NATIONAL QUALITY FORUM

Moderator: Reva Winkler
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Operator: Welcome everyone. Please note today's call is being recorded. Please standby.

Reva Winkler: Thank you, everybody. This is Reva Winkler at the National Quality Forum along with Suzanne and (Jane), the project staff for the Perinatal Endorsement Maintenance Project.

This is the conference call for workgroup number 2 and I believe we've got the five members of the workgroup. In a second I'm going to ask you to briefly introduce yourself to each other and, of course, when we meet in two weeks we'll have a chance to meet each other in person.

The purpose of our call today is to go over the preliminary review of five of the measures that we are discussing. Thank you all very much for having done your preliminary ratings. We've got something from each of you. I think that will provide a good starting point for discussion.

And our goal today is to really see where people agree, where people don't agree, where there might be some questions or issues, see if there are areas that need clarification from the developers, or others, and really make sure that we're ready to go into the in-person meeting, able to discuss each of the measures against the measure evaluation criteria, and be able to focus in on the issues that are particularly important, where there's general across-the-board agreement, we can be more expeditious in our evaluation, so that is our purpose today.

I think the materials that you need are really access to the measure evaluation forms. So however you find it's useful to access them, whether it's if you printed them, whether you've got them on your own computer, or we do have them showing on the Webinar, those will be the documents we're using today.

So I think at this point I'd like to ask each of the folks in the workgroup, just introduce yourself briefly to the rest of the group. I will tell you that this call is being recorded. There are several other members of the steering committee from other workgroups listening in as well as this is an open and public call. So we could have other folks joining us to listen to the discussion as well. So in terms of just brief introductions, let's start with Joanne Armstrong, Joanne?

Joanne Armstrong: Hi, yes, good morning. This is Joanne Armstrong. I'm a Senior Medical Director and the head of Women's Health at Aetna and a boarded OB/GYN. I practice at Baylor College of Medicine.

Reva Winkler: Great, thank you, Joanne. Jennifer Brandenburg?

Jennifer Brandenburg: Hi, I'm Jenny Brandenburg from Decatur Memorial Hospital. I'm the Director of Women and Children's Services.

Reva Winkler: Great, thank you. Bill Callaghan?

Bill Callaghan: Hi, I'm Bill Callaghan. I'm an Obstetrician and Gynecologist and Preventive Medicine Specialist, and I work in CDC's Division of Reproductive Health.

Reva Winkler: Great, thanks. Andrea Gelzer?

Andrea Gelzer: Hi, I'm Andrea Gelzer and I'm Corporate Chief Medical Officer for the AmeriHealth Mercy Family of Companies and we are a managed Medicaid entity in several states. And I'm an internist by training.

Reva Winkler: Okay, great and Jaleel.

Mambarath Jaleel: Hi, I am Jaleel. I'm the - I'm a Neonatologist from UT Southwestern Medical Center in Dallas. I'm the Medical Director for the Neonatal Intensive Care Unit over here.

Reva Winkler: Great, thank you, all. Okay. I hope that you've all received from Suzanne, the results of the preliminary ratings that you all have done. This is both in a Word document as well as a spreadsheet. The spreadsheet, I think, gives you the, sort of, overall summary view of how all five of you felt about the criteria.

Hopefully, having done this, you're now familiar with the criteria. And so what I'd like to do as we go through each of the measures is just, whoever the lead discussant is, to just briefly talk about, you know, important points for the major criteria or any areas where it seems to be differences of opinion.

So we're going to start with Measure 480, which is Exclusive Breast Milk Feeding. This measure is from the joint commission. This measure assesses the number of newborns exclusively fed breast milk during the newborn's entire hospitalization.

This is a measure that was endorsed, previously, in QF's 2008 Perinatal Project, so it is up for maintenance review. Also, the joint commission has taken over stewardship of this measure from the folks at the California Maternal Quality Care Collaborative. So, Joanne, I believe this measure is yours.

Joanne Armstrong: Okay, so I wasn't on the prior call, so the format is to, sort of, walk through each of these columns, if you will? Is that it, and then those people who...

Reva Winkler: No, I think that we don't need to do - we don't necessarily need to do each and every column, but for instance, we can look at the evaluations of all five of you for the importance criteria. We can start with that.

Joanne Armstrong: Okay, got it.

Reva Winkler: The first one, of course, is impact, the second is gap, and the third one is evidence.

Joanne Armstrong: Got it. Okay. So from an importance of exclusive breast feeding during the hospital period it looks like the, you know, most of us thought it was high. Jennifer thought it was of medium importance. From an evidence point of view, there is, you know, significant evidence, both in quantity and quality, about the importance of breast feeding on infant health.

You know, one of the questions I had was the literature is on the importance of breast feeding on infant health, the measure is exclusive breast feeding during the hospital period.

So the inference is - and I guess one is, sort of, a necessary, but not sufficient requirement to continue breast feeding, i.e. you do it in the hospital before you continue to breast feed through the three and six months that are recommended and are part of the Healthy People 2010 and '20 goals.

Do you want to - it looks like Jennifer ranked the importance of the measure as, sort of, medium and the others high. Do you - is the format to, sort of, explore what the difference of that opinion is?

Reva Winkler: Yes.

Joanne Armstrong: Okay.

Reva Winkler: See if Jennifer wants to comment on - the one B criteria on the gap, Jennifer, you rated it medium - or also on impact, so any comments on your rating?

Jennifer Brandenburg: Yes, I'm trying to follow along here on your spreadsheet. Where are you seeing gap at? I'm looking for...

Reva Winkler: If you look at the column under importance, 1B.

Jennifer Brandenburg: Okay. Oh, I see, okay. First - oh, okay. Well, part of that was because they had talked about the difference between just the initiation at discharge versus, you know, the six months after.

And there seemed to be a little bit of discrepancy as to which one they thought was more important. And I thought what they were trying to say was the six month is what they were thinking maybe wasn't as important as the initiation piece.

Reva Winkler: Okay. Comments from anybody else on the committee? So in general, though, with the rest of the workgroup members, generally rated this pretty high, pretty high in terms of the evidence supporting the benefit of breast feeding on infant health and long-term outcomes.

And all of you felt that it met the importance criteria, so any other comments? Okay. If you have any questions about the measure, we do have measure developers on the phone with us.

Mambarath Jaleel: Can I make a suggestion on the spreadsheet?

Reva Winkler: Yes.

Mambarath Jaleel: If we can have all the measures individually listed it would be better, like grouped together. If you have exclusive breast feeding, all the comments on, one below the other, that might be helpful.

Reva Winkler: Right, on your spreadsheet you can sort...

Mambarath Jaleel: Oh, okay.

Reva Winkler: ...inside that column. And that will be helpful.

Mambarath Jaleel: How do I do that?

Reva Winkler: But you're right, we should have sent it to you pre-sorted.

Mambarath Jaleel: How do I do that?

Jennifer Brandenburg: If you look under Column K, there's a dropdown menu box. And right now it sounds like Select All is checked. If you click on that, you can check Select All to uncheck all the boxes and then pick the measure that we're developing...

Mambarath Jaleel: Oh, okay.

Jennifer Brandenburg: ...we're discussing, sorry. And then...

Mambarath Jaleel: Okay, got it. Thank you.

Reva Winkler: That'll make it a little easier because you're right; you want to look at them all together.

Mambarath Jaleel: Yes, okay, thank you.

Reva Winkler: Does that work for you?

Mambarath Jaleel: Yes.

Reva Winkler: Okay. So it sounds like there's general agreement on the support for the evidence. There is an opportunity for improvement in performance and the impact is solid. So there don't seem to be any confusing or questionable issues around that.

So we can move on to the scientific acceptability of the measure. And this is evaluated in two, sort of, sub-criteria. One is the testing and evidence for reliability of the measure, and testing and reliability of validity of the measure. Wrapped up in all of those are the decision of the specifications, the addressing of the exclusions, are they appropriate or not, whether there is any risk adjustment needed, why or why not, so, Joanne, how did you think about the reliability and validity of this measure?

Joanne Armstrong: I thought that, let me just pull my notes here, that some of the exclusions in the denominator were perhaps a little bit elusive. One is the exclusion for documented "reasons not exclusive" - for not exclusively breast feeding.

I couldn't pull up an ICD9 list of what those were. And, you know, again, I didn't get a handle on how objective those were, you know, cleft lip palate versus some sort of softer diagnosis, if you will. I don't know if others have comments about that.

Reva Winkler: Anybody else in the workgroup? If you'd like, we can ask the measure developers if they have any comment in terms of their experience in using and testing the measure. Ann or Celeste?

Ann Watt: Yes, I didn't know if you were asking us or if you were asking the committee if they wanted to ask us? This is ((inaudible)) from the joint commission and Celeste Nelson is going to answer the question.

Celeste Nelson: Okay. I think you were asking about what the reasons were for not exclusively feeding breast milk. Was that the question originally?

Joanne Armstrong: Yes.

Celeste Nelson: Okay, those are not ICD9 codes. Those are maternal reasons. We have those listed under the data element, reason for not feeding breast milk. And it's come to us from the CDC, AAP, ACOG, and A1 recommendations where it should be avoided.

For example, the mother is HIV positive, she has active, untreated tuberculosis, herpes simplex lesions on the breast, active alcohol or substance abuse, mothers taking medications where, if she discontinues the medications, the morbidity outweighs the benefits of breast feeding the baby, the mother's on chemotherapy, or she's receiving radiation therapy.

So they're pretty much all geared towards maternal reasons that need to be documented in the newborn's medical record as a reason for not exclusively feeding breast milk. As far as newborn conditions, those are derived from ICD9 codes.

If the newborn in diagnosed with galactosemia or received total parenteral nutrition during the hospitalization they would be excluded, or if the infant did expire, that infant would be excluded also from the measure.

And any newborn that is transferred within two days of birth to another acute care facility would also be excluded from the measure as well as those newborns that were admitted to a neonatal intensive care unit at any time during the hospitalization, they would also be excluded from the measure.

Joanne Armstrong: Okay, very good. Thank you.

Reva Winkler: Any other questions like that, clarifications? So it looks like, generally, the workgroup rated this high on - there was an occasional moderate for some of the ratings, but in general, that would qualify it to pass the scientific acceptability criterion, and you all agreed that it did.

Are there any other comments around reliability, validity, the specifications, the exclusions, as we just discussed? Anything else there that you need clarified or - okay, doesn't sound like it.

So we'll move on to the third general criterion, which is usability. And in this, we're trying to get an assessment of how usable is the information to a wide variety of stakeholders, including the public, including policymakers, including purchasers, as well as professionals and providers. So in general, it looks like this group rated it pretty high. Comments, Joanne?

Joanne Armstrong: No, it looks like everyone rated highly. My own personal opinion is it's very understandable to the general population, I think, translates well into QI efforts, so it's pretty clear.

Reva Winkler: Okay. It looks like, Jennifer, you rated this one moderately. Was there any concerns that you had?

Jennifer Brandenburg: Well again, it comes back to trying to monitor this, I think, for - my thought was for, what was it, six months, I think, afterwards, after they're discharged?

Reva Winkler: Right, but I don't think that the measure can capture that, although I think that is sort of the more global goal.

Jennifer Brandenburg: I think that was my concern as far as the feasibility of how, you know, how could you really actually do that and what the feasibility of doing that would be.

Reva Winkler: Celeste, do you want to comment on that?

Celeste Nelson: Yes, actually we are only looking at during the hospitalization, but the evidence shows that if they're exclusively fed breast milk during the entire hospitalization, they're more likely to continue on to exclusively breast feed for the first three to six months of life, which, you're right, is the overall goal here.

If you look at the Healthy People goal, it's 75% of those mothers in the hospitals that have fed the baby only breast milk. It's the time up from birth until the time of discharge.

Reva Winkler: Any further concerns, Jennifer, or others?

Jennifer Brandenburg: On usability or feasibility?

Reva Winkler: On usability. Okay. So generally, again, a high to moderate rate - high for most, moderate, one - but, in general, it seems like you feel that it meets the criteria for that. So now we will move on to feasibility. And, Joanne, did you just want to start us off and see what others have to say?

Joanne Armstrong: Yes, so from a feasibility point of view, it seems like some of the data elements come from chart review, you know, plus/minus electronic in the electronic records where they exist. So in terms of the, sort of, burden to collect the hospital, the cost, you know, that will increase it.

And my other concern was about the exclusivity - the exclusion, rather, of the reason for not breast feeding. It sounds like it is captured in administrative data, based on the comments from the joint commission folks on the call, so that's, perhaps, is less of a concern of mine now.

Reva Winkler: Okay. Jaleel, I think - no, that was Joanne, I'm sorry. Who else? Jennifer, did you all have any other concerns? I think it's important to clarify and, Celeste, you're probably better than me, but your discussion of the exclusion talked about the maternal reasons are not from ICD codes so that they would not be found in administrative data.

Celeste Nelson: Yes, you are correct, but would be a review of the records or a note that would be placed in the newborn's record. If they weren't being exclusively fed breast milk that there's a maternal reason.

Reva Winkler: Celeste, it might be useful to just briefly explain how the joint commission collects this data for this measure as well as the other four that will come before the committee.

Celeste Nelson: We work through performance instrument systems vendors who provide data collection tools to each one of the facilities that elects to report on this measure set. We verify that all the data elements have been embedded correctly into the data collection tools, part of them being disseminated to the hospitals.

And basically, we work from the data elements that are not administratively derived and there are questions that we have for each one of the data elements that would require a medical record review for each one of the measures. So depending on what the measure is - for this measure in

particular, there would be just two questions that you would be asking and that would be - actually three.

First, you'd look to see if they were admitted to a NICU, and if it's a yes, then you stop extracting. Then, beyond that, you would look to see if they were exclusively fed breast milk. If yes, then you'd stop extracting. If no, then you would look to see if there would be a reason documented that would be, as I had mentioned earlier, included in our list of reasons.

And if that was present, you'd say yes. If not, then you would say no, and that would be what you would be extracting from the record.

The rest of the information would be administratively derived, like the admission type, point of origin, discharge date, admission date, and birth date. Does anyone in the workgroup have any questions in terms of the feasibility? Generally you've rated it moderate to high, and there were a couple of comments about the fact that it does require data extraction directly from the medical record, any other comments in terms of feasibility?

Jennifer Brandenburg: This is Jenny; do they track in the medical record, though, once they're discharged? I guess that's where I'm confused. I understand, like, at discharge, and an initiation, and all of that, but it's the three to six months out, are they tracking that in their medical record somewhere, in the hospital medical record?

Reva Winkler: No, that's not the goal of this measure. This measure is strictly looking at exclusive breast milk feeding during the birth hospitalization. However, we did talk about three and six months because that is a longer term goal when you look at the evidence.

But more importantly is, the evidence shows that if the baby is exclusively fed breast milk during the hospitalization, they're more likely to continue to exclusively feed breast milk at three and six months.

Even a single feeding of formula or water will, in many cases, undermine the continuation of exclusive breast milk feeding to those goals that are out there nationally. So it's very important that we look at this during the hospitalization. We can make a big difference in reaching longer term goals, but this measure does not look at anything beyond the hospitalization.

Jennifer Brandenburg: Well, thanks.

Reva Winkler: Okay. Any other questions from the workgroup? Do you feel there's any additional information you need to understand the measure or evaluate it against the criteria?

All right. So generally it sounds like the workgroup feels that this is a good measure and you've rated it highly and feel that it should continue to be endorsed. We'll see what the - we'll certainly have a wider discussion with the entire committee in our in-person meeting.

If we're finished with that, we might as well go ahead and go on to the next measure, and in fact, really the next two measures are very much related - 481, first temperature measured within one hour of admission to the NICU and 482, first NICU temperature less than 36 degrees.

So we will talk about first one and then the other, but realize, the two of them do go together. So I think, Jennifer, I think these measures were yours. So if we start out with the first one, 481, this is the preliminary evaluation by the workgroup members. There is some question about whether it meets the importance criteria, so do you want to talk about that?

Jennifer Brandenburg: Okay, well it looks like Joanne and I put it at a medium. The other three put it at a high.

Reva Winkler: That was on impact, yes.

Jennifer Brandenburg: That's right, for importance, on opportunity, though, it looks like three of us put it as low.

Reva Winkler: Right.

Jennifer Brandenburg: I don't know if this was - I don't know. The opportunity to the NICU within the first hour, I'm assuming they're saying that the opportunity is probably low because of, if they're being first admitted to the NICU there's so many other things going on that maybe temperature isn't the first thing they're checking. That's, kind of, what I at least...

Bill Callaghan: This is Bill and my rationale for this is that, granted, I suppose there's some subjectivity in here, but only hospitals in the bottom quartile are below 98% for the measure already, and even below the 10th percentile, it's still at 90%, so how far can this needle move?

Jennifer Brandenburg: Yes, that was my comment as well the gap is small.

Bill Callaghan: Unless we set a standard of 100%.

Andrea Gelzer: This is Andrea, and I agree. And I also, I mean, I'm sitting here thinking, my goodness, this is a vital sign. And to do a vital sign check within one hour of admission to the NICU it also seemed like a pretty low-bar measure to me. It's important, obviously it's important, but it's very low bar.

Reva Winkler: Okay.

Mambarath Jaleel: This is Jaleel, I'm from UT Southwestern. I would disagree with the first person about the feasibility of doing this in the first one hour because this is one of the most important vital signs, and keeping the temperature up is very important in the neonatal unit, so this will trump any other thing that we're doing in the NICU.

Jennifer Brandenburg: I don't think it's not important. I'm just trying to figure out why. I mean, do we think it's - because to me, it wouldn't be a low opportunity it would be - everybody would already be doing it. So I guess - and that's kind of what we're saying I think, this is already, sort of, been done, and the measures are already good. So are we saying we don't think it's important simply because everybody's already, kind of, meeting the measure already?

Mambarath Jaleel: But since it is linked to the second measure I think that it still stays important.

Jennifer Brandenburg: Well, I wonder, do we know historically, you know, historically was it important to measure it to get the performance up there and now it's there and it's, maybe, less relevant?

Reva Winkler: That's a good question. Do we have the measure developers with us, maybe not today. Beth?

Operator: I'm sorry, were you calling out to Beth?

Reva Winkler: Yes.

Operator: Beth, your line is open.

Beth Anderson: Suzanne?

Suzanne Theberge: Hi, Beth?

Beth Anderson: Can you hear us?

Suzanne Theberge: Yes, we can hear you.

Beth Anderson: Okay, sorry, we have been talking but you couldn't hear us at first.

Suzanne Theberge: Okay.

Reva Winkler: Did you want to respond to the question about, you know, what has performance of this measure been doing?

Joe Carpenter: Well, I mean, clearly the data showed that most hospitals are doing this, but the thought being that, if hospitals are not doing this, that it really is a quality improvement indicator.

But that's - I mean, I agree it's pretty low bar, but it does marry with the other measure, 0482, and the two together are key indicators of how well the hospitals are doing with regard to, you know, measuring temperature and assuring temperature is maintained.

Mambarath Jaleel: I agree with Bill. This is Jaleel. It is an important measure and we have to be 100% with this. I mean, even if it is 95%, it is not acceptable.

Reva Winkler: I guess a question, as we discuss both of these measures, to keep in the back of our mind is do we need two measures or is there some way that we can package the concept into a single measure and perhaps address some of these issues.

So it sounds like there really is a difference of opinion among the workgroup members in terms of the gap for this measure because there was a real split among the workgroup members in terms of whether this measure meets the importance criteria.

I think that this will be an important for the entire steering committee to really get their hands around so we can determine whether this measure goes forward or not. Again, this is a measure that was endorsed three years ago and is under maintenance review.

In terms of trying to understand, are there other questions or other information that workgroup members think they would benefit from to help, either when we're talking to the entire steering committee or to help yourselves understand?

Joanne Armstrong: Yes, one of the, this is Joanne, one of the things - I mean, the reason why I rated it low was because the gap seems very small, not that it's not clinically important to take this vital sign, and because the companion measure is less than 36.5 degrees is there as well, and it says the first temperature should be that.

It's, sort of, you know, in my, sort of, head I link the two, that the first temperature should be taken and it should be less than 36 degrees. So can we look at the data that's available in that second measure and see, of those who don't meet that measure, how many of them have no - you know, have not taken a temperature at all?

Reva Winkler: Let’s ask our measure developers if they can respond to that question.

Joanne Armstrong: In other words both questions may be asked in the second measure if just display the data.

Joe Carpenter: I mean, if you're asking whether or not the two measures can be combined, I don't think there's any question that they certainly could be.

The way we currently report it in the network is we're trying to get at the, you know, we're trying to get at the point that, you know, if you don't measure the temperature at all, you have one sort of problem, and if you do measure and you have temperature not being maintained as appropriate, then that's a different sort of problem.

So that's the way we've been reporting it, but there's no question that they could be combined.

Jennifer Brandenburg: This is Jenny, I agree. I, kind of, think that if they were combined, it might be a better measure. I mean, because that's really what you want is, not only did they take it, but was it, I mean, was it a good temperature as well.

Bill Callaghan: Yes, this Bill again, and I, sort of, thought that perhaps it's kind of implicit right now in the way the two measures are separated and if there's a way to make it explicit by combining them, might just be the only way of doing this.

Andrea Gelzer: This is Andrea and I would echo that as well.

Mambarath Jaleel: This is Jaleel, I agree with that too.

Reva Winkler: All right, well it sounds like there's, sort of, movement in that direction that perhaps the 481 measure, on its own, may not be all that strong and robust, but that measure 482, which we can go on to discuss, which is the outcome measure, could incorporate the measurement as well, and perhaps reduce the overall number of measures and make for a strong single measure.

So if the group would like, we can go and, kind of, move on and look at 482.

Mambarath Jaleel: This is Jaleel; I had a question about the denominator exclusions.

Reva Winkler: Okay, go ahead.

Mambarath Jaleel: It says one, infants outside the birth rate range of 500 to 1500 gram, which is okay. The second one is the one which I had question about, outborn infants admitted more than 28 days after birth, so why not say outborn infants, because they're not going to come into your NICU within the first one hour?

Joe Carpenter: Yes, the reason they're - well the way the measure works is, we would expect that, even an outborn infant who, of course, is not going to be there within one hour of birth.

But it's important to take the outborn infant's temperature because what we've observed is that, outborn infants, in particular, have a problem with temperature control.

Mambarath Jaleel: Yes, I agree with that.

Joe Carpenter: Okay.

Reva Winkler: Do you have your question answered, Jaleel? Or there other...

Mambarath Jaleel: Yes, yes, yes.

Reva Winkler: Okay. Were there any other concerns about this measure on 481 that are unique and unlikely to be part of 482?

Okay. So perhaps we can look at 482, which is the outcome measure, the temperature less than 36 degrees, and, Jennifer, I think this is also yours. So in terms of, and on this one, the entire group did rate the importance criteria highly with high to moderate ratings on all the sub-criteria. Do you want to make any comments about the measure?

Jennifer Brandenburg: Well I'm not really sure why I got a medium on there because it should have been a high. I don't know if I just accidentally clicked the wrong thing or what.

Reva Winkler: Okay.

Jennifer Brandenburg: But it should have been a high.

Reva Winkler: Okay. Any other comments? I remember seeing somebody had a comment about the definition, why the 36 degrees?

Mambarath Jaleel: Yes that was me, Jaleel.

Reva Winkler: Okay, great. Did you want to talk a little bit more about that?

Mambarath Jaleel: Yes, the criteria as it stands, the measure as it stands says 36 degrees. WHO recommendation for a normal temperature, 36.5 to 37.5, and if you look at the NRP recommendation, that also says the temperature should be between 36.5 and 37.5.

So why are we picking 36 instead of 36.5 was my question. So are we giving the wrong impression to the outside saying, hey, 36 is okay even though it is hypothermia?

Reva Winkler: Do we have a response from our measure developers?

Joe Carpenter: Yes. I know that this question has come up a number of times, and at one point we were reporting in Vermont Oxford network, the less than 36.5.

Mambarath Jaleel: Yes.

Joe Carpenter: And it was called to our attention, or there was a question I should say, about whether that was truly hypothermic. So we did change that and I'm sorry I don't have all the specifics, but we could get that and send that information to you.

Reva Winkler: Okay.

Mambarath Jaleel: Because if WHO and NRP are saying one thing and we are saying a different thing, then it doesn't sound right. Because we are a part of the - our institution is a part of the Vermont Oxford Network and we do get the temperature's display split out into less than 36 and less than 36.5 both.

So I don't know if that is a feasibility difficulty with this and that's why we chose 36 or whether it is for convenience.

Reva Winkler: Any comments from the developers?

Joe Carpenter: Again, I'm sorry I'm going to have to...

Reva Winkler: It's okay.

Joe Carpenter: ...defer that question for now...

Mambarath Jaleel: Okay. All right.

Joe Carpenter: ...and send the information to you.

Reva Winkler: Okay. That would be great. As soon as you can get it to us we'll share it with the workgroup and the community. That would be important.

Okay. So there is that question on the target value, but otherwise, I think the workgroup felt this is an important intermediate outcome measure. Were there any other issues besides on the actual value?

Okay. Then in terms of scientific acceptability, again, there were little bits of differences, I'm trying to look at a couple of the comments that people made as there was some question about the number of records that are excluded in the calculation of the measure and, oh, and B, specification of the source of the temperature whether it's rectal, axillary, or skin temperature.

And then there was some question on conducting the reliability evaluation. So anybody on the workgroup want to amplify any of those comments?

Mambarath Jaleel: Yes this Jaleel, my question was about the source of the temperature, whether it is axillary, or rectal, or skin temperature because various units use different methods to take this temperature, and obviously we know that one is not the same as the other. So we have not specified in the measure whether it is an axillary temperature, or rectal, or skin temperature that we want.

If we look at the data from Dr. (Labtuc)'s paper, which was mentioned in this measure, Dr. (Albert Labtuc)'s paper did say that the temperature is measured in all three different sites and some 77% of the units used axillary temperature and there were some - I can't find it right now, but yes,

I got it, 77% in the axilla, 15% was rectal temperature, and 7% was skin temperature, so I would like the members to comment on that.

Joe Carpenter: So the way the definition reads is, core body temperature may be measured by taking a rectal, esophageal, tympanic, or axillary temperature.

Mambarath Jaleel: Okay, but we know that this not the same, an axillary temperature is not the same as a rectal temperature.

Female: It'd be recorded differently.

Andrea Gelzer: This is Andrea that sounds like a very excellent point.

Joe Carpenter: This would have to be another point that I will discuss with our neonatologist here.

Mambarath Jaleel: Yes.

Reva Winkler: Okay. Right, that would be helpful if you could, you know, clarify that a little bit more for the committee because I think they're pointing out the precision, the specification in implementation that there is a real, sort of, standardization of process.

I think it was, Joanne, you mentioned some concern about the number of charts, or the percentage of charts, that were excluded? And your comment basically said that there are...

Joanne Armstrong: Oh, I'm sorry, I was on mute. I'm sorry, I was on mute. I have a question back to Jaleel, if you don't mind before going on to my comment, so, Jaleel, is your recommendation that the temperature be taken per rectum versus something, you know, axillary? Is there a, kind of, standard around how the temperature should be taken?

Mambarath Jaleel: No, there is no recommendation. One of the things that people worry about when doing a rectal temperature is about translocation of organs because these are premature babies and they are vulnerable to infection with low immunity, whether we will be translocating organs because of the damage to the skin.

That is one of the concerns that has been raised in the past, but it is not very relevant because these babies are not colonized within the first one hour of birth.

So many units, including our unit, we do rectal temperatures and within the last 30 years, we have been doing rectal temperatures. And it's not been an issue in our unit, but most of the units do hesitate to do rectal temperatures.

So as you see from the paper, this paper from (Dr. Labtuc) is from the Neonatal Research Network of the NICHD. There are 16 to 18 centers now, who are in the Neonatal Research Network. They are big, large institutions in the U.S., and 77% of them do axillary temperature, so there is no recommendation from anybody.

When you look at the WHO paper which gives you this temperature, it does not clearly mention whether it should be axillary or rectal, but in one small corner of the paper, it does mention that axillary temperature can be taken.

But again, when WHO is doing this on all babies, so term babies getting an axillary temperature versus a rectal doesn't make much of a difference. But in preterm babies who are extremely, small it might make a significant difference.

Joanne Armstrong: Okay. Thank you. Yes and just my other question, or my comment, was the percent of the population excluded is 6%, it was 9.3% a few years ago, so it's getting smaller, but I just

wondered if there's something about the population that's being excluded that is somehow systematically biasing the performance on the measure?

Joe Carpenter: The primary exclusions I think are babies who die in the delivery room. But I don't think that's systematically biases the measure.

Joanne Armstrong: Okay.

Reva Winkler: Are there any other questions on scientific acceptability? I think we're going to wait to see the responses from the developer on the several questions that have been posed to help clarify things for the workgroup members and for the committee. So as soon as the developers are able to get those responses back to us we'll shoot them out to you.

So in terms of the next criteria, usability, any thoughts there from anybody in the workgroup? Generally, you all rated it a moderate to high. Jennifer, anything specific from you?

Female: Can you hear?

Reva Winkler: Okay. I think it's, Joanne, you had some comments under usability about the data and elements not documented in the chart or may not be in the EMR, so, oh, I'm sorry, I skipped to feasibility.

Joanna Armstrong: Yes, no I just thought it was better for QI purposes and, sort of, a public's understanding of quality per se.

Reva Winkler: Okay, but you still rated it moderately usable. I think my experience among public representatives, and we do have several consumers, and purchasers on the committee who'll be

able to chime in, but they feel that there are a lot of things that they're capable of understanding, a lot of things that, perhaps may not seem so on the face of it.

Okay. So usability seems okay and let's move on to feasibility. Again, everybody rated it high, with the exception, I think, of Joanne. And you had the concerns about the data elements being accessible in any EHR. Did you want to talk a little bit further...

Joanne Armstrong: Yes, and just simply that, whether they're in a EHRs, if hospital have them, and then, again, from an administrative perspective, from a plan perspective, it's not independently measurable.

Joe Carpenter: I know, excuse me, this is Joe Carpenter again from Vermont Oxford. I know that we discussed with the folks working with the eMeasures as this being an excellent candidate for inclusion as an eMeasure, and it currently is not, but it's our view that that would be an excellent candidate for that.

Reva Winkler: Okay and just another one of the myriad of things that is going on. Over the next couple of years, NQF will pretty much require measures being submitted to have the eMeasure version.

And to that end, we just launched a measure authoring tool that helps developers, you know, create the electronic data elements that match their measure and produces, both a machine readable as well as a human readable form.

So we're really in transition of that expectation and so, while we don't require it now, certainly on the next go around, we would want to see that that eMeasure has been created for all of these measures.

So it sounds like the thinking and support for an EHR version is there and making that transition using the measure authoring tools is something that can be accomplished.

Okay. Are there any further questions or clarifications on these measures on temperature for the developers since we're going to be expecting some responses to the issues you've raised?

Jennifer Brandenburg: This is Jenny; I just have one quick question. For one of the exclusions it says infants who's temperatures are not measured within the hour of admission to the NICU, so any baby that did get admitted to the NICU, which is kind of the first measure about getting that temperature actually taken within the first hour.

If they didn't get it taken, they're not in the second study, am I understanding that right?

Joe Carpenter: That's correct.

Jennifer Brandenburg: So in combining these two, we're going to include them again.

Joe Carpenter: That's correct, yes they would just be temperature not taken as a response.

Reva Winkler: So just, this is Reva, to clarify, so in a combined measure, a provider would not need to measure if they didn't take the temperature, or if the temperature was less than whatever target we land on, less than 36 right now.

And I would think for QI purposes, you could break that out because of the data elements.

Joe Carpenter: Yes, yes we could definitely do that.

Reva Winkler: Any further comments from the committee on a combined measure? Okay. So I think we've pretty much exhausted the discussion on these two measures. And I want to thank our folks from Vermont Oxford for joining us today and helping the workgroup understand the measures.

We're going to do two more. The next one is Measure 483, and that is the proportion of infants 22 to 29 weeks of gestation screened for retinopathy of prematurity. So it's those premature infants who were in the reporting hospital at the postnatal age recommended for ROP screening by AAP and who received the retinal exam prior to discharge from the hospital. So, again, focus on the very premature.

And, Andrea, I think this measure was yours? Do you want to start out by talking about the importance criteria?

Andrea Gelzer: Sure. An internist talking about the most clinically relevant measure, or clinically detailed measure, but anyway, I think there was general agreement that the measure is important. Well actually, we all said it was of - hang on, I got to get my spreadsheet the right way. I'm not over there.

So we all said it was of high importance. I think, Jennifer, you said it was of medium importance, but I think, generally, we all agree that it is an important measure. And then - in talking about the gap there, the data that was presented on the 1B as to the opportunity for improvement.

The evidence has not been published. Although, you know, there is a survey that Vermont Oxford Network continues to do and it does appear that there is a gap according to that data. Am I summarizing that correctly?

Joe Carpenter: I'm sorry. I'm just looking for the numbers here.

Andrea Gelzer: They're at the 25% of hospitals with the lowest rates of screening, over 12% of all infants over 22 to 29 weeks. And over 23% of infants at 29 weeks gestation were not screened prior to discharge. And that was in unpublished data from the Vermont Oxford Network of 31,401 infants. So having said that, this is already an endorsed measure. Is this correct?

Reva Winkler: That's correct.

Andrea Gelzer: This is the maintenance review.

Reva Winkler: This is a maintenance, correct.

Andrea Gelzer: I guess the question...

Joe Carpenter: So...

Andrea Gelzer: Yes.

Joe Carpenter: Sorry.

Andrea Gelzer: No, go ahead.

Joe Carpenter: So in the report that we did for the measure maintenance, you know, we did stratify that by gestational age. And certainly looks like that the, you know, the rate of compliance is quite low.

Reva Winkler: All right. I think, Jennifer, you rated this one lower on the gap in terms of the current performance. Did you want to comment on that?

Jennifer Brandenburg: I think what, if I remember right, it was mainly because of the shortage of specialists as it actually even performed this test, and whether or not they were available, and whether or not they were going to be able to hit all of the baby that were necessary.

So, I mean, the opportunity was probably was going to be the struggling part of it, not that it wasn't important.

Reva Winkler: Okay, certainly a concern. Does everybody feel comfortable that the evidence for the screening and the guidelines from AAP on when to screen is solidly evidence based? Everybody seemed to rate that pretty high.

Bill Callaghan: Yes.

Female: Yes.

Mambarath Jaleel: This is Jaleel; I had a question about the inclusion criteria. So it says 22 to 29 weeks, while the AAP recommendation is all infants whose birth weight is less than 1500 gram, or gestational age of less than or equal to 32 weeks. So, why only up to 29 weeks while this is so important that we need to include up to 32 weeks?

Joe Carpenter: Yes. The actual criteria that we saw - well, I should say at the beginning that, we have a complete denominator for infants 22 to 29 weeks, we do not have for over 29 weeks. But the criteria that we saw in the latest paper from AAP, it did have a specific recommendation, but there were some, and I don't have that paper in front of me, but there was a caveat with regard to, I believe it's infants over 30 weeks, it may be 30 weeks and over, but over 30 weeks I think there was a caveat there, and I'd have to get that paper, again, I could do some research on that and send that to you.

Mambarath Jaleel: Okay. The AAP guidelines were from 2006, is that the same thing that you're mentioning?

Joe Carpenter: Yes. And then I think there was a published revision to that, but I'll have to look.

Mambarath Jaleel: Yes.

Reva Winkler: I guess I want to just expand on your comment about, you said that Vermont Oxford has a complete dataset for the 22 to 29 weeks, but not greater than that. That allows you to look at that particular group, but other folks, who would be doing this measure, you know, may not be exclusively participating in Vermont Oxford, or non-participants, could still use this measure in their own activities.

Mambarath Jaleel: Yes, I completely agree with that, that we need to include what is recommended by the AAP and not just because Vermont Oxford does not have that capability.

Joe Carpenter: Yes. I mean, I have no disagreement at all with that. And the only thing I was saying is that, I think when the measure was originally created, that the thinking was that, you know, we have a complete denominator. But there was this other caveat issue too, that was part of that, and I'll have to look at that paper.

Reva Winkler: Okay.

Mambarath Jaleel: Okay.

Reva Winkler: So I think the question on the table is, why not have a measure that completely aligns with the AAP recommendation?

Mambarath Jaleel: That's right.

Reva Winkler: So your response to that would be very helpful for the groups at the meeting.

Joe Carpenter: Sure.

Reva Winkler: Okay. So any other questions from the workgroup on the scientific acceptability of this measure? You've rated it generally high on both reliability and validity. There is this question about alignment with the AAP in terms of the specifications, is there anything else in terms of the exclusions, or definitions, or anything else?

Mambarath Jaleel: This is Jaleel again; I have a question about the denominators again. So the outborn infants admitted to the reporting hospital more than 28 days after birth, they are not included, so I was wondering why they are not included.

Andrea Gelzer: And this is Andrea, I have that same question.

Joe Carpenter: Yes. That's part of the Vermont Oxford Network eligibility criteria. That is, in order to be eligible for the VON database, the baby, if the baby is outborn, they must be admitted on or before Day 28.

Mambarath Jaleel: Okay. So the same applies over here as well. Most of these kids who are born at 23 or 24 weeks gestation, by the time they reach different hospital they might be more than 28 days old and they have not been discharged home. So those hospitals should be held accountable to this as well, I would guess. So if the baby is transferred after 28 days, it still should be a measure.

Reva Winkler: Any thoughts from the measure developer?

Joe Carpenter: I can't disagree with that. All I can say is that, the way the Vermont Oxford Network currently works, you know, the baby isn't tracked if, you know, the baby is admitted after Day 28.

Reva Winkler: I guess the argument would, sort of, be the same thing is, to make the measure more generally applicable across all potential users and not necessarily just totally the Vermont Oxford Network participants.

Joe Carpenter: Understood. I have that paper by the way, I just haven't brought up on the screen, and the caveat I was mentioning too is that, there's a footnote beside infants 31 and 32 weeks of age, and then 22 and 23 as well, by the way. And it - oh, I'm sorry, no, it's 31 and 32 only.

Mambarath Jaleel: Right.

Joe Carpenter: Because it says, if necessary, so the timing of the first exam based on gestation weight. So that was another part of our thinking, but I would say that, you know, this 22 to 29 week denominator was also a key part of our thinking when we set the measure as we did.

Reva Winkler: All right. Well having heard the concerns of the workgroup, perhaps you all can, kind of, give it some consideration on - because these issues will be raised by the entire steering committee at the in-person meeting, and I think are significant enough issues in terms of, you know, how valuable and useful the measure is, and that'll give you an opportunity to, kind of, respond to these concerns.

Joe Carpenter: Sure.

Reva Winkler: All right. So any other issues on scientific acceptability from the workgroup? Okay. So we go into usability, again, mostly rated highly by the workgroup. A couple of boddards in there. Any particular concerns from workgroup measures - or members, sorry?

I guess the question is, so one of you mentioned, sort of, tangentially I think, that this measure is probably heretofore been used only, you know, by the participants in the Vermont Oxford Network, which is more focused on quality improvement rather than accountability. And I guess I want to ask the developer your thoughts, or do you know if there are particular participants, or other folks, who may be using this measure, not just internally, but for an accountability purpose?

Joe Carpenter: Well, I'm not clear myself on what you mean by that.

Reva Winkler: Well either public reporting, or paper performance, or credentialing or, you know, something like that.

Joe Carpenter: Oh, we have reason to believe that that's the case. I don't have any data to support that, but I've certainly heard that, from surveys that we have done, that members do use Vermont Oxford data for public reporting, for state collaboratives, for example, is another use where states may be involved in quality improvement or accountability.

Reva Winkler: Okay.

Joe Carpenter: So I can't support that with data, but just from what I've learned in my position.

Reva Winkler: Okay.

Mambarath Jaleel: This is Jaleel, sorry.

Joe Carpenter: I was just going to add that I'm a statistician, so that's ((inaudible)), but I've seen that.

Mambarath Jaleel: This is Jaleel. I'm not a representative for the Neonatal Research Network, but our institution is a part of the Neonatal Research Network of the NICHD, and we do collect those measures in all the 18 neonatal centers of the network and publish that data.

Reva Winkler: Okay. When you say publish, where is it published?

Mambarath Jaleel: On the, again, it is every few years the data is published and I'm not sure whether they have it on their Web site. I'm not sure. We do get the data from all the 18 hospitals because we are a part of the center, but I'm not entirely sure whether they publish that on their Web site.

Reva Winkler: Okay. We'll see if we can search it out and find out for sure or not. That would be important to know.

Mambarath Jaleel: Yes, and I can check it from here as well, from our representatives over here.

Reva Winkler: I appreciate that.

Joe Carpenter: And Vermont Oxford also reports that data, but I'm just not sure in terms of its, you know, how different people are using the data.

Reva Winkler: Yes, right. If there's anyone else at Vermont Oxford that might be able to address that question more specifically, I think it would be very helpful for the committee to understand how it's used beyond just the traditional network.

Okay. So moving on to feasibility, this is one everybody has rated pretty much high across the board. There's one or two moderate ratings, but generally high. Does anybody want to talk about issues around feasibility for this measure?

Okay. So generally, I think everyone feels that it meets the criteria. Does anybody else have any final questions about this particular measure to share with the group or question the measure developer?

Okay this is Reva, and I'd like to ask the folks in Vermont Oxford is, do you collect any data on whether the baby received the actual surgical treatment, if indeed, they're screening?

Joe Carpenter: Yes, we do.

Reva Winkler: Okay. I think, you know, it's something to think about. That would be a particularly interesting measure of performance to extend the idea, okay, you screened them. That's good, but then did you act upon the screening in an appropriate and timely fashion as a way of really trying to strengthen this whole area which is very important for premature babies, but to really understand the performance is appropriate response to screening.

Joe Carpenter: Thank you.

Reva Winkler: Okay. To the rest of the group, we'll move on to our last measure which is 484, which is proportion of infants 22 to 29 weeks treated with Surfactant who are treated within two hours of birth. And, Jaleel, I think this is your measure, correct?

Mambarath Jaleel: Yes, that's right.

Reva Winkler: Okay, why don't you help the group get started discussing it and start with importance.

Mambarath Jaleel: Okay, I think I'll be going all around with this, but at the outset, I want to say that this measure, the way it is measured right now, is not suitable for endorsement. So five years back, or

even three years back, routine management of these babies who are less than 28 weeks used to be incubate in the delivery room, give the Surfactant as quickly as possible.

Now, in the last five years, there has been increasing observational evidence that that might not be the right strategy, and trying these babies on CPAP initially, and seeing how they do, has come into prominence. And in the last three years, in 2008, there was a study called the COIN trial. And there was another one which was published in 2010, which is called the SUPPORT trial.

These are big studies, multi-center, randomized control trials which were published and both of them looked at - one ARM was having these babies on CPAP in the delivery room and transferring these babies to the NICU on CPAP, and the other ARM was incubating these babies in the delivery room and giving Surfactant as quickly as possible.

And they found no difference in the primary outcome, which was incidents of BPD and mortality, so there was no difference between the two groups. So there is a move towards using more and more CPAP. So when this measure was initially developed, we did not have this evidence. But now that we have the evidence, which doesn't support the measure, I think it is time to relook at the measure.

Joe Carpenter: Yes, I think that we at Vermont Oxford are very aware of this work that's been done. And we completely agree that CPAP, you know, initiating CPAP early and trying the baby on CPAP is a less invasive and important new approach, if I may say it that way.

Mambarath Jaleel: Okay.

Joe Carpenter: I guess the thought we have is that, if the baby, you know, needs Surfactant, that Surfactant given early, and as Jaleel said, you know, that is based on some fairly dated information.

On the other hand, I would like to consult with our neonatologist here to answer your concern about it because I don't think I have the clinical knowledge to really deal with it. So I guess I would just like to know if the committee would consider, you know, a statement from him in this regard.

Reva Winkler: We definitely want to hear your response to Jaleel's concerns. I think that, sort of, is a fundamental aspect of this measure, if the evidence has changed, and as we certainly can happen over time, and treatment options and practice has evolved and changed, it's important that the measures also keep up.

And if that's a basic issue for this measure, we definitely want to hear the response from Vermont Oxford in terms of why you think we should continue using it, or why you are continuing using it, and to help understand that issue.

So I think, Jaleel, you've, kind of, brought the conversation to a bit of a halt, because the importance criteria, which includes the evidence basis for the measure is a must-pass criteria, it is fundamental, and I think that you've raised a very critically important, you know, issue with this measure, and that is, the evidence has changed.

And so, you know, is the measure still appropriate, or had it, or has it, or can it evolve with the evidence. And I think at this point we're really going to have to hear back from Vermont Oxford to see what their thoughts are on that.

But I think this, again, just raises that these are the kind of really critical issues that we're counting on you guys as steering committee members to point out and raise, because we do know that measures don't necessarily last forever, and the world around them changes.

So I think this is, sort of, a critical one for this measure. Just to be sure that there aren't other questions for this measure, was there, from any of the workgroup members, were there any other issues that you noticed in terms of the, say, the specifications, definitions, exclusions, or any concerns about the usability, feasibility? Just to be able to address them in case?

Mambarath Jaleel: This is Jaleel again. I know that Vermont Oxford Network collects the data between 22 and 29 weeks, and that's the reason for the denominator to include 22 up to 29 weeks. And it's a minor point, but the two studies which have been done recently, they have not included 29 weeks within those studies, so that's one of them.

And then I was wondering about the other denominator exclusions. Outborn infants admitted more than 28 days of birth. Why 28 and why not the first 48 hours? Again, probably it is because of the Vermont Oxford Network's data that are just considered as an exclusion, but generally, we don't give Surfactant to babies who are more than two days old.

Joe Carpenter: Yes, that's true. We do track when it is given, however, at Vermont Oxford. So, I mean, I have no problem with that being standard treatment. It's just that, outborn babies are not eligible if they're admitted after Day 28. And if a baby, for example, were given Surfactant on Day 21, even though that's an uncommon therapy, we would know that. We would have that information.

Mambarath Jaleel: Yes, it's a minor point, but I was not clear on that because it is very, very unlikely that they will give Surfactant after first two, or maybe three days of age.

Joe Carpenter: No, I understand. It's just that we had, in our database, almost 60,000 very low birth weight babies, 501 to 1500 grams last year, so, you know, there are some.

Mambarath Jaleel: Yes and the reasons for that are not hyaline membrane disease. The reason is BPD or where people have tried everything and nothing has worked, and they're just throwing the kitchen sink.

Joe Carpenter: I see.

Mambarath Jaleel: So it's not a good measure if they're giving Surfactant at 31 days of life.

Joe Carpenter: No.

Mambarath Jaleel: Yes.

Reva Winkler: Okay. Any other thoughts on scientific acceptability, or questions? Okay. Anything on usability and feasibility from the group? Okay. Well I think we've had a chance to go through the issues that the work group has identified and pose the questions.

Again, I thank the folks at Vermont Oxford for joining us and we'll look forward to your responses that we will share with the workgroup as well as the entire committee. And certainly, these will be the issues to be discussed when the entire steering committee meets.

Any other comments from the workgroup on any of these measures? Okay. What I'd like to do is ask, (Shannon), if anybody who's listening wants to ask a question? Any public comment if they will? So, (Shannon), would you see if anybody wants to - who's out there listening, wants to ask a question?

Operator: Sure, absolutely, all lines are open.

Reva Winkler: Great. Lee or Carol, I know you're out there. Any other steering committee members who might be listening in, did you guys have any questions you'd like to pose to either the workgroup or any of the developers?

Carol Sakala: This is Carol, and I have two questions. One is about 480, exclusive breast milk feeding. I regard this as a very important measure because it applies to such a large proportion of the population and has potentially very favorable implications for both mothers and babies.

And I would like to ask the developer if they would consider expanding the level of analysis, the currently issued is facility and national population. And I think it would be really wonderful to ask health plans to get engaged in some pressure around improving practices at this time. And also I think that state populations could take an interest in this, I'm certainly thinking of Medicaid programs and probably a good deal of variation across states.

Reva Winkler: Do we still have anybody from the joint commission on the line? I think they may have left, but, Carol, we'll pass that question along...

Carol Sakala: Okay.

Reva Winkler: ...because I think it's an important one.

Carol Sakala: Great.

Reva Winkler: Great.

Carol Sakala: And I had one more question about the retinopathy of prematurity screening. I was wondering if there is a sense of any responsibility toward those newborns who are discharged

before the appropriate time for the screening. So, for example, would it be appropriate to include referral on discharge or some appropriate action as a part of this measure?

Reva Winkler: Anybody from Vermont -

Joe Carpenter: I think that's a really good question. This is a problem, for sure, with the ROP. Babies often are discharged before they reach the age that, you know, they're recommended to have an exam. And just tracking whether or not babies have ROP is a problem in many cases.

So we currently do not do that. We don't have a question about, you know, was the infant referred, but it's a good question. I'm not sure whether it would be a separate measure or I suppose it could be included as part of this as a combined measure, for example.

Reva Winkler: Yes, any other questions from anybody else out there? Thank you, Carol.

Carol Sakala: Okay.

Reva Winkler: Okay. Well I think we've had a chance to talk to everybody. This group was particularly efficient, not needing the whole two hours to get through everything. What we're going to be doing going forward is summarizing all the comments and we will be making these available to the steering committee when we meet in person.

There have been several need for additional information which will be in contact with the measure developers to get that follow up so that we can have that for the steering committee during the meeting.

Is there anything else that the members of the workgroup feel that they would want or need to have to be able to present and discuss these measures when the entire committee meets?

Okay. So just as a preview for the workgroup members, essentially what we're going to do is reprise, you know, this conversation for each of the measures when there is, you know, where there are no issues and everybody in the workgroup has generally, you know, thought everything was pretty good we can be very concise and very focused.

As we go through each of the measures, we will be going through each of the main criteria. So we'll start with importance, raise any issues, and then the entire committee will vote on that criteria. We'll move on to scientific acceptability, raise the issues, discuss whatever, vote on all the way through the four main criteria, and then there will be an overall vote on the recommendation whether this measure is suitable for endorsement.

So that's what we're going to be doing and your assignments as the lead discussant for the workgroup will be maintained for the steering committee meeting. I'm trying to think if there's anything else I can tell you that would help you prepare for the meeting. Any questions from anybody?

Lee Patridge: Reva this is Lee. Joanne, I gather, raised the question of the extent to which some of the measures under discussion are entirely appropriate and good for QI, but not necessarily as valid for public reporting. I suspect that's going to come up around several of the measures, and I wonder whether it will be a good idea at the top of the face to face meeting, to have - to focus a little bit on that issue so that everybody has a pretty clear understanding of what the standards are against which we're measuring.

Reva Winkler: Okay. We can do that. Thank you. Any other thoughts from the steering committee or from the workgroup? Okay. Well then, thank you all for all the work you did ahead of time that made this a very efficient phone call. And you'll be hearing from us as we send you out the materials for the in-person meeting.

If you're having any issues accessing SharePoint or getting hold of the documents, please let Suzanne or (Jane) know so we can help you through that. Otherwise, unless anybody else has a comment to make, I think we're finished for today. And I thank you all very, very much for your time and I look forward to meeting with you in two weeks, it looks like.

Jennifer Brandenburg: Thanks.

Andrea Gelzer: Thank you.

Mambarath Jaleel: Thank you.

Reva Winkler: Everybody.

Joanne Armstrong: Thank you.

END