NATIONAL QUALITY FORUM

National Consensus Standards for Perinatal and Women's Health

Standing Committee Orientation

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December 8, 2017

Welcome

Project Team

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Agenda for the Call

- Standing Committee Introductions
- Overview of NQF, the Consensus Development Process, and Roles of the Standing Committee, co-chairs, NQF staff
- Overview of NQF’s portfolio of Perinatal and Women’s Health measures
- Review of project activities and timelines
- Overview of NQF’s measure evaluation criteria
- SharePoint Tutorial
- Measure Worksheet example
- Next steps

Perinatal Standing Committee

- **Kimberly Gregory, MD, MPH** (Co-Chair)
- **Carol Sakala**, PhD, MSPH (Co-Chair)
- J. Matthew Austin, PhD
- Jennifer Bailit, MD, MPH
- Amy Bell, MSN, RNC-OB, NEA-BC, CPHQ
- Tracy Flanagan, MD
- Gregory Goyert, MD
- Ashley Hirai, PhD
- Mambarambath Jaleel, MD
- Diana Jolles, CNM, MS, PhD (c)
- John Keats, MD, CPE, CPPS, FACOG, FAAPL
- Deborah Kilday, MSN
- Sarah McNeil, MD
- Jennifer Moore, PhD, RN
- Kristi Nelson, MBA, BSN
- Juliet M Nevins, MD, MPA
- Sheila Owens-Collins, MD, MPH, MBA
- Cynthia Pellegrini
- Diana E. Ramos, MD, MPH, FACOG
- Naomi Schapiro, RN, PhD, CPNP
- Karen Shea, RN, MSN
- Marisa "Mimi" Spalding, JD, MPH
- Sindhu Srinivas, MD, MSCE
- Rajan Wadhawan, MD, MMM, CPE, FAAP
- Carolyn Westhoff, MD, MSc
- Janet Young, MD

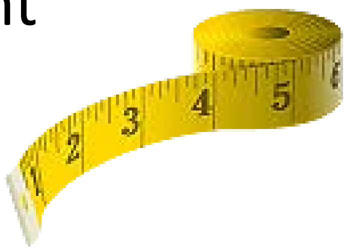
Overview of NQF, the CDP, and Roles

The National Quality Forum: A Unique Role

Established in 1999, NQF is a nonprofit, nonpartisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare performance measurement. The goal is to make healthcare in the U.S. better, safer, and more affordable.

Mission: To lead national collaboration to improve health and healthcare quality through measurement

- An Essential Forum
- Gold Standard for Quality Measurement
- Leadership in Quality



NQF Activities in Multiple Measurement Areas

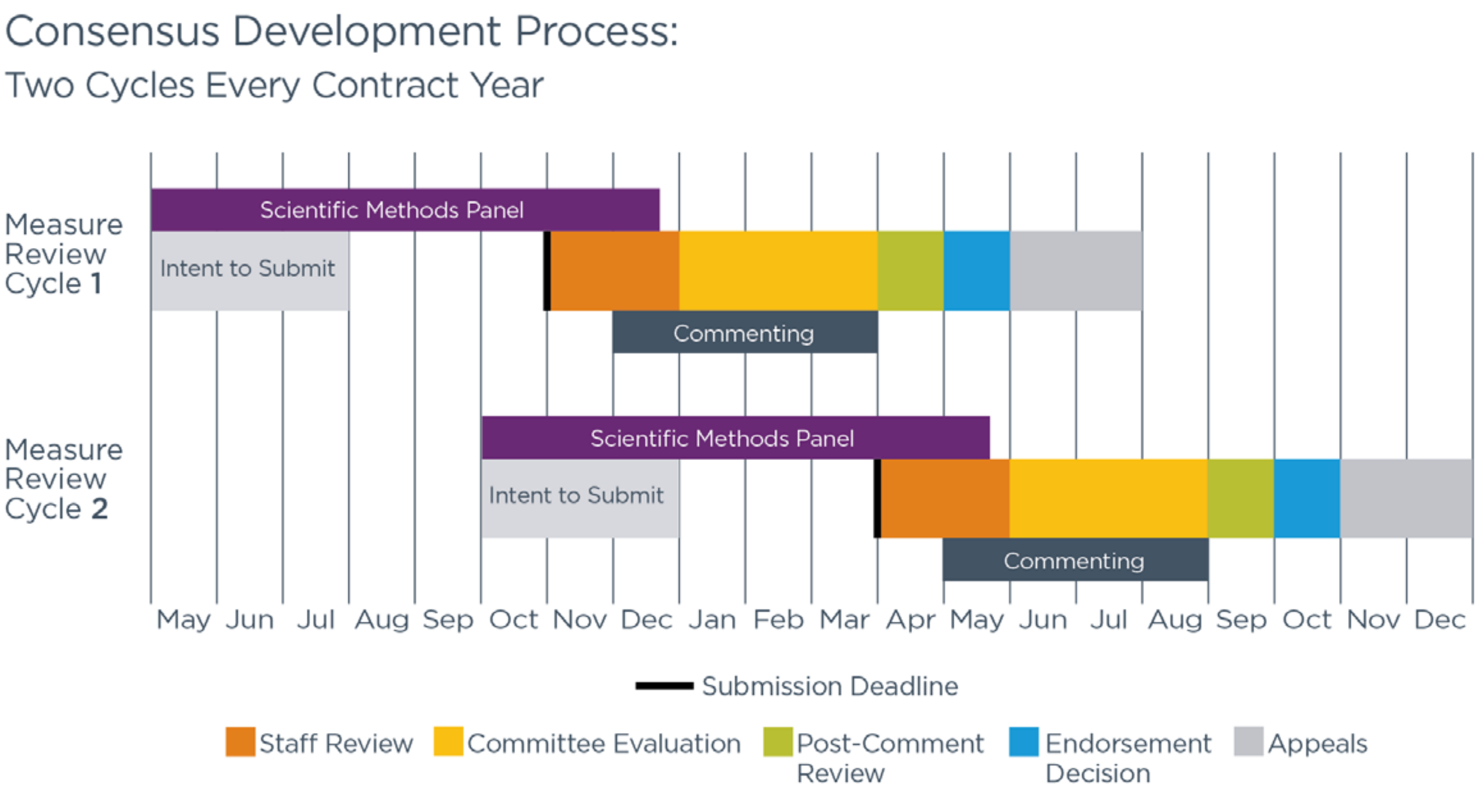
- **Performance Measure Endorsement**
  - *600+ NQF-endorsed measures across multiple clinical areas*
  - *15 empaneled standing expert committees*
- **Measure Applications Partnership (MAP)**
  - *Advises HHS on selecting measures for 20+ federal programs, Medicaid, and health exchanges*
- **National Quality Partners**
  - *Convenes stakeholders around critical health and healthcare topics*
  - *Spurs action: recent examples include antibiotic stewardship, advanced illness care, shared decision-making, and opioid stewardship*
- **Other Activities**
  - *Convenes private and public sector leaders to reach consensus on complex issues in healthcare performance measurement*
    - Examples include HCBS, rural issues, telehealth, interoperability, attribution, diagnostic accuracy, disparities, ED transitions

NQF Consensus Development Process (CDP)

6 Steps for Measure Endorsement

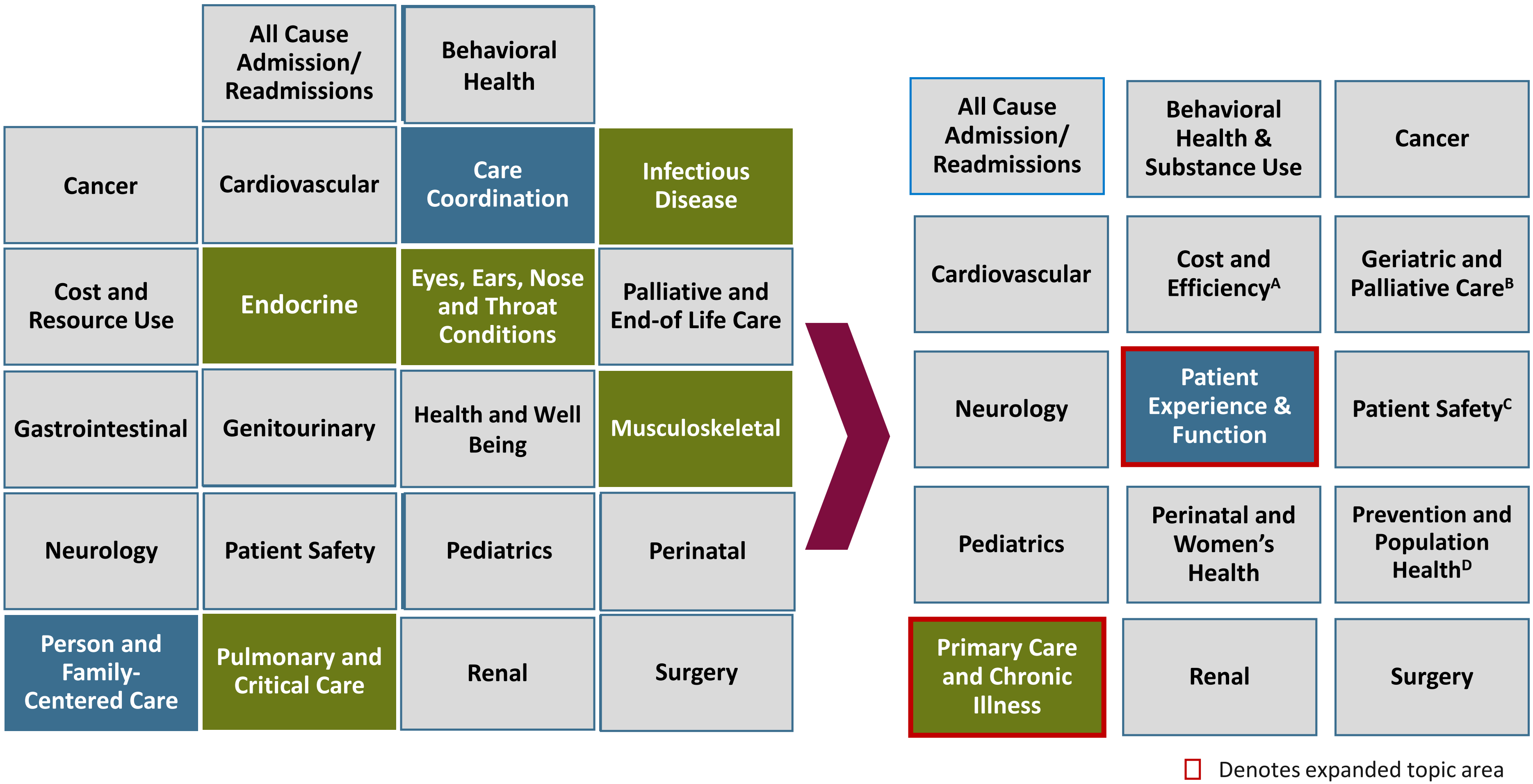
- Intent to Submit
- Call for Nominations
- Measure Review
  - *New structure/process*
  - *Newly formed NQF Scientific Methods Panel*
  - *Measure Evaluation Technical Report*
- Public Commenting Period with Member Support
- Measure Endorsement
- Measure Appeals

Measure Review: Two Cycles Per Year



NQF CDP Measurement Review Cycles 1 and 2

15 New Measure Review Topical Areas



[A] Cost & Efficiency will include efficiency-focused measures from other domains
[B] Geriatric & Palliative Care includes pain-focused measures from other domains
[C] Patient Safety will include acute infectious disease and critical measures
[D] Prevention and Population Health is formerly Health and Well Being

Graphic showing the reduction of the former 22 CDP topical areas into 15 topical areas

Role of the Standing Committee
General Duties

- Act as a proxy for the NQF multistakeholder membership
- Serve 2-year or 3-year terms
- Work with NQF staff to achieve the goals of the project
- Evaluate candidate measures against the measure evaluation criteria
- Respond to comments submitted during the review period
- Respond to any directions from the Consensus Standards Approval Committee (CSAC)

Role of the Standing Committee Measure Evaluation Duties

- All members evaluate ALL measures
- Evaluate measures against each criterion
  - *Indicate the extent to which each criterion is met and rationale for the rating*
- Make recommendations to the NQF membership for endorsement
- Oversee Perinatal portfolio of measures
  - *Promote alignment and harmonization*
  - *Identify gaps*

Role of the Standing Committee Co-Chairs

- Co-facilitate Standing Committee (SC) meetings
- Work with NQF staff to achieve the goals of the project
- Assist NQF in anticipating questions and identifying additional information that may be useful to the SC
- Keep SC on track to meet goals of the project without hindering critical discussion/input
- Represent the SC at CSAC meetings
- Participate as a SC member

Role of NQF Staff

- NQF project staff works with SC to achieve the goals of the project and ensure adherence to the consensus development process:
  - *Organize and staff SC meetings and conference calls*
  - *Guide the SC through the steps of the CDP and advise on NQF policy and procedures*
  - *Review measure submissions and prepare materials for Committee review*
  - *Draft and edit reports for SC review*
  - *Ensure communication among all project participants (including SC and measure developers)*
  - *Facilitate necessary communication and collaboration between different NQF projects*

Role of NQF Staff
Communication

- Respond to NQF member or public queries about the project
- Maintain documentation of project activities
- Post project information to NQF's website
- Work with measure developers to provide necessary information and communication for the SC to fairly and adequately evaluate measures for endorsement
- Publish final project report

Role of Methods Panel

- Scientific Methods Panel created to ensure higher-level and more consistent reviews of the scientific acceptability of measures
- The Methods Panel is charged with:
  - *Conducting evaluation of complex measures for the Scientific Acceptability criterion, with a focus on reliability and validity analyses and results*
  - *Serve in advisory capacity to NQF on methodologic issues, including those related to measure testing, risk adjustment, and measurement approaches.*
- The Methods Panel review will help inform the standing committee's endorsement decision. The Panel will not render endorsement recommendations.

NQF Consensus Development Process (CDP) Measure Evaluation

Complex Measures

- **Outcome measures, including intermediate clinical outcomes**
- **Instrument-based measures (e.g., PRO-PMs)**
- **Cost/resource use measures**
- **Efficiency measures (those combining concepts of resource use and quality)**
- **Composite measures**

Noncomplex Measures

- **Process measures**
- **Structural measures**
- **Previously endorsed complex measures with no changes/updates to the specifications or testing**

Role of the Expert Reviewers

- In 2017, NQF executed a CDP redesign that resulted in restructuring and reducing the number of topical areas as well as a bi-annual measure review process

- Given these changes, there is a need for diverse yet specific expertise to support longer and continuous engagement from standing committees

Role of the Expert Reviewers

- The expert reviewer pool serves as an adjunct to NQF standing committees to ensure broad representation and provide technical expertise when needed
- Expert reviewers will provide expertise as needed to review measures submitted for endorsement consideration by:
  - *Replacing an inactive committee member;*
  - *Replacing a committee members whose term has ended; or*
  - *Providing expertise that is not currently represented on the committee.*
- Expert reviewers may also:
  - *Provide comments and feedback on measures throughout the measure review process*
  - *Participate in strategic discussions in the event no measures are submitted for endorsement consideration*

Questions

Overview of NQF’s Perinatal Portfolio

Perinatal Portfolio of Measures

- This project will evaluate measures related to Perinatal and Women's Health that can be used for accountability and public reporting for all populations and in all settings of care. The first phase of this project will review the following measure:
  - *3327 Cesarean Birth*
- NQF currently has 18 endorsed measures within the area of perinatal care and women's health. Endorsed measures undergo periodic evaluation to maintain endorsement – "maintenance".

Portfolio of NQF-Endorsed Perinatal and Women's Health Measures

Reproductive Health
- 0033: Chlamydia Screening in Women (CHL)
- 2903: Contraceptive Care – Most & Moderately Effective Methods
- 2902: Contraceptive Care – Postpartum
- 2904: Contraceptive Care – Access to LARC (Long Acting Reversible Contraception)

Labor and Delivery
- 0469: PC-01 Elective Delivery
- 0469:2829: PC-01 Elective Delivery [eMeasure]
- 0470: Incidence of Episiotomy
- 0471: PC-02 Cesarean Section

Labor and Delivery: High-Risk Pregnancy
- 0476: PC-03 Antenatal Steroids

Newborn
- 0716: Unexpected Complications in Term Newborns
- 0475: Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Center Discharge

Portfolio of NQF-endorsed Perinatal and Women's Health Measures (cont.)

Newborn: Premature/Low Birthweight

- 1382: Percentage of low birthweight births
- 0304: Late sepsis or meningitis in Very Low Birth Weight (VLBW) neonates (risk-adjusted)
- 0478: Neonatal Blood Stream Infection Rate (NQI #3)
- 1731: PC-04 Health Care-Associated Bloodstream Infections in Newborns
- 0483: Proportion of infants 22 to 29 weeks gestation screened for retinopathy of prematurity

Postpartum

- 0480: PC-05 Exclusive Breast Milk Feeding
- 0480:2830: PC-05 Exclusive Breast Milk Feeding [eMeasure]

Standing Committee Activities

Meeting	Date/Time
Orientation Call & QA Call	Friday, December 8, 2017, 12-2pm ET
Measure Evaluation Web Meeting	Friday, January 26, 2018, 12-2pm ET
Post-Meeting Conference Call	Friday, February 9, 2018, 12-2pm ET
Post Draft Report Comment Call	Friday, April 27, 2018, 12-2pm ET

Questions

Measure Evaluation Criteria Overview

NQF Measure Evaluation Criteria for Endorsement

NQF endorses measures for accountability applications (public reporting, payment programs, accreditation, etc.), as well as quality improvement.

- Standardized evaluation criteria
- Criteria have evolved over time in response to stakeholder feedback
- The quality measurement enterprise is constantly growing and evolving – greater experience, lessons learned, expanding demands for measures – the criteria evolve to reflect the ongoing needs of stakeholders

Major Endorsement Criteria *(page 20)*

- ***Importance to measure and report**: Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where this is variation in or overall less-than-optimal performance (**must-pass**)*

- ***Scientific Acceptability of the Measure Properties: Reliability and Validity**: Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented (**must-pass**)*

- ***Feasibility**: Extent to which the specifications, including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement*

- ***Usability and Use**: Extent to which potential audiences are using or could use performance results for both accountability and performance improvement to achieve high quality care (**Use is must-pass**)*

- ***Comparison to related or competing measures***

Criterion #1: Importance to Measure and Report (page 30-38)

1. **Importance to measure and report -** Extent to which the specific measure focus is evidence-based and important to making significant gains in healthcare quality where there is variation in or overall less-than-optimal performance.

   1a. Evidence: *the measure focus is evidence-based*

   1b. Opportunity for Improvement: *demonstration of quality problems and opportunity for improvement, i.e., data demonstrating considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or disparities in care across population groups*

   1c. Quality construct and rationale *(composite measures only)*

Subcriteron 1a: Evidence (page 31-37)

- Outcome measures
  - *A rationale (which often includes evidence) for how the outcome is influenced by healthcare processes or structures.*
- Structure, process, intermediate outcome measures
  - *The quantity, quality, and consistency of the body of evidence underlying the measure should demonstrate that the measure focuses on those aspects of care known to influence desired patient outcomes*
    - » Empirical studies (expert opinion is not evidence)
    - » Systematic review and grading of evidence
      - *Clinical Practice Guidelines – variable in approach to evidence review*

Evidence (subcriterion 1a): Strengthen requirements for outcome measures

- **Revised criterion**
  - *For all outcomes: Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias.*
  - *For measures derived from patient report, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful.*
    - Additional guidance: Examples of such evidence include, but are not limited to, patient input in the development of the instrument, survey, or tool; focus group input regarding the value of the performance measure derived from the instrument/survey/tool.

Evidence (subcriterion 1a): Additional guidance for instrument-based measures

- Current requirements for structure and process measures (i.e., a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence that the measured structure/process leads to a desired health outcome) also apply to patient-reported structure/process measures.

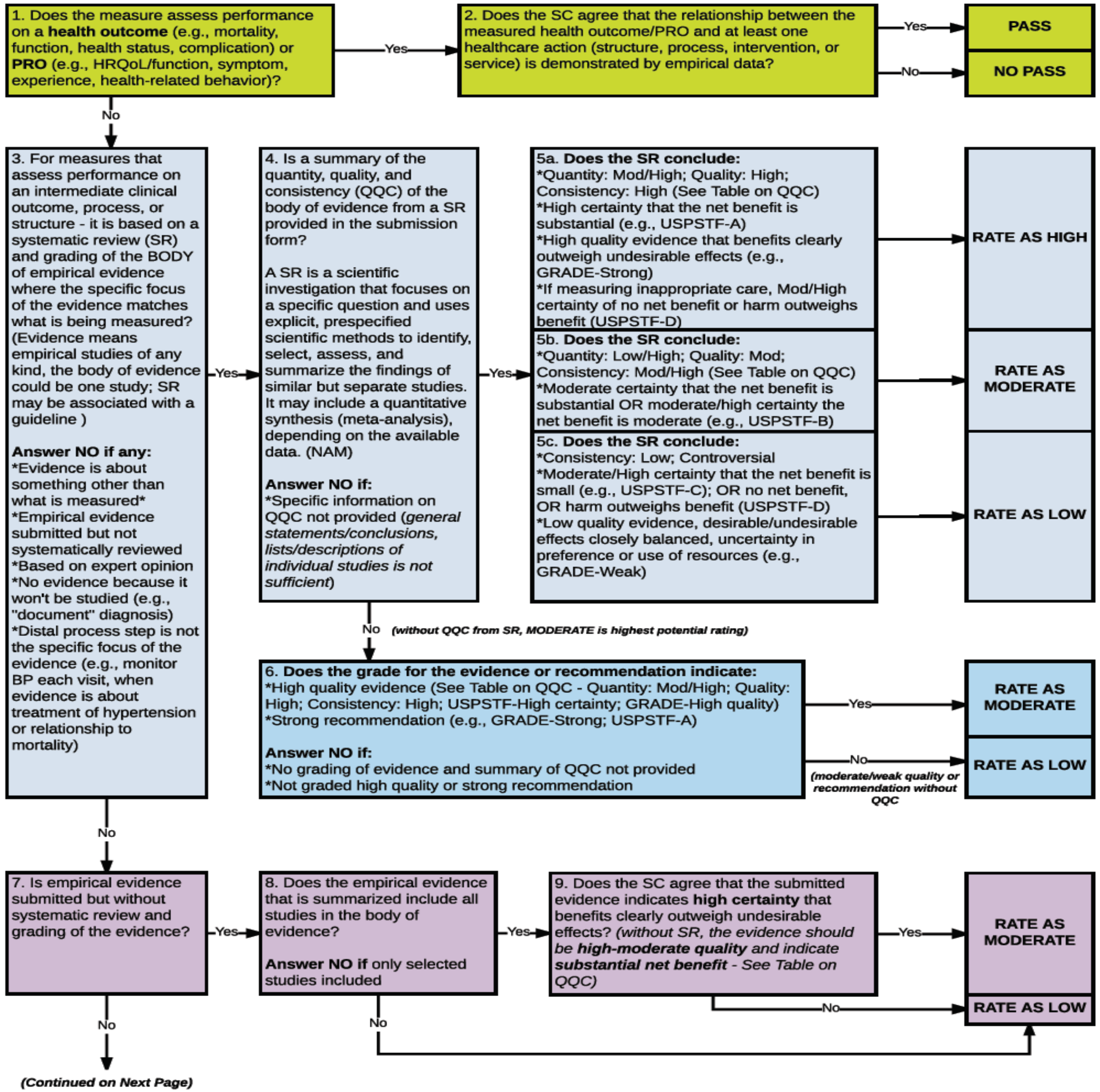
Evidence (subcriterion 1a): Additional guidance for thresholds and timeframes

- Evidence for specific timeframes or thresholds included in a measure should be presented. If evidence is limited, then literature regarding standard norms would be considered.

Performance Gap (subcriterion 1b): Additional guidance

- For maintenance measures
  - *Measure stewards are expected to provide current performance data. If limited data are available (e.g., use is voluntary), data from the literature can be considered.*

Rating Evidence: Algorithm #1 – page 34



Criterion #1: Importance to measure and report Criteria emphasis is different for new vs. maintenance measures

New measures	Maintenance measures
• Evidence – Quantity, quality, consistency (QQC) • Established link for process measures with outcomes	**DECREASED EMPHASIS**: Require measure developer to attest evidence is unchanged evidence from last evaluation; Standing Committee to affirm no change in evidence IF changes in evidence, the Committee will evaluate as for new measures
• Gap – opportunity for improvement, variation, quality of care across providers	**INCREASED EMPHASIS**: data on current performance, gap in care and variation

Criterion #2: Reliability and Validity– Scientific Acceptability of Measure Properties (page 39 - 49)

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of health care delivery

2a. **Reliability (must-pass)**

2a1. Precise specifications including exclusions
2a2. Reliability testing—data elements or measure score

2b. **Validity (must-pass)**

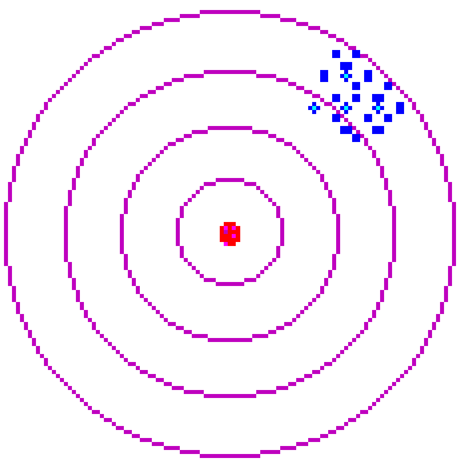
2b1. Specifications consistent with evidence
2b2. Validity testing—data elements or measure score
2b3. Justification of exclusions—relates to evidence
2b4. Risk adjustment—typically for outcome/cost/resource use
2b5. Identification of differences in performance
2b6. Comparability of data sources/methods
2b7. Missing data

Reliability (subcriterion 2a): Potential for additional guidance

- Establishing thresholds for testing results
  - *NQF will ask our newly-formed Scientific Methods Panel for input on norms and/or rules of thumb*

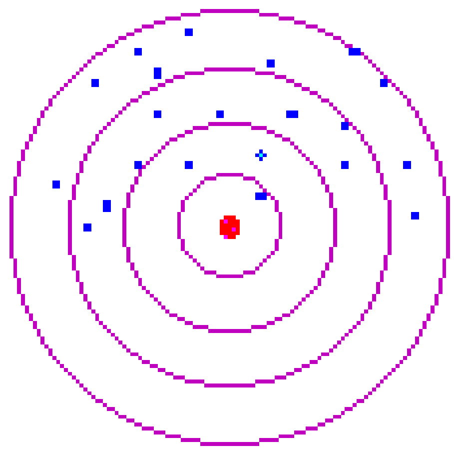
Reliability and Validity (page 40)

Assume the center of the target is the true score…



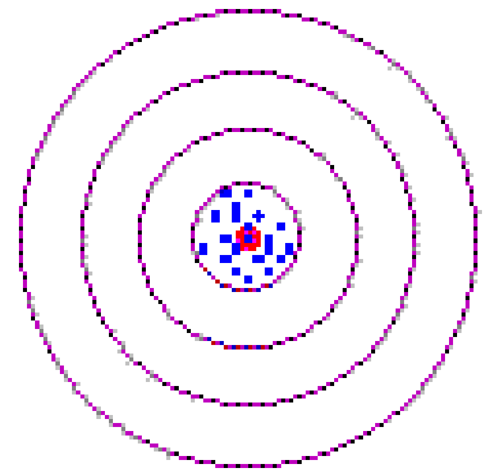
Reliable
Not Valid

Consistent,
but wrong



Neither Reliable
Nor Valid

Inconsistent &
wrong



Both Reliable
And Valid

Consistent &
correct

Measure Testing – Key Points (page 41)

Empirical analysis to demonstrate the reliability and validity of the *measure as specified,* including analysis of issues that pose threats to the validity of conclusions about quality of care such as exclusions, risk adjustment/stratification for outcome and resource use measures, methods to identify differences in performance, and comparability of data sources/methods.

Reliability Testing
Key points - page 42

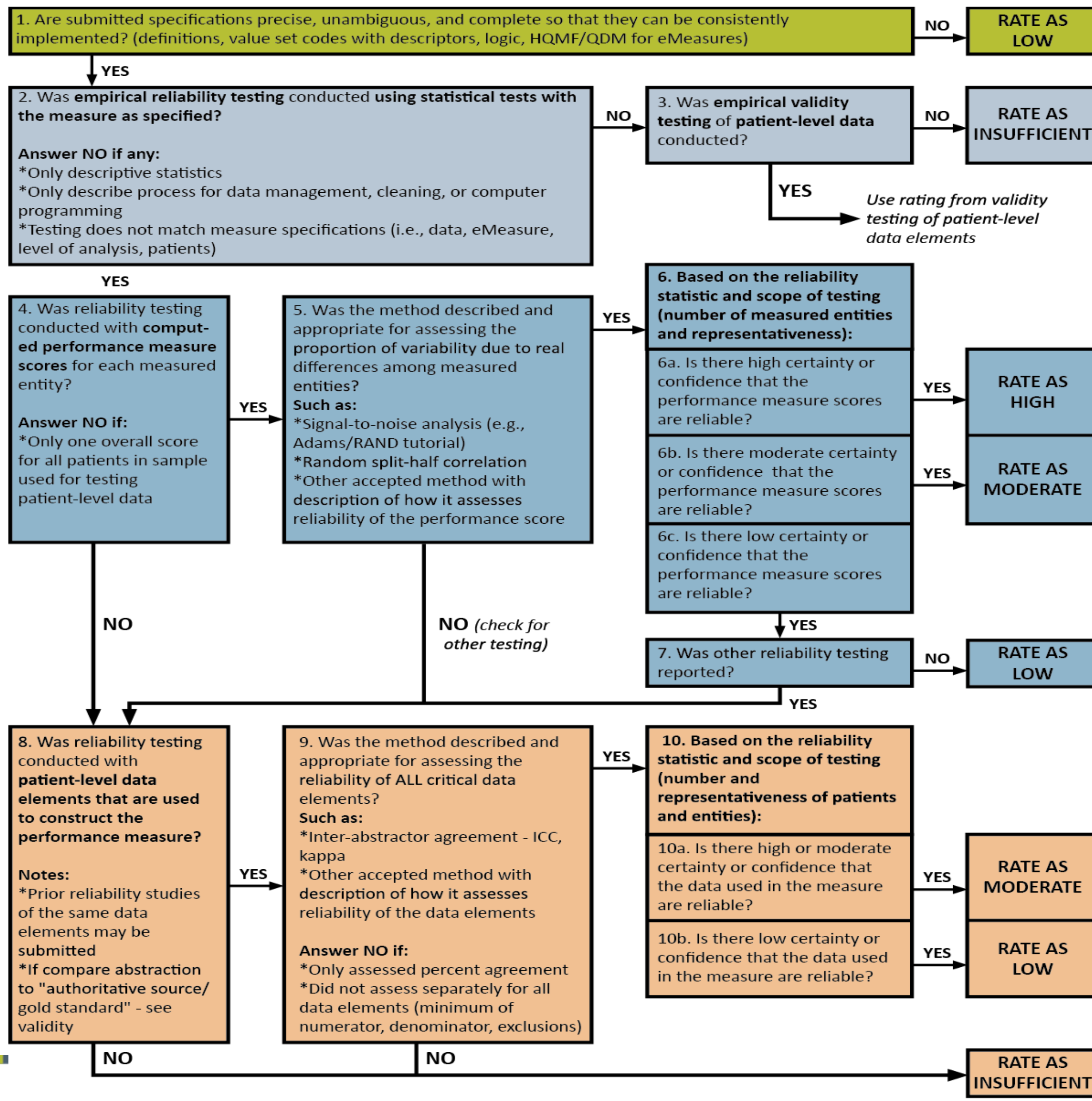
- Reliability of the ***measure score*** refers to the proportion of variation in the performance scores due to systematic differences across the measured entities in relation to random variation or noise (i.e., the precision of the measure).
  - *Example - Statistical analysis of sources of variation in performance measure scores (signal-to-noise analysis)*

- Reliability of the ***data elements*** refers to the repeatability/reproducibility of the data and uses patient-level data
  - *Example –inter-rater reliability*

- Consider whether testing used an appropriate method and included adequate representation of providers and patients and whether results are within acceptable norms

- Algorithm #2

Rating Reliability: Algorithm #2 – page 43



Validity testing (pages 44 - 49) Key points – page 47

- **Empirical testing**
  - *Measure score* – assesses a hypothesized relationship of the measure results to some other concept; assesses the correctness of conclusions about quality
  - *Data element* – assesses the correctness of the data elements compared to a "gold standard"
- **Face validity**
  - *Subjective determination by experts that the measure appears to reflect quality of care*

Validity (subcriterion 2b): Remove "evidence aligns with specifications"

- Subcriterion 2b.1 now removed
  - *The measure specifications are consistent with the evidence presented to support the focus of measurement under criterion 1a. The measure is specified to capture the most inclusive target population indicated by the evidence, and exclusions are supported by the evidence.*

- Evidence now considered as part of subcriterion 1a

Validity (subcriterion 2b): Strengthen guidance for face validity

- **Revised guidance**
  - *Empirical validity testing is expected at time of maintenance review; if not possible, justification is required.*
  - *Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.*

Validity (subcriterion 2b): Exclusions criterion re-worded

- **Revised criterion**
  - *Exclusions are supported by the clinical evidence and are of sufficient frequency to warrant inclusion in the specifications of the measure*
    - *Previous wording:* Exclusions are supported by the clinical evidence; otherwise, they are supported by evidence of sufficient frequency of occurrence so that results are distorted without the exclusion

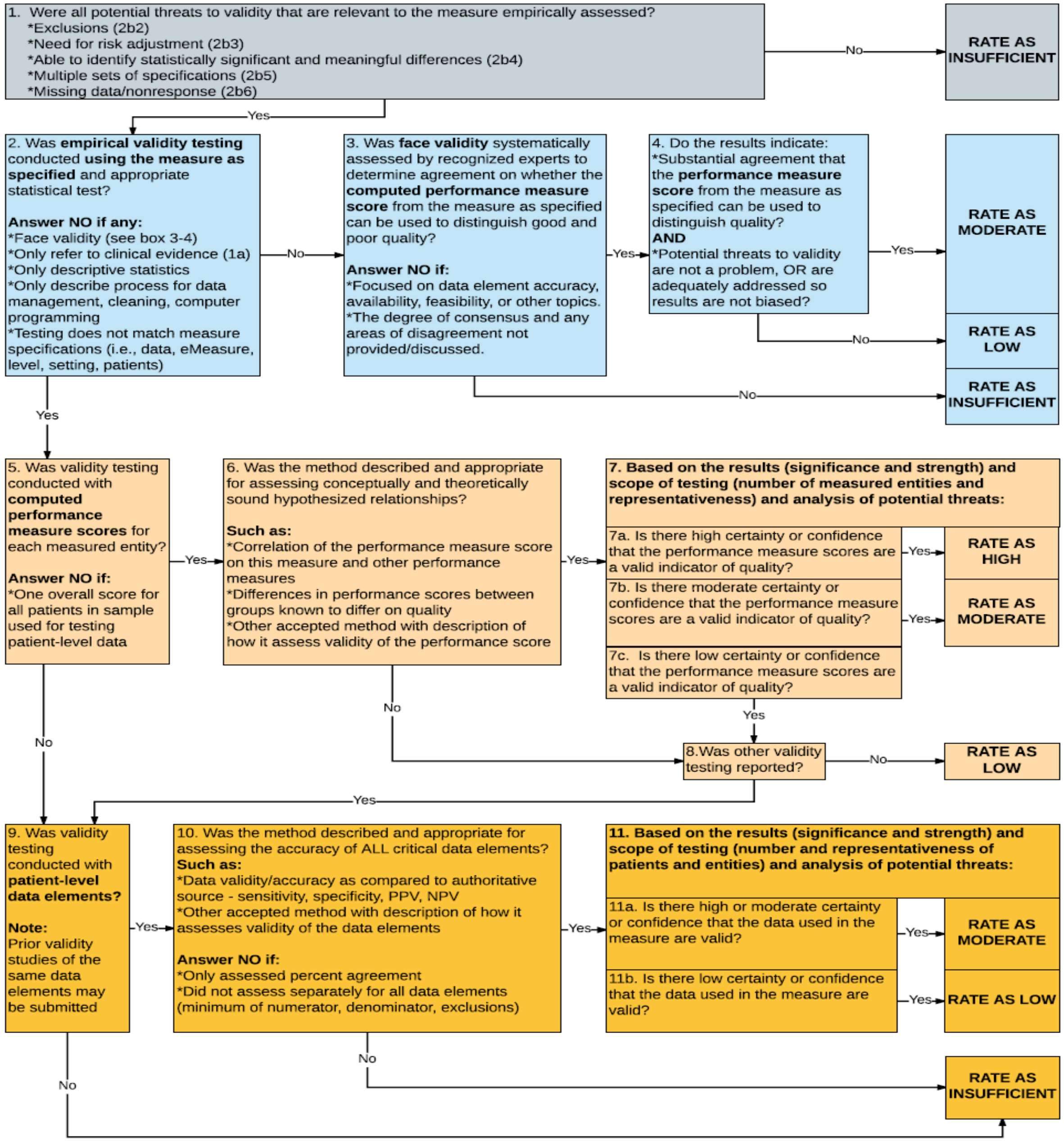
- Potential for updated guidance
  - *Will ask NQF's newly-formed Scientific Methods Panel for input on what might be sufficient frequency and how to handle non-uniformity of frequency across providers*

Validity (subcriterion 2b): Missing data requirement (2b.7) applicable to all measures

- Revised criterion
  - *Analyses identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias.*

    - *Previous criterion*: For **eMeasures, composites, and PRO-PMs** (or other measures susceptible to missing data), analyses identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias.

Rating Validity: Algorithm #3 – page 48



Threats to Validity

- Conceptual
  - *Measure focus is not a relevant outcome of healthcare or not strongly linked to a relevant outcome*
- Unreliability
  - *Generally, an unreliable measure cannot be valid*
- Patients inappropriately excluded from measurement
- Differences in patient mix for outcome and resource use measures
- Measure scores that are generated with multiple data sources/methods
- Systematic missing or “incorrect” data (unintentional or intentional)

Criterion #2: Scientific Acceptability

New measures	Maintenance measures
• Measure specifications are precise with all information needed to implement the measure	NO DIFFERENCE: Require updated specifications
• Reliability • Validity (including risk-adjustment)	**DECREASED EMPHASIS**: If prior testing adequate, no need for additional testing at maintenance with certain exceptions (e.g., change in data source, level of analysis, or setting) Must address the questions for SDS Trial Period

Criterion #3: Feasibility (page 49)
Key Points – page 50

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

3a: Clinical data generated during care process
3b: Electronic sources
3c: Data collection strategy can be implemented

Criterion #4: Usability and Use (page 50)
Key Points – page 51

Extent to which potential audiences (e.g., consumers, purchasers, providers, policymakers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a: Accountability and Transparency: Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement

4b: Improvement: Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated

4c: Benefits outweigh the harms: The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4d: Vetting by those being measured and others: Those being measured have been given results and assistance in interpreting results; those being measured and others have been given opportunity for feedback; the feedback has been considered by developers.

Usability and Use: Now partly must-pass for maintenance measures

- Use: Change to must-pass for maintenance measures
  - *In use in accountability program within 3 years and publicly reported within 6 years*
  - *Measure has been vetted by those being measured or others*
- Usability*: still not must-pass
  - *Demonstrated improvement*
  - *Benefits outweigh evidence of unintended negative consequences to patients*

* Information for these two subcriteria may be obtained via literature, feedback to NQF, and from developers during the submission process.

Criteria #3-4: Feasibility and Usability and Use

New measures	Maintenance measures
Feasibility	
• Measure feasible, including eMeasure feasibility assessment	NO DIFFERENCE: Implementation issues may be more prominent
Usability and Use	
• Use: used in accountability applications and public reporting	**INCREASED EMPHASIS**: Much greater focus on measure use and usefulness, including both impact and unintended consequences
• Usability: impact and unintended consequences	

Updated guidance for measures that use ICD-10 coding: Fall 2017 and 2018

- Gap can be based on literature and/or data based on ICD-9 or ICD-10 coding
- Submit updated ICD-10 reliability testing if available; if not, testing based on ICD-9 coding will suffice
- Submit updated validity testing
  - *Submit updated empirical validity testing on the ICD-10 specified measure, if available*
  - *OR face validity of the ICD-10 coding scheme plus face validity of the measure score as an indicator of quality*
  - *OR face validity of the ICD-10 coding scheme plus score-level empirical validity testing based on ICD-9 coding*
  - *OR face validity of the ICD-10 coding scheme plus data element level validity testing based on ICD-9 coding, with face validity of the measure score as an indicator of quality due at annual update*

Best practices for ICD-10 coding

- Use team of clinical and coding experts to identify specific areas where questions of clinical comparability exist, evaluate consistency of clinical concepts, and ensure appropriate conversion
- Determine intent
- If desired, use appropriate conversion tool
  - *Not required, but also not sufficient by itself*
  - *If using conversion tool, consider both forward and backward mapping*

Best practices for ICD-10 coding (continued)

- Assess for material change, if possible
  - *Assess extent to which the population identified with the new code set overlaps with that identified in the old code set*
  - *Assess whether the conversion results in rates that are similar within defined tolerances; options include:*
    - » Test using dual-coded data if possible OR
    - » Face validity (using the above code-conversion process, including use of clinical/coding experts) OR
    - » Criterion validity (if dual-coded data not available) OR
    - » Consistency across time (pre/post conversion)
- Solicit stakeholder comments

eMeasures

- “Legacy” eMeasures
  - *Beginning September 30, 2017, all respecified measure submissions for use in federal programs will be required to use the same evaluation criteria as respecified measures – the “BONNIE testing only” option will no longer meet endorsement criteria*
- For all eMeasures: Reliance on data from structured data fields is expected; otherwise, unstructured data must be shown to be both reliable and valid

Criterion #5: Related or Competing Measures (page 51-52)

If a measure meets the four criteria <u>and</u> there are endorsed/new related measures (same measure focus <u>or</u> same target population) or competing measures (both the same measure focus <u>and</u> same target population), the measures are compared to address harmonization and/or selection of the best measure.

- 5a. The measure specifications are harmonized with related measures **OR** the differences in specifications are justified.
- 5b. The measure is superior to competing measures (e.g., is a more valid or efficient way to measure) **OR** multiple measures are justified.

Evaluation Process

- **Preliminary analysis (PA)**: To assist the Committee evaluation of each measure against the criteria, NQF staff and Methods Panel (if applicable) will prepare a PA of the measure submission and offer preliminary ratings for each criteria.
  - *The PA will be used as a starting point for the Committee discussion and evaluation*
  - *Methods Panel will complete review of Scientific Acceptability criterion for complex measures*
- **Individual evaluation**: Each Committee member conducts an in-depth evaluation on all measures (responses collected via SurveyMonkey
  - *Each Committee member will be assigned a subset of measures for which they will serve as lead discussant in the evaluation meeting.*

Evaluation Process

- **Measure evaluation and recommendations at the in-person/web meeting**: The entire Committee discusses and rates each measure against the evaluation criteria and makes recommendations for endorsement.
- **Staff will prepare a draft report** detailing the Committee's discussion and recommendations
  - *This report will be released for a 30-day public and NQF member comment period*
- **Post-comment call**: Committee re-convenes for a post-comment call to discuss comments submitted
- **Final endorsement decision by the CSAC**
- **Appeals** (if any)

Questions

SharePoint Overview

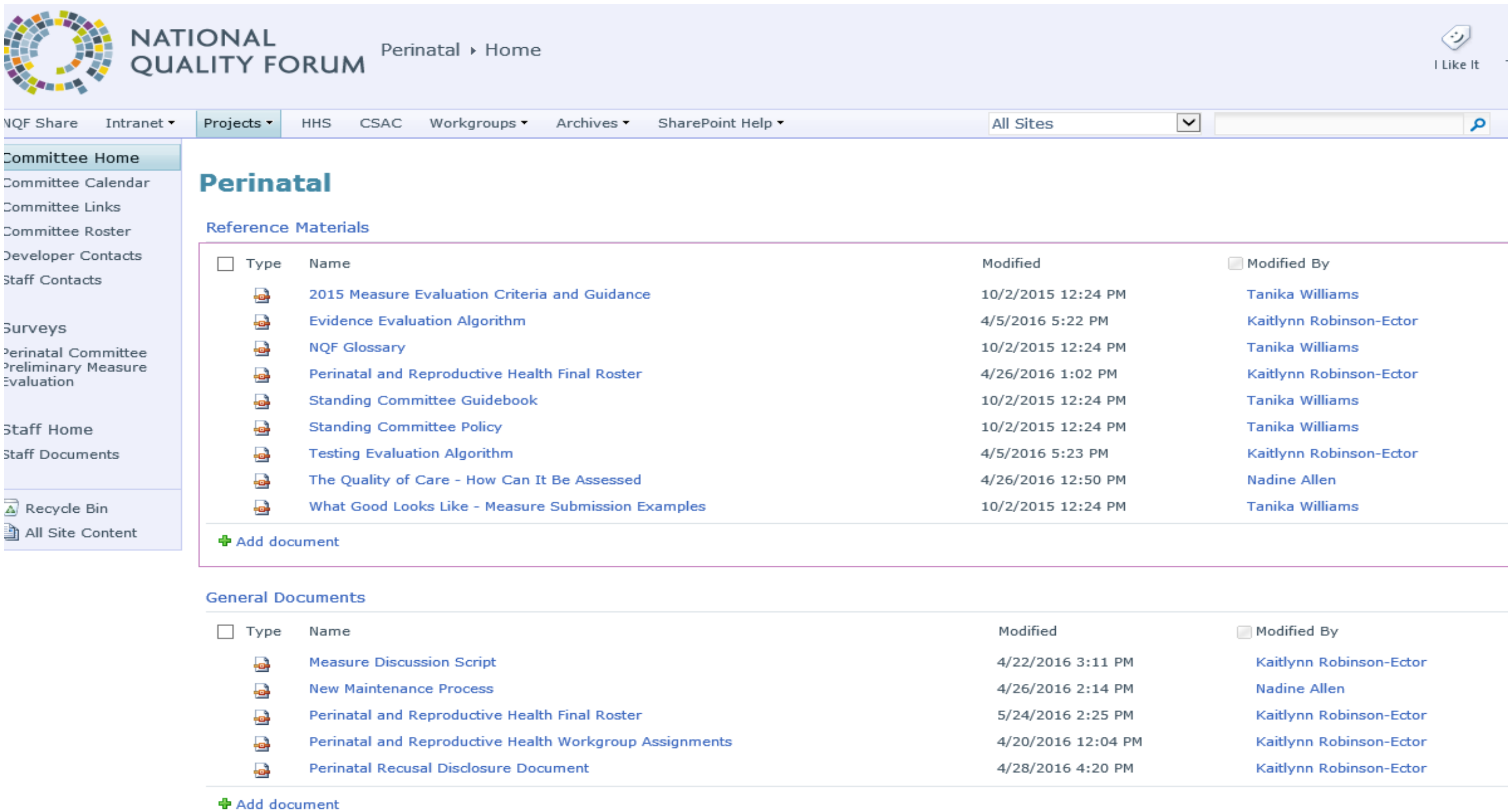
SharePoint Overview

http://share.qualityforum.org/Projects/Perinatal%202015/SitePages/Home.aspx

- Accessing SharePoint
- Standing Committee Policy
- Standing Committee Guidebook
- Measure Document Sets
- Meeting and Call Documents
- Committee Roster and Biographies
- Calendar of Meetings

SharePoint Overview

- **Screen shot of homepage:**



Screenshot of NQF Perinatal Committee SharePoint homepage

SharePoint Overview

- Please keep in mind:
- + and – signs :

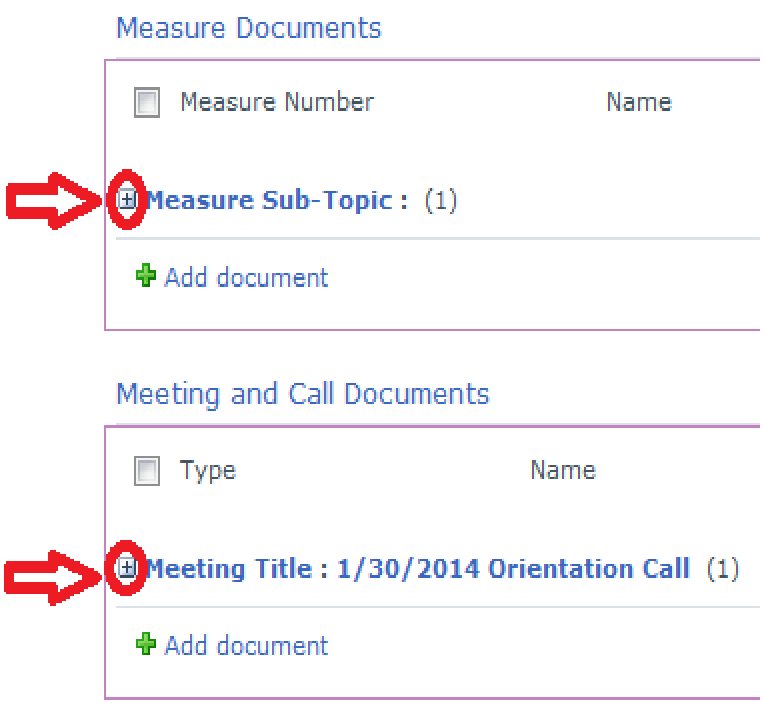


Image of SharePoint site not displaying nested documents

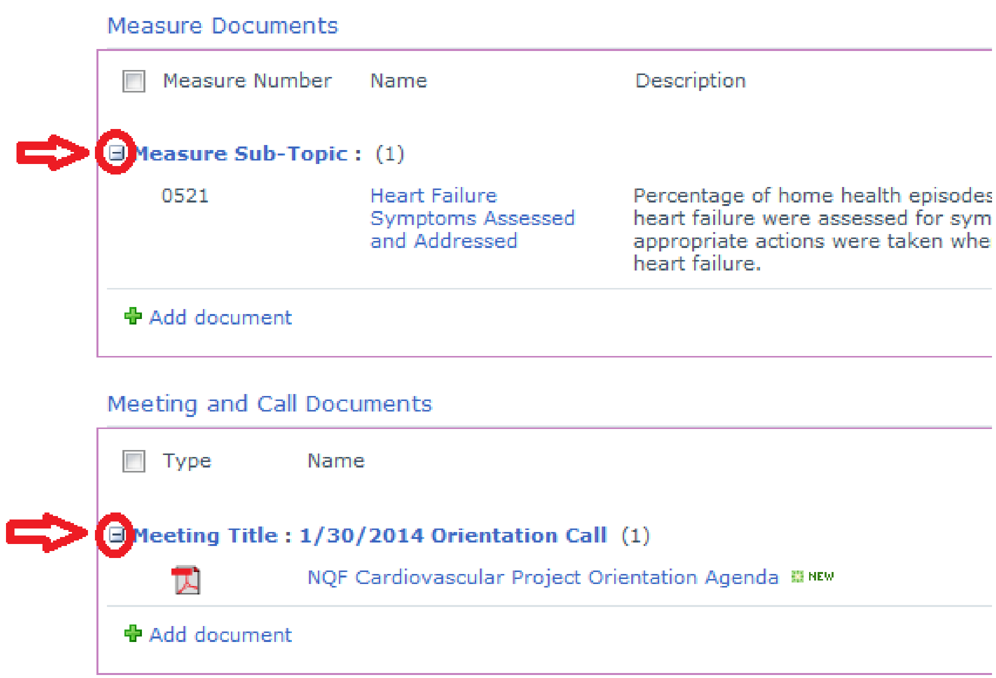


Image of SharePoint site displaying nested documents

Measure Worksheet and Measure Information

- Measure Worksheet
  - *Preliminary analysis, including eMeasure Technical Review if needed, and preliminary ratings*
  - *Member and public comments*
  - *Information submitted by the developer*
    - Evidence and testing attachments
    - Spreadsheets
    - Additional documents

Next Steps

- Measure submission and preliminary analysis sent to the Committee by January 1, 2018

- Measure Evaluation Web Person Meeting
  - *Friday, January 26, 2018, 12-2pm ET*

Project Contact Info

- Email: perinatal@qualityforum.org
- NQF phone: 202-783-1300
- Project page: http://www.qualityforum.org/Perinatal_and_Womens_Health.aspx
- SharePoint site: http://share.qualityforum.org/Projects/Perinatal%202015/SitePages/Home.aspx

Questions

THANK YOU