this information. And I think as people read through the calculation is quite scary.

But it - I think if I'm reading it correctly there are enough databases such that this information can be obtained fairly reliably.

Do you want to go through it systematically?

Reva Winkler: Well why don't we just quickly ((inaudible))...

Laura Riley: Impact and opportunity.

Reva Winkler: Yes.

Laura Riley: So in terms of impact I mean there's no question that it has a high impact. I mean I think prematurity we know is a huge issue. A lot of short and long term consequences.

There's a lot of data which suggests that betamethasone given in a complete course which is two doses prior to delivery would significantly decrease the risk of respiratory distresses as well as other sequelae in prematurity.

It's hard to sort of argue with any of that. There's a lot of evidence.

Is there anything else you want me to say about that?

Reva Winkler: No. Just the opportunity for improvement, i.e. the Joint Commission says their aggregate performance is 64.9%.

Laura Riley: Right, so which suggest that there's clearly a gap there.

Reva Winkler: Right.

Laura Riley: So there's, you know, there's room for improvement which I think is important.

Reva Winkler: Yes. All five members of the committee rated this highly on all the sub-criteria and overall on the importance criteria so given that unless any of the other work group members want to offer anything, do we want to just briefly look at the scientific acceptability? Are there any issues or concerns from the work group members?

Female: No.

Reva Winkler: Okay. Again all five of those ratings were high and yes, it's passing.

The fourth one - the usability criteria again rated highly by all the work group members. Any questions or points of discussion for the work group?

Lee Partridge: This is Lee. I just had a question. I think it's more appropriate in the usability section than elsewhere.

Some of this administration occurs prior to the pregnancy and outside of the hospital, i.e. by a physician who's not on a hospital clinic staff or something like that.

I just wondered, we're reporting it now as hospital-based data. And what problem is it for the hospital to know whether it's occurred?

I guess this is burden or it's probably feasibility.

Reva Winkler: Okay either one. (Celeste) or Ann, any thoughts?

Female: Yes. In our specifications we actually state that they can look at clinic visits or physician visits or prior hospitalization, but it has to be documented in the medical record when the delivery took place.

Female: So in other words, that's a situation in which the tending - the OB record is available to the hospital. And that's what they use to document it.

Female: That or they could and actually it can be written anywhere in the medical record. We don't specify. So if it's in a progress note or the history and physical or if they've given one dose prior to and then the second dose is recorded in the medication administration record, that's what they'd be looking for.

Female: I guess I'm thinking back to my days when I was here. And I'm also in the District of Columbia. We have a protocol which I'm afraid it's still in place that if you go into labor you're taken to the nearest hospital where the record - your prior - your pregnancy records may not be. And I would say if we're curious about the burden issue.

Female: Okay.

Reva Winkler: All right, anything on, further on feasibility? I guess I'd like to hear just from the developers on the actual data collection and to what extent the data can be collected electronically.

Female: A lot of the data elements can be but there are some that are going to need to require manual extraction.

For example looking for the fact that the full course of steroids was given would require a record review.

Gestational age is something that if you have a computerized record you might be able to pull that out but at this point in time it's something you'd have to look for in the medical record.

Reva Winkler: Okay. Any other questions from the work group for this measure, any other discussion points you'd like to bring up?

Barbara Kelly: And this...

Female: ((inaudible)) go ahead.

Barbara Kelly: ...is Dr. Kelly. I agree with one comment which was the antepartum care facility may not be the same as the delivering facility particularly when you're delivering a premature baby.

So that is something that we need at least to stress under the feasibility and usability criteria. Because I do think it's going to be a little bit of a struggle in some situations to get that data.

Sharon Sutherland: This is Dr. Sutherland. I guess I had a question about the exclusion of diagnosis of fetal distress because I think the way the measure is written when I looked at the ones that did not get steroids, I think 26% of them were cases where there was a diagnosis of fetal distress.

Female: I think you mean fetal demise.

Sharon Sutherland: No. I think it may have been - in other words they didn't get - they didn't wait to do the delivery for steroid time because there was some concern about fetal wellbeing.

Female: Well the way it is right now with the version of the manual if there's documentation that the delivery occurred prior to the second dose of steroid it's implied that they didn't get the full course and they were removed from the measure.

Sharon Sutherland: Is that considered a failure?

Female: No. They're not a part of the measure because they weren't eligible to get two doses due to the precipitous delivery.

Sharon Sutherland: If it wasn't precipitous, you did a C-section because of an abnormal heart rate tracing.

Female: Same thing. They're delivering them before they can get the opportunity to give that second dose. So they would be removed from the measure. It would be an implied reason.

Sharon Sutherland: Okay.

Reva Winkler: Any other questions for this measure?

Okay. Well all right, we're speeding up a bit.

The next measure is measure 477. This is under 1500 gram infants not delivered at appropriate level of care. This is also a measure that was reviewed three years ago in a Perinatal Project. It was brought to us from the California Maternal Quality Care Collaborative.

And this is the number of - number per 1000 live births, less than 1500 gram infants delivered in hospitals not appropriate for that size infant.

So who is the primary for that?

Sharon Sutherland: It's me. Dr. Sutherland.

Reva Winkler: Okay, great Sharon. Thanks.

Sharon Sutherland: So...

Reva Winkler: What are your thoughts on the importance criteria for this measure?

Sharon Sutherland: Well looking at everybody's survey it looks like they agreed that it is important. I think a lot of this has to do with factors other than medical factors. And I think a few of the folks brought those up.

I think there's plenty of information that shows that - I think there's the best was a 60% greater rate of survival in a little three in the queue versus some other level in the queue.

All of the data when I looked up the actual studies was based on observational information. The study that was done by Caswell which was one of their citations was a meta-analysis and they looked at the adequacy of evidence. They through out the majority of studies that did not feel they had adequate evidence.

But of those that they felt had good scientific validity, there was a strong correlation with the survival benefit at a little in the queue.

Reva Winkler: Okay. Any other comments from the work group members on the importance criteria because you all did rate it pretty consistently high?

Sarah Brown: Well this is Sarah. At some point I want to discuss these sort of nonhospital or nonmedical factors. Because if our assessment is that the main factors influencing whether or not infants are delivered at the appropriate level has nothing to do with anything doctors control or, you know,

the usual suspects in these measures that it's all about, you know, underfunding of ambulances or, you know, weird hospital blah, blah, I'm not sure the measure is - I don't know if it's not that it's important but it may not be useful.

Sharon Sutherland: This is Dr. Sutherland. I could speak to that a little bit. What people might not be familiar with there's some other regulations for example things like EMTALA which hospitals can be assigned for transfer of pregnant women.

And so there are a couple of disincentives to transfer patients in a situation such as this. There's also the economic disincentive because they're going to lose the revenue from the delivery when the patient transfers and delivers elsewhere.

And I know it's crass to bring up those issues but...

Sarah Brown: Well I think it's absolutely critical.

Sharon Sutherland: So that's where part of it is, you know, the question is at what level of authority will we be able to put pressure on institutions to do what's right for patients.

And from a legal perspective what kind of protections can we seek for specific situations like this in which transfer is critical for a patient for EMTALA?

Laura Riley: But I thought that EMTALA means that you need to evaluate the patient. You can't turn her away without seeing her.

But that doesn't necessarily mean that once you evaluate her and determine that she's 24 weeks that you can't transfer her into the appropriate institution.

Sharon Sutherland: Well the definitions state the patient's in labor. They can't be transferred.

Now obviously we do it. But, you know, I don't know how much of the California experience has to do with this particular issue because it's...

Reva Winkler: Do we have anybody - yes. Do we have anybody for the measure developer on the line?

Oh Dr. Main, Elliott, are you there?

He said he was going to call in.

Sarah Brown: See I think this is important because I - just to make it overstated. I think the idea of these measures in general is that, you know, people in a department or a hospital or region will look at a number on one of these and say gee we can do better than that. That's important. Let's develop checklists. Let's develop, you know, programs in the EMR or whatever.

And if this is about - if this is being driven by factors outside of the usual levels of control and improvement and so forth then I - it's not that it's unimportant but it just won't do anything because the results don't go to the people who are making the decisions. They'll go to a hospital Board or the, you know, physician, whatever.

And if they're not the principal drivers of where women are transferred or if they're transferred then we shouldn't do it.

Sharon Sutherland: My only other concern reading this measure is that it excluded hospitals that did less than 50 deliveries per year which generally speaking means it's a hospital without a maternity service.

So by not tracking those hospitals you lose the opportunity to improve triage of pregnant women from those sites because those patients are at the worst disadvantage if they deliver in a hospital without a maternity service and without any kind of specialized pediatric care.

So I was just curious if anybody knows why we exclude those sites.

Sarah Brown: Great question.

Reva Winkler: Yes. I think these are excellent questions we'll need to get our developer to address. Like I say Elliott was supposed to be on the line.

Janet Young: This is Janet Young. From a pre-hospital perspective since that is a little bit of my forte often times especially in rural areas, actually lots of hospitals that stay open and remain open simply for this very reason. We have an ambulance crew who is LBS certified who can have a preterm, pre - well even sometimes pre viable patient in labor and they're going to go to the nearest ER. End of discussion. Especially in places outside where you have a hospital, you know, every square mile, these hospitals often times are doing courtesy of OB-GYN management in less than ideal environment.

Reva Winkler: In looking at the ratings by the work group beforehand, you rated all highly for importance, highly for scientific acceptability and highly for feasibility. But usability I think was the one where there is quite a variation, one high, three moderate, one low.

And I think is this the issue that you're concerned about is the action ability of who can use this data to actually make improvements or is there some other issue?

Barbara Kelly: This is Dr. Kelly. That was my issue. And I also have the same issue with the small hospitals because well in Colorado, we have a lot of small hospitals. And they're hampered by weather as well as their size and location to get the patient transferred in a timely manner.

So I'm wondering if there's a way to put in the data kind of some assessment of when the transfers don't occur and why not to be able to address those issues and try to improve the care overall.

Kathleen Simpson: This is Kathleen. There are only 84 hospitals in the United States that have less than 50 births per year that say they have an OB service. So it's not as small. You know there's 3265 hospitals with OB service so it's a very small number they're excluding.

Laura Riley: Say that number again.

Kathleen Simpson: It's 3265 hospitals in the U.S. that have a OB service and also 84 have less than 50 births per year.

Sharon Sutherland: But do all hospitals have to report this even if they don't have a maternity service?

Laura Riley: No. Why would they be collecting quality measures on (the metrics) if they don't have any OB patients.

Sharon Sutherland: Yes. Because if you look at - for - I'm in Ohio so if you look at Ohio hospital compare, they track this. How many sites that again don't really do OB?

But it will show up as being tracked.

Kathleen Simpson: Well in that data there's only 42 hospitals in the United States that have any births that said they were not an OB service - did not have an OB service. So, you know, there's really nothing (that)...

Sharon Sutherland: That's what we're reporting.

Kathleen Simpson: You know so there's not that many in the entire United States that had a birth that didn't have an OB service. And those numbers were only one-in-two per hospital.

Female: I think...

Female: Well there's...

Female: Yes.

Female: I'm sorry. I didn't mean to interrupt.

This was not - this information is not from Elliott's submission. But we have found using data from birth records which is the source for this one and this gets into the feasibility area. It is sometimes difficult to access that data.

Now here you're reporting but here the hospital is supposed to be reporting. No, I'm sorry.

Elliott Main: So I'm sorry. This is Elliott.

Female: Elliott, well good.

Elliott Main: I got sidetracked by Maternal Mortality Review Committee which is scheduled at the same time here in California.

I was thinking this was a Pacific Coast time rather than in the East Coast time.

Female: ((inaudible)).

Elliott Main: So I'm sorry to get in here late. It is very - extraordinarily easy to do with (vital) records as was pointed out.

And birth weight there's a high reliability data element on a birth certificate. It's one of the best there is of all the different data elements and we do have a gestational age floor so that 20 week is not included.

It is - what we're working on in a number of states already is the sort of free the data. Making vital stats data available for quality improvement in a real time basis. We have probably five or six states already that have active programs in that because that is the future which is to use administrative data for and reduce the burden of data collection.

So I see that happening actually more and more around the country. I think that's a good thing to encourage for everybody's sake in terms of reducing burden and improving the quality of the administrative data set, but please...

Laura Riley: Elliott, this is - Elliott?

Elliott Main: Yes.

Laura Riley: This is Laura. We're all onboard with the measure except we came into a stumbling block in the last like ten minutes of the conference call, so where we were a little stumped was this question of whether things like the EMTALA Rule and things that are outside of the...

Elliott Main: Sure.

Laura Riley: ...control of the provider or even the hospital sort of how do you deal with that and is there any way of getting the information from this...

Elliott Main: Sure.

Laura Riley: ...to the people who actually make the - those rules. There's a little...

Elliott Main: Sure.

Laura Riley: ...difference of interpretation about the EMTALA Rule anyway.

Elliott Main: Well...

Laura Riley: But, you know...

Elliott Main: Sure. What's interesting is that we defend in California the under 1500 gram births that occurred in non-level three hospitals their average length of stay hospital (A) before birth was between 8 and 14-ounce.

So these weren't patients who came in and delivered. This is obviously going to happen everywhere occasionally.

And there is a - you know, so you're never going to get a zero (rating) on these.

But there are a number of hospitals that just have high rates that are, you know, two center deviations above everybody else really catch attention. And that's really the focus is not to create, you know, the zero level. But to have over a threshold.

And we were able to identify those kind of thresholds looking at 300 or 280 hospitals in California that had more 50 births. That, you know, showed and actually the hospitals that were - had issues were not in the rural areas. You know, California has a huge number - huge - large number of rural hospitals. They got their moms out.

It was downtown LA where the level three hospitals were not far away and it was economically driven that the moms were kept there and then the babies were transferred.

Female: Okay.

Elliott Main: So this is really turning what is a healthy person 2010 and 2020 measure into something that can be used at a hospital level for quality improvement is having a public health measure hasn't really changed much until you change the practices at the hospital level.

So no, you're not going to get a zero because there are going to be some others and they're going to deliver. But these are - it is impressive how different physician practice styles can change some of the measures, kind of effect on these measures.

Please.

Sarah Brown: Can I ask a follow-up question on that?

Can you tell us what the principal factors are that affect whether or not a baby is delivered at the appropriate level?

Is it within a physician's control or the hospital control or is it county ambulance rules or whatever?

What drives this measure?

Elliott Main: It's the largely the physician wanting to deliver the patients that he or she has cared for. And saying well it really doesn't make any difference. We'll just transfer the baby afterwards.

Yes, there's some county hospital issues in which the mom may be taken to a local hospital. But they need to be able to triage and send them onto level three hospitals. This is about, you know, the whole issue of do we believe regionalization of care is good.

And that data is very strong. I gave a number of references for that. For these very low birth weight infants that's well documented.

Sarah Brown: Right, that's not the question.

Elliott Main: The date - oh. So that's the driver here. And it is to a certain extent an (outrage).

Sarah Brown: Which is the driver?

Elliott Main: The driver here is physician practices and economics.

Sarah Brown: Well a quality measure I think can and we hope affect physician practice. Can you give us a scenario where - how it would, a measure like this how it would affect economics?

Elliott Main: No, no, no. The economics are the physician wants to get the delivery say which he might not get if he transfers the mother to another hospital.

Sarah Brown: Oh ((inaudible)).

Elliott Main: So it's a physician practice economics. And to a certain extent there are some payer economics that are perverse incentives here as well. Because they may have to pay more if the mother goes and delivers at a level three facility than at a level one facility.

Sarah Brown: Right.

Elliott Main: So there are some perverse incentives in play here that we want to be able to address if it's for example that California is looking at this to be a Medicaid Quality Indicator on their dashboard. And then the Managed Medicaid Plan will have to report how they do on it. So that would be a plan level report as well as a hospital level report.

And then you could start getting alignments in the correct direction and the incentive alignments correct.

But it is certainly not expected to be zero for everyone all the time who's not a level three. There's going to be some moms that come in and deliver. That may be true of obstetrics but it shouldn't be so skewed and it shouldn't be a large number of them.

Reva Winkler: Thanks Elliott very much. Does anybody else in the work group have any other questions about this measure?

Okay, then why don't we go ahead and...

Elliott Main: And I apologize for coming in late on that.

Reva Winkler: No problem. Thanks for being here Elliott.

Elliott Main: Sure, okay.

Reva Winkler: I appreciate it.

Elliott Main: No problem.

Reva Winkler: Okay. The last measure to discuss today is measure 1746. This is a new submission. This is antepartum antibiotic prophylaxis for Group B Strep. This is from Massachusetts General Hospital. The percentage of pregnant women who are eligible for and receive appropriate antepartum antibiotics prophylaxis for Group B Strep.

Who's measure is this?

Kathleen Simpson: Kathleen.

Reva Winkler: Kathleen, great ((inaudible)).

Kathleen Simpson: First off, was this submitted in the last go around three years ago? I seem to recall this.

Reva Winkler: I do recall there were several measures around Group B Strep that were submitted.

And if my memory is correct the major reason none of them were put forward was that because it was felt that the guidelines had been in place for a significant period of time and performance was generally quite high across the board. And there was limited opportunity for improvement.

Kathleen Simpson: That's my recollection. However the data here suggests that there is opportunity for improvement.

Laura Riley: But the last time we didn't have that data.

Kathleen Simpson: Okay.

Laura Riley: So we had that - so when we had the discussion oh it's great. Everybody said it was great.

Kathleen Simpson: Yes.

Laura Riley: There was nothing to say that they weren't right.

Kathleen Simpson: Okay.

Laura Riley: So that's why it got - that's why it went away.

Kathleen Simpson: Yes. I was surprised to see this again. But then when I looked at the data I said well wait a minute. No, it does.

All right so anyway this is - there are guidelines that offer, you know, recommendations for how to handle this situation. And based on the evidence in terms of a opportunity for improvement it looks like there is some opportunities for improvement and there's - it's broken down between those who are term and those who are preterm.

And it looks like that everybody does not get appropriate chemo prophylaxis. So I think there are, you know, some opportunities for improvement and I guess this data wasn't available last time.

So I thought it was important on that perspective.

And then looking at the ability to collect the - well first of all, there are national guidelines. And, you know, from the CDC and then they have also been adopted and summarized by ACOG. And so I thought that was appropriate and they're easy to understand.

We know that if they get the appropriate antibiotics the more likely than not, highly more likely than not to - it's going to work. So that was helpful.

And it appeared that the numerator and the denominator were appropriate. There's appropriate exclusions.

I think the data can be easily collected but still have, you know, may require some manual chart review depending on the level of EMR at individual hospitals.

So, you know, I thought this was high in all areas of analysis and was very supportive.

Reva Winkler: The ratings from the work group are in generally quite high as well and agree with you Kathleen.

Do we have anybody from the developer on the line with us?

Jeff Ecker: Yes. This is Jeff Ecker.

Reva Winkler: Hi Jeff. How are you?

Jeff Ecker: I'm well.

Reva Winkler: Good. Are there any other comments from the work group?

Any questions for Jeff?

I guess the one question I would have is this - are you intending for this measure to be stratified by term and preterm births?

Jeff Ecker: It's amendable to doing that. But important for both pre - term and preterm. So if your group say boy, a gap of 13% isn't enough. We want a gap of 35%. Then you focus on preterm, but the numbers are such that the actual group numbers are the 13% of terms that are missed are going to be a larger group.

Reva Winkler: Yes.

Kathleen Simpson: Yes. I agree. I thought that it should not be just for preterm. I thought that the opportunities for improvement were significant for both groups. I was surprised to see these data.

Reva Winkler: Any other thoughts from any other work group members? Are there any questions about the feasibility of the measure?

Is this a chart review measure?

Is there electronic data sources?

Jeff Ecker: Yes. It is a chart review measure except for those places that are, you know, interested in looking at it and have configured their EMRs or other systems to capture the data.

So for example here it's something that we can capture readily because we're interested in focusing on it and perhaps if enough groups like yours were interested in it then it's relatively easy to wire into the system.

Reva Winkler: We had some conversation about the ease of adapting EHRs earlier. Anybody else want to comment on that?

Lee Partridge: Yes. This is Lee. I would think your exclusions might be a little tricky, not - particularly the second one. How do you know this is a planned C-section?

Just not sure how much of that kind of information is captured in a term.

Jeff Ecker: Right.

Female: Well if they're scheduled.

Jeff Ecker: Yes. It depends on the system and the chart but...

Lee Partridge: If you have a hospital where they document that its scheduled - a scheduled delivery is always a C-Section.

Jeff Ecker: No.

Female: No.

Jeff Ecker: A scheduled delivery is not always a C-section.

Female: Right.

Jeff Ecker: But C-sections may be scheduled deliveries without labor. I mean that's going to be germane to other measures that you all will look at on other phone calls like the less than 39 week elective delivery measure.

Lee Partridge: Right. I same ditto with regards - the screening negative of 35 to 37 weeks you would pick up presumably from the medical record of pregnancy related - of care prior to delivery.

Jeff Ecker: Yes.

Lee Partridge: Again it would require to have access to that information, but we've discussed that in the context of another measure earlier today. And apparently its feasible.

Jeff Ecker: Sure. I mean again it depends on for example here and, you know, we don't - not everyone's going to have the same medical record. But here because we're interested in looking at whether or not folks got appropriate GBS prophylaxis we ask folks to enter as part of delivery information whether they were at risk for GBS sepsis.

And if so, what was given and when? So we don't have to go back to.

Lee Partridge: Did you ask the patient?

Jeff Ecker: We ask the providers who were caring for the patients, etcetera.

Lee Partridge: Yes. Right.

Laura Riley: So part of the "Good care" behind this practice in the first place is knowing what their GBS status is when they arrive on labor and delivery.

So, you know, it's important for receptacle units to be able to transmit that information from the office to the hospital or from the lab to the delivery system. Because the CDC has shown in their studies looking, you know, at this ABC surveillance they've shown that that's where the - where things fall through the cracks is that the provider on labor and delivery doesn't know the woman's status at the time they're deciding whether or not she needs antibiotics. And there was a missed opportunity.

Sharon Sutherland: This is Sharon. One of my questions for the developer is looking at the issues false negatives. I know that the citation from Van Dyke was listed and it said 61% of the infants with Group B Strep Disease at term had negative cultures.

And I wondered if you had seen the article that was put out by Intermountain. It was back in 2009. They looked at I think 127,000 deliveries and that a significant number of babies that had GBS were actually mothers that were cultured and culture negative.

And I was just curious to see because this measure would completely missed those - missed that opportunity. I was just curious to see what your comments would be.

Jeff Ecker: Well in some sense there's no way around that opportunity. And of course that's exactly what you'd expect because ideally the folks that culture positive are all going to increasingly get antibiotics.

And so GBS is going to develop in those that, you know, were false negatives. If you target an effort on treating the positives then the disease is going to be less than the false negatives.

Sharon Sutherland: Because if I understand it we're really not treating risk factors anymore. We're just treating culture results.

Jeff Ecker: Exactly and that's based...

Sharon Sutherland: So I'm just curious about your opinion about that. Should we be doing a measure that actually involves both?

Jeff Ecker: No. The - since about 2002 CDC based on comparative studies has endorsed a culture only approach because the evidence showed it performed better.

So no. I wouldn't endorse a mixed approach. In part because it would kind of contradict what our widespread recommendations but in part because those recommendations were themselves up in space.

Reva Winkler: This is Reva. I just wanted to ask the developer to clarify when - on the measure specifications under the denominator details, you talk about the population must be further restricted on the basis of following and all the stuff on the cultures.

Then under unknown GBS status delivery less than 37 weeks amniotic membrane rupture equal to 18 hours. Do you mean greater than or equal to 18 hours?

And also antepartum temperature greater than or equal to 104?

Jeff Ecker: Sure.

Reva Winkler: Yes. Just again we'll want to have you correct that.

Jeff Ecker: Sure. Glad to do it.

Reva Winkler: Yes. Any other comments from the work group members in terms of this measure?

You talked about feasibility, usability. Okay, all right, we've just come in about time.

We've gone through five measures. We've looked at the preliminary evaluations by the work group members. You've had an opportunity to share notes and thoughts about these measures in preparation for our meeting on November 29th and 30th.

There were a few questions raised on some of the measures and we will try to see if we can, you know, work with the developers and get some of those addressed a little more - in more detail as possible.

Is there anything else that the work group members feel you need to prepare for the November meeting where you will be presenting sort of the pros and cons and of these measures to the entire Steering Committee?

Janet Young: This is Janet Young. I actually sent you an email while we were on the phone asking for those files that we just looked at on the webinar to be sent out individually. I could not find them on our web site. And I'm sorry about that.

Reva Winkler: Okay.

Janet Young: So it would be helpful for those of us who are a little less computer savvy to perhaps get those in a - either a PDF or a separate email please.

Reva Winkler: Will do. Thank you very much for that.

Janet Young: And the other issue is that I'd love to be able to have the measure developer, the initial measure developer identified so that if we do have questions we can actually get in touch with that person either by email or telephone so that we can discuss where they got their initial database because rather than reinventing the wheel of the work that was already done by the initial measure developer, my goal is to kind of go above and beyond that.

Reva Winkler: All right. If you could give me offline maybe Janet, you can give me some specifics and we can help figure out the best way to do that.

Janet Young: Thank you.

Reva Winkler: All right, there were - Operator?

Operator: Yes, I'm here.

Reva Winkler: Yes. I know there were a couple of participants. We need to open the line to see if there are any comments from any of the participants on...

Operator: Oh.

Reva Winkler: ...the feature pad.

Operator: Okay. If you would like to ask a question or make a comment today, please press star 1. Again if you are in a - on a muted line, you can press star 1 and I'll open your line.

And I have no one in my queue at this time. But I'd like to remind everyone it's star 1.

Reva Winkler: Okay. All right, if there are no comments we're just a few minutes before. I want to thank everybody on the work group. This is sort of the first of the four work group Sessions that we'll have over the next two weeks in preparation for our meeting in the end of November.

Again Suzanne and Gene and I are here to help the Steering Committee with whatever it is you need to do these evaluations.

Suzanne, do you have anything specific to...

Suzanne Theberge: No. Just a few slides that you had an issue with SharePoint please give me a call or an email after the call and we'll try to figure out what's going on. As I mentioned before this is brand new technology at NQF so we're doing a lot of troubleshooting and we want to help it work - make it work for you so jus let me know.

Reva Winkler: Suzanne, do you think we need to meet with the committee afterwards?

Suzanne Theberge: I don't think so.

Reva Winkler: Yes. I think we're all in pretty good shape.

Thank you all especially the work you've done over the last few days to get this - the ratings in so that we could look at them in an aggregate to see where the issues were for the work group.

That's an important part of this.

And if you have any issues or questions in anticipation of the meeting at the end of November feel free to get in touch with us at anytime.

But I think we're probably concluded for today unless there are any further questions.

Operator: I have no further questions over the telephone.

Reva Winkler: Okay, all right. With that then I wish you all a very good day and we'll look forward to seeing you in person in November. Thanks everyday.

Female: Thank you.

Female: Thank you.

Operator: That does conclude our conference call today. Thank you all for your participation.

Female: Thank you.

Female: Thank you.

END