NATIONAL QUALITY FORUM

Moderator: Kim Patterson
February 7, 2020
1:00 am CT

Robyn Nishimi: Hey, it's Robyn.

Woman: Muted.

Suzanne Theberge: Hello.

((Crosstalk))

Woman: Holds on both nicely, yes, okay. So we will…

((Crosstalk))

Suzanne Theberge: Hi, this is NQF. We heard a few beeps. Has anyone other than Robyn joined? Hi, this is NQF.

Kimberly Gregory: Hi, it's Kim Gregory.

Suzanne Theberge: Great, thanks, Kim. We'll begin in…

Kimberly Gregory: So do we have both of these links opened at the same?

Suzanne Theberge: Yes, both the voting link which won't be - the votes won't be active yet. You won't be able to vote, but you'll need that link as well as the webinar.

Kimberly Gregory: And do we put our name in or - sort of screen name…

Suzanne Theberge: If it asks for a name, put in your name, yes.

Kimberly Gregory: Or actually you could skip it. It keeps on asking do you want this anonymous or not.

Suzanne Theberge: It's helpful if you can put in your name just so we know if we have any trouble figuring out how many votes, like if somebody is having trouble entering a vote and you know, that would help - that's helpful. But you also do not have to if you would rather not. We don't…

Kimberly Gregory: Yes.

Suzanne Theberge: It hides most of the names anyway. It's more for a troubleshooting.

Kimberly Gregory: Got it, okay.

Suzanne Theberge: Hi, this is NQF.

Tracy Flanagan: Hi, Tracy Flanagan.

Suzanne Theberge: Welcome. We'll be getting started soon.

Amy Bell: Hi, this is Amy Bell.

Suzanne Theberge: Welcome. This is Suzanne at NQF. We'll be getting started soon.

Danielle Hessler-Jones: Wonderful. This is Danielle Hessler-Jones from the UCSF Team. Thank you.

Suzanne Theberge: Great, great, thank you.

Christine Dehlendorf: And Suzanne, Christine Dehlendorf is on as well.

Suzanne Theberge: Great, thanks for letting us know you're here.

Carol Sakala: And hi, Carol just came on.

Suzanne Theberge: Great, awesome, everyone.

Deborah Kilday: Hi, it's Deb Kilday joining.

Suzanne Theberge: Great, thank you. Thanks to everyone who has joined so far. We'll be getting started pretty soon. Welcome, this is NQF. Who has joined?

Sheila Owens-Collins: Sheila Owens-Collins.

Martha Carter: This is Martha Carter. Sorry.

Suzanne Theberge: Great, thank you.

Kimberly Gregory: Could you please send me the text presentation email that I would like to vote, but I would via text according to Hannah. So could you send me that information?

Suzanne Theberge: Yes, we are working on that now, so we'll get that to you shortly.

Kimberly Gregory: Great, great. Okay, great. Thank you.

Martha Carter: Two of us answered. This is Martha Carter. Did you get - did you record my presence.

Suzanne Theberge: Yes, thank you. We'll be doing our formal roll call, but thanks for letting us know that you're here.

Martha Carter: Great, okay, then.

Suzanne Theberge: Yes, we'll do that once we get started. Hi, this is NQF. Thanks for joining. We'll be getting started shortly.

Rajan Wadhawan: Okay, this is Dr. Raj Wadhawan:

Suzanne Theberge: Great, thank you. Welcome, folks. We'll be getting started soon.

Woman: Thank you.

Suzanne Theberge: This is NQF. Thanks for joining. I heard several beeps. We'll be getting started in just a few minutes. Hi, everyone, thanks for joining. We'll be getting started very soon.

Woman: Yes, I don't know why because I - I don't know like affinity to the provider so that's why I was like - I felt like…

Suzanne Theberge: Everyone, we'll be getting started. Hi, everyone, we'll be getting started in just a few minutes.

Matthew Pickering: All right, well, good afternoon, everyone. Thank you very much for joining this web evaluation meeting for this fall 2019 cycle.

My name is Matthew Pickering. You see my name listed on the slide here. I will do some intros for the others on the slide here in a little bit. I'm the senior director here at NQF and overseeing this portfolio, and it's a pleasure of mine to be working with you all for this fall 2019 cycle.

Before we do get started, I just do want to make a quick sort of housekeeping type of reminder. If you could just remember to put your calls on mute if you are not speaking. Try not to put this call on hold even though that we all like to listen to that lovely hold music. I think we would just ask that you not put this call on hold so we can continue the call accordingly.

Also, if you are using the chat platform or, excuse me, the web platform, there is a chat feature that you can utilize and we will be monitoring chats that come in. So please feel free to use those if you'd rather, you know, use that and we will continue to address those.

And so we'll go on to the next slide here, so we'll just do some brief intros for those in the room here. You'll see some new names listed on here, myself in particular. So like I said, I'm the senior director here at NQF and working on this portfolio. I'll go to Hannah who's in the room with me.

Hannah Ingber: Hi, everyone. I'm Hannah Ingber. I'm the project analyst on this project and I'm really excited to hear about all your thoughts on the measure today.

Matthew Pickering: Thanks, Hannah.

Apryl Clark: Hi, this is Apryl Clark. I'm the acting vice president of quality measurement here at NQF.

Martha Carter: Thank you, Apryl. Suzanne?

Suzanne Theberge: Hi, everyone, this is Suzanne Theberge. I'm the senior project manager on the team. I'm delighted to be here with you today. Thank you. Robyn?

Robyn Nishimi: Hi, Robyn Nishimi. I'm the senior consultant for NQF. I'm pleased to have everyone on the call today.

Matthew Pickering: Great, thank you. And we'll just go to the next slide, so before I go to the agenda, I do also want to make sure I recognize our two co-chairs as well and give them an opportunity to give any welcoming remarks as they wish. So, Kim, Carol, would you like to introduce yourself and give any welcoming remarks?

Kimberly Gregory: Sure, I'm Kimberly…

Carol Sakala: Go ahead, Kim.

Kimberly Gregory: Okay, sure, I'm Kimberly Gregory and I want to thank everyone for joining and welcome our new members. It's exciting to actually have a new measure to review, and to thank the NQF and the committee members for all the pre- work that they've put in to this which hopefully will make this a pretty efficient process today.

Carol Sakala: And hi, this is Carol Sakala and I as well am delighted that we're getting to review a new measure. Thanks to our committee members and also to the volunteers who have offered to lead up our discussions. And also thanks to the developers for bringing us a measure for consideration.

Matthew Pickering: Great, thank you, Kim. Thank you, Carol. And again thank you all for your participation.

Being on this committee, you are being a proxy for NQF members. You bring a multi-stakeholder perspective to this conversation, and with that, we imagine there may be some disagreements and some conflicting opinions towards topics and issues, but we welcome those conversations and we do expect that there is some respect that is given to those types of conversations.

And so today what we are going to be talking about obviously is reviewing a measure that comes through for fall 2019. So we'll go through some introductions and some disclosures of interest with Apryl. She will be doing that here shortly.

And then we will dive into an overview of the evaluation process and that will be Suzanne who will be taking us through that as well as the consideration for the candidate measure. Our co-chairs will be facilitating that conversation. We also have some discussions that we'll be leading those conversations as well.

And then we will open it up for NQF member and public comment based on any conversation that we've had or if there are others from the public who'd like to share comments about the measure as well as - and then closing out with some next steps and then adjournment.

So with that, I will go ahead and turn it over to Apryl who is going to go through some introductions from you all and also some disclosures of interest. Apryl?

Apryl Clark: Thank you, Matt. So before I start, I just wanted to say a big thank you to our committee members. You volunteer your time to do a lot of, as the chairs have mentioned, pre-work to review the measure as well as to, you know, sit here in this meeting and talk through the measure.

We couldn't do our work without you. You've brought some amazing expertise that helps us, you know, enhance our work and so I just wanted to sort of always start out with a big thank you for all of you and the work that you do.

We're going to combine introductions with disclosures of interest. You should have received a measure-specific disclosure of interest form from us. In that form, we asked you a number of questions about your professional activities. We'll ask you to orally disclose any information you provided that you believe is relevant to the committee. We are especially interested in grants, research, or consulting related to the committee's work.

Just a few reminders, you sit on this group as an individual. You do not represent the interest of your employer or anyone who may have nominated you for this committee. We are interested in your disclosures to both paid and unpaid activities that are relevant to the work in front of you.

Finally, just because you disclosed does not mean that you have a conflict of interest. We do oral disclosures in the spirit of openness and transparency

I will say I'm relatively new so I missed pronounced your name, please accept my apologies in advance. So starting with our co-chairs, we're going to ask everyone to state your name, who you're with and if you have anything to disclose. So starting with our co-chairs, Kim Gregory.

Kimberly Gregory: Yes, my name is Kimberly Gregory. I'm at Cedars-Sinai Medical Center. I have a PCORI grant on patient satisfaction with the birth experience and I receive funding from the NIH via the Institution of CTSI mechanism. I do not feel that I have any conflicts of interest with this measure.

Apryl Clark: Carol?

Carol Sakala: This is Carol Sakala, yes, and I work for the National Partnership for Women and Families, and I do not have any disclosures relating to this measure.

Apryl Clark: Great. So moving to our committee members, Jill Arnold? Matthew Austin?

Matthew Austin: Yes, good afternoon. This is Matt Austin. I'm with the Johns Hopkins, Armstrong Institute for Patient Safety and Quality. And the only disclosure I would probably want to offer is that I do sit on NQF's scientific methods panel and the subgroup I'm on actually did review these two measures as part of the validity and reliability assessment.

Apryl Clark: Okay, great. Jennifer Bailit?

Jennifer Bailit: Hi, I'm Jennifer Bailit. I'm with Case Western Reserve Universe and MetroHealth Medical Center. I have some funding through the NICHD Maternal-Fetal networks, but no conflicts with this measure.

Apryl Clark: Okay, great. Amy Bell?

Amy Bell: Hey, good afternoon. I'm Amy Bell. I work for Atrium Health as the assistant vice president for Performance Improvement and I have no conflicts of interest.

Apryl Clark: And I'm sorry, did you have any disclosures?

Amy Bell: I do not, no conflicts of interest.

Apryl Clark: Great. Martha Carter?

Martha Carter: Good afternoon. I retired a year ago as the CEO of FamilyCare Health Center. I'm currently a commissioner on the MACPAC, Medicaid and Chip Payment and Access Commission. I consult the HRSA for grant reviews and operational site visits. I have no conflicts on this measure.

Apryl Clark: Great. Tasha Cooper?

Tasha Cooper: Hi, Tasha Cooper, I'm with Cigna Healthcare. I don't have any disclosures or conflicts.

Apryl Clark: Great. Tracy Flanagan?

Tracy Flanagan: Hi, Tracy Flanagan, the director of Women's Health for Kaisser Permanente Northern California. I'm employed by the Permanente side and I have no disclosures.

Apryl Clark: Lisa Holtzclaw? Mambarambath Jaleel?

Mambarambath Jaleel: Hi, I'm Mambarambath Jaleel. I'm a neonatologist at UT Southwestern Medical Center. I have nothing to disclose.

Apryl Clark: Great. Diana Jolles? Deborah Kilday?

Deborah Kilday: Good afternoon, everyone. I am with Premier Healthcare Incorporated, managing Women, Infants and Children Services, and I have nothing to disclose. Thank you.

Apryl Clark: Sarah McNeil? Jennifer Moore?

Jennifer Moore: Hi, I'm Jennifer Moore. I am the executive director at the Institute for Medicare Innovation and also - and faculty at the University of Michigan Medical School in the Department of Obstetrics and Gynecology.

And my only disclosure is that six years ago when I worked in U.S. Department of Health and Human Services, I was part of the early federal workgroup to explore whether a dousing measure would be possible for the contraceptive care measures. But I have not been involved with this particular measure that is before us.

Apryl Clark: Great. Sarah Nathan?

Sarah Nathan: Yes, I'm with the University of California, San Francisco. I have a hosted grant right now nurse practitioners and nurses to be forensic - sexual assault forensic examiners. But I don't have any disclosures around this measure.

Apryl Clark: Great. Kristi Nelson? Sheila Owens-Collins?

Sheila Owens-Collins: Hi, I'm Sheila Owens-Collins. I'm also a neonatologist and I'm with Neonatal-Perinatal Consulting in Healthcare, and I have no disclosures to disclose.

Apryl Clark: Diana Ramos?

Diana Ramos: Hi, I'm Diana Ramos. I'm an OB-GYN and public health medical officer for the California Department of Public Health. The only information I should be sharing is that I am listed on the ERASE grant for maternal mortality for the state of California.

Apryl Clark: Okay, great. Sindhu Srinivas? Nan Strauss?

Nan Strauss: Hi, this is Nan Strauss with Every Mother Counts and I have no disclosures.

Apryl Clark: Great. Angeline Ti?

Angeline Ti: Hi, everyone. I am Angeline Ti. I am at Emory University as an assistant professor and I'm a family physician. I did disclose that I'm trained at UCSF under Dr. Dehlendorf during my family planning fellowship, but I had no involvement with this measure.

Apryl Clark: Okay, great. Rajan Wadhawan?

Rajan Wadhawan: Hey, this is Raj Wadhawan. I'm with AdventHealth in Orlando, neonatologist I the background I served as the CEO for Children's Hospital, Women's Hospital at AdventHealth. No relevant disclosures.

Apryl Clark: Okay, great. Is there anybody's name that I didn't call or anybody who has joined since we started the roll call? Okay, then I'd like to remind you that if

you believe that you have a conflict of interest anytime during the meeting, please speak up. You may do so in real-time during the call, or you can send a message via chat to your chairs or to anyone on the NQF staff.

If you believe that a fellow committee member may have a conflict of interest or behaving in a biased manner, you may point this out during the meeting and you can send a message to your chairs or the NQF staff.

Do you have any questions or anything you'd like to discuss based on the disclosures made today? I will take that as a no and turn it back over to Matt.

Matthew Pickering: Great. Thank you, Apryl. So, next, I'm going to hand it over to Suzanne who's going to walk us through the measure evaluation process and some of the inputs - excuse me, yes, I'll hand it over to Suzanne to go through this piece of it and then we'll hand it over to our co-chairs as well to go through our inputs to date and kick this off.

Suzanne Theberge: Great. Thanks, Matt. So before I begin, I would just ask, by our count, we have achieved quorum on this call, but if you do have to leave early, please let us know either verbally or via chat so that we can track on that and we'll know if we've lost quorum at any point.

So with that, I want to talk about what we'll be doing today and what we've done so far this cycle. As you may recall, from the orientation call, we did two measures submitted this cycle, two new measures, both were complex which I'll talk about more in a minute, and one passed our scientific methods panel review and did not.

So the NQF process has quite a few input into the standing committee's evaluation you all even get the measures. We have a methods panel that looks

at the scientific acceptability criteria for the measure, the reliability and the validity. We have a public and NQF member comment period in which people can submit comments on the measures.

And then on occasion although not for this project, we do have technical expert panel that may provide additional input on a clinical or other topical questions. And all of these other groups feed into your work, the standing committee, and you are the ones that make recommendations for endorsement after apply the evaluation criteria to each measure.

So as I mentioned, the two measures that we got for review this cycle were both outcome measures which means they are complex and they went through our methods panel. And there are a couple of different avenues depending on how the methods panel ranks the measure against our reliability and validity criteria.

And for measures that passed, as the PCCC measure did, it goes on to you. For measures where the methods panel didn't reach consensus, it also goes on to you for evaluation. And then for measures that don't pass our reliability or validity testing criteria, the developer receives feedback and we work with them to bring the measure back for review in another cycle. So we are hoping to have that infection measure come back at a later date for evaluation in the future.

The methods panel consists of individuals that have statistical and measurement methodology expertise. They help make sure that complex measures are evaluated consistently across NQF projects and they can provide some really expert input.

For the measures that we got this cycle, the PCCC measure got high on reliability and high on validity. But for 3528 which was the CDC/VON infection measure, they needed some additional work on the specifications to really ensure that the testing was sufficient, and so, as I said, we sent it back to them with feedback and we'll be working with them to bring that measure back in the future.

I will pause here and ask if there are any questions before we talk about the process, what we're going to do today. Okay, hearing none, I wanted to talk briefly about the endorsement criteria before we actually evaluate the measures today.

NQF has five major criteria. Importance to measure and report looks at whether a measure can help drive improvements in care and it's really a must-have criteria. You have to pass the sub-criteria in importance which are; evidence, is there evidence underlying the measure and evidence so providers can make changes and improve the care, or - and is there a gap, you know, either disparities in care? Is there a room for improvement in general performance? So those are both must-haves.

The next must-have criteria is the scientific acceptability and that’s made up of reliability and validity. The goal here is to make valid conclusions about the results of the measure. A measure must be reliable and valid in order to be useful and in order to be usable, and these two also must pass.

Next, we look at the feasibility, how easy is it for providers and facilities to report on a measure, what's the burden of data collection and analysis, et cetera.

And then we look at usability and use, how is the measure is being used or how is it planned for use, and how is feedback given to the people being measured as well as to the measure developer and the measure steward so that they can improve the measure.

And then once the measure has passed all of these criteria and is recommended for endorsement by the committee, we would look to see if there are any related or competing measures, measures that look at the same population and the same kind of topic area. And then we would, if needed, make a best-in-class recommendation at that point.

So you will be voting on each of these criteria throughout today's webinar. You'll discuss them and then vote. We did send out an email with a link to the voting Web site and we'll be doing a test vote shortly to make sure it works. We have actually - just late breaking news, there is now a mobile device voting so let us know if you are not at a computer. But we can accept votes via text or an app I guess.

But we will be voting and if you didn't get the voting webinar, let us - sorry, the voting link, let us know and we'll resend you that link for the committee members only to be clear.

So just a couple a brief ground rules, you know, in addition to the general things about putting your line on mute and all of that. You know, we do ask that you have reviewed the measures beforehand, that your recommendations are really solidly based in NQF criteria, and that you try to keep your comments concise and focused. We are - we do have to stop at queue and so, you know, we hope to get through everything today on the measure.

When we start the measure discussion, we will open it first to the measure developer that team from UCSF will give a very brief introduction to their measure and address any other comments they wish to based on your preliminary comments. And then we will turn it over to the lead discussant and discussant. They will be asked to open the discussion and kind of get things going. That portion of the meeting will be facilitated by the chairs.

And then once the lead discussant and the discussant have spoken, everyone else can chime in and you know, make your opinions heard and then ask questions to the developer as needed, and then we'll vote. And then we discuss and then vote on each criterion before moving on to the next one.

Again, we do have somebody assigned to be a lead discussant which is just getting everything started, refine it, and things flow more smoothly if someone is asked to be the first person to speak.

So now I'm going to just - it looks like we've got duplicate slide in here. But again we'll vote on evidence and then gaps, then reliability and validity. The committee may choose to discuss reliability or accepts the method panel recommendation.

We'll ask you to vote on whether or not you wish to accept the methods panel recommendation and if anybody wishes to have a discussion and voting, then we would do that and have you vote to make your recommendation which may or may not be the same as what the methods panel recommended.

The same for validity, you can either accept the methods panel rating of high or you can make - choose to make your own recommendation on that. We'll discuss and vote on feasibility, and then on usability and use, and then overall

suitability for endorsement. If the measure fails on any of these must-have criteria, then we would stop and it would not move forward.

We have 23 active members on the committee this cycle and so that means we need 16 people to vote. So if anybody leaves, please do let us know so that we can be assured of track consensus. For something to either pass or be recommended, it must receive greater than 60% of what we consider yes votes. Yes votes would either be passed or high and moderate combined.

And a measure fails if it gets less than 40% of yes votes. And then we also have what we call the gray zone or consensus not reached. Any measure that achieves between 40% and 60% of yes votes, meaning either pass or high plus moderate, if not - has not achieved consensus and that it's calculated based on the people that are on the call, so out of a denominator of 17 and that number also - the gray zone is inclusive of both 40% and 60%.

And if something do not reach consensus on the must-have criteria, we continue through the criteria and you do not vote on the overall recommendation for endorsement, but you would make that vote again and make that recommendation at the post-comment call later this spring.

So with that, I'm going to turn it over to Hannah. Yes?

Woman: Excuse me, Suzanne, before you go on, can you confirm the number of people on the call today?

Suzanne Theberge: By our count, we had 17. If any committee members have joined and did not do the introductions and disclosure of interest, let us know and we'll do another track once we start voting to see if anybody has joined.

((Crosstalk))

Woman: Thank you.

Suzanne Theberge: By our count, we are 17. All right, so I'm going to turn it over to Hannah for our voting test. Hannah?

Hannah Ingber: Thank you, Suzanne. So I will be opening the test shortly. You should follow the instructions in the email that we sent out with the voting link and put in an answer of yes please so that we can ensure that everyone is voting the right way. I will confirm once we have all the votes.

It appears we only have 13 votes. If there are individuals having trouble voting, please feel free to chat us or speak up.

Sheila Owens-Collins: Okay, this is Sheila Owens-Collins and I have - I'm using my phone and so I put yes in, and so I don't know if you got it. But then I got a message that I have to reply with A, B, or leave.

Hannah Ingber: So A is for yes and B is for no.

Sheila Owens-Collins: Okay, all right, I'll do that and you can see if you get it. You got it?

Hannah Ingber: Yes, thank you.

Sheila Owens-Collins: Great, okay.

Hannah Ingber: I'll read out to letters for the results - for the responses so it is clear for you. Thank you, Sheila. Okay, we have 17 so that's all the votes in. Thank you for conducting this test. I will hand it back to Suzanne.

Suzanne Theberge: Great. Thanks, everybody. So any other questions before we begin the measure evaluation for standing committee. All right, hearing none, I would turn it over the measure developers, the UCSF Team, to begin their presentation.

Christine Dehlendorf: Thank you so much, Suzanne. This is Christine Dehlendorf and I'm here with our team including Danielle Hessler-Jones who's a psychometrician who works on this measure with us.

So we're very grateful to you all for considering our measure, the Patient-Centered Contraceptive Counseling measure or PCCC as we've come to call it. And as we described in our application, the motivation for this measure grew out of the process of having previous measures endorsed by NQF related to contraceptive method provision high or moderately effective methods or LARC method.

And during - a few years ago, during the process of endorsement, the concern was raised about the possibility of this measure having an unintended consequence of incentivizing provider pressure towards specific method and discounting the importance of patient-centered counseling focused on patient's own needs, values, and preferences.

And the statement from the National Partnership for Women and Families which was submitted at that time in public comment summarizes well and it stated, "It is extremely important to keep in mind that reproductive coercion has a troubling history and remains an ongoing reality for many."

And then they went on to say, “We hope this measure will be paired with a woman-reported balancing measure of experience of receiving contraceptive care. Such a measure can be expected to help identify and/or check inappropriate pressure from the healthcare system.”

Importantly, however, we also want to note that this is not the only motivation for this measure, but it's also important to measure quality of care and experience for its own ethical reasons that it matters in and of itself, patient experience of care and that, in fact, PRO-PM, patient-reported outcome performance measure focused on continued experience are considered an outcome measure, not a process measure by NQF in accordance with the recognition of the importance of patient experience.

So the process of the NQF endorsement of the previous measure was us receiving funding to develop a PRO-PM on Patient-Centered Contraceptive Counseling. We built on work that we had previously done for research-based measure that had been grounded in qualitative work we've done with patients about their priorities and preferences for contraceptive counseling, including the three domains that they identified as being important; interpersonal connection between healthcare provider and patient, support in the contraceptive decision-making process, and adequate information to make the decision.

We worked extensively to enhance feasibility of using this is a PRO-PM by reducing this from 11 measures - 11 items to 4 items that represented patients’ own values and preferences using qualitative and quantitative data. I will note that the four items that we ultimately ended up with when we placed this through a reading level evaluation with the third grade reading level.

We then proceeded to work with a variety of sites and things that need - actually to use in primary care sites to collect data for validation, and reliability and validity testing. We specifically worked to these sites to optimize the implementation processes and that is how we arrived at the implementation specifications that we've described in our application around the identification and delivery of the survey using either electronic or paper means.

I would add that this has the added benefits of same-day delivery of the survey. It had the added benefit that we had very low amounts of missing data overall. It's 13% missing data compared to often what's seen in for example CAHPS survey of up to 60% to 80% missing data.

And I will just conclude by saying that we are currently working extensively to increase our access to information about both the data, the performance of this measure and implementation of this measure in a range of sites including working with the National Association of Community Health Centers to implement it and activate use, and also with a large managed care organization to think about delivery over a patient portal which would be something that we would explore for future (link) if this measure was to be endorsed.

Thank you very much. So, Suzanne, I'll hand it to you and the co-chairs.

Suzanne Theberge: Great, thank you. So at this time, we would turn it over to the committee to begin the discussion starting with our lead discussant, Amy Bell.

Amy Bell: Hey, good afternoon, everyone. So just to introduce the measure and thank you to the team for the excellent presentation of the work that you've done

particularly so far, this will be NQF number 3543, Patient-Centered Contraceptive Counseling PCCC.

The description, it's a four-item patient-reported outcome performance measure. It's to assess the patient centeredness of contraceptive counseling at the individual provider and at the facility levels. Patients are asked to rate how well their provider gets the four items on the five-point marker scale.

Those items are: respecting me as a person, letting me say what matters to me about my birth control, taking my preferences about my birth control seriously, and giving me enough information to make best decision about my birth control method.

The target population is ages 15 to 45, those that are assigned female at birth, and those that have received contraceptive counseling as part of their recent visit. And it does exclude patients that are currently pregnant.

The level of analysis would be then as the clinician, the individual clinician level and also at the facility level. It is a new measure. With that, it is also defined now as an (ethical) measure and it is defined as patient-reported measure. It allows patient to evaluate their experience in taking contraceptive counseling. It is visit-specific.

The individual provider score is determined by the proportion of patient. Today, the highest rating for all four questions on the survey, the number of patients that report a top score in other words, and it's the same methodology used for facility scoring.

It's intended to serve as a balancing measure to two other NQF endorsed measures regarding contraceptive measure. Those are NQF number 2903 and

2904 to help address and monitor patients' protection of reproductive coercion. So with that, we can move into a committee discussion on this first part.

Sheila Owens-Collins: This is Sheila Owens-Collins. I just had a quick question and I think that's a great measure and one that's truly very needed. I'm wondering if you have vetted in the way you recruit patients to evaluate literacy - help literacy and their understanding of contraception as well as looking at the co-balancing variables of religion and culture, and other political influences on their decision to have contraception that may bias their experience with it.

Christine Dehlendorf: So thank you very much for that question. With respect to how patients were identified to receive the survey, it was done again at a facility level and we had a standardized implementation process that was made with - adjust to their own structure and process to use within the clinic itself.

And so, in general, the idea was to provide it everyone who received contraceptive counseling. And as we described in the application, we did work with four sites to ascertain if there was bias in the way in which patients were collected their (CSA) measure and did not find evidence of this.

So the literacy perspective, we definitely focused as I described on making sure that this was something that could be used and answered by the majority of people and we generally - and we worked extensively with our patients' stakeholder group here in our program as well as doing focus group interviews around the country to make sure that voting instructions in the survey itself were at a low level of literacy and were interpretable to the target population.

Sheila Owens-Collins: Okay.

Christine Dehlendorf: In terms of - so just really quickly, in terms of the question about different populations and their process to contraceptive counseling, we very much centered the fact that people have different values and preferences related to contraception in our development of (unintelligible), and that is why it is about looking in their preferences, what matters to them.

And it's designed as a result to be about what people themselves want as opposed to - and therefore the answer to that would not be biased by people having different perceptions that would in fact be reflective of those different perceptions.

Sheila Owens-Collins: Okay, great, yes.

Kimberly Gregory: This is Kim Gregory. Can you clarify - is contraceptive counseling a new prescription, or a change in prescription, or every single time contraception was prescribed, may we seek contraceptive counseling?

Christine Dehlendorf: So we had a standardized definition for the study in terms of how we define contraceptive counseling and it did not have to require that they change method, but rather they just stick to their value, their interest in contraception and considered either a new method, or starting contraceptive from scratch, or changing method.

And it was defined in that way so that this acknowledged the fact that people can receive contraceptive counseling even if they don't necessarily start or change method.

Matthew Austin: This is Matt Austin. A quick question, is the survey offered in languages other than English at this point?

Christine Dehlendorf: Thank you. I should have said that in my introduction. It is - we did intensive work to assess item of equivalence and overall acceptability of the survey in Spanish. And so we do as well have it in Spanish and had validated it using the Spanish language as well. We do not at this time have other languages, but we're very interested in thinking about this moving forward.

Matthew Austin: Thank you.

Martha Carter: This is Martha Carter. As a follow-up to that question, were you able to test whether the survey tool is translatable through a - you know, a live interpreter service into other languages or to women who can't - either are illiterate, or blind, or some other reason that they can't take a written test in English or Spanish? Tell me more about that please.

Christine Dehlendorf: Yes, so I think that's a great question and I think, as I said, we worked hard to maximize inclusivity of the survey. But there are populations that we struggled. I think in terms of women who had difficult - have limited English proficiency, or written literacy, limited literacy specifically, I think there's definitely the option for this to be something that can be read to them by others. That is not something that we have explored, but I think that's something we could definitely look into moving forward.

In terms of the translation option, I would hesitate for that to be something that we would consider from the perspective of endorsement because I do think that the nuance around what it means to the described measure during our process of translating into Spanish is not insignificant.

And so I think that we would want to have a standardized approach to the different language as opposed to using an interpreter who may not be

specifically familiar with patient-centered construct or have engaged with this before, deciding on how to translate this item.

Martha Carter: So do you have a recommendation on how this tool would be used in clinic situations where they have a high proportion of women who aren't served in - or aren't best served in English or Spanish?

Christine Dehlendorf: I think that moving forward, what we would like to do and including through this project we mentioned and the National Association of Community Health Centers, we were interested in doing the work - that work to increase the number of languages in which the survey is offered so that we can address their needs.

Tracy Flanagan: Hi, Tracy Flanagan, I have a question. This is really about administration of survey. What we find when we surveyed people on their way out the door is very different than we find when we surveyed people with some interval and then were in anonymous way. Could you comment on that both from the standpoint of timing and how it gets administered, as well as if you have any comment on written versus electronic?

Christine Dehlendorf: Yes, thank you for that question. This is something that we definitely struggled with a lot in the process of validating this measure, and we initially had planned on doing an after the visit mailed or emailed, or texted survey. And what we've heard from our site was that that was not going to be feasible for them in terms of their implementation, and so that is why we transitioned the same-day approach. But we definitely understood the potential for acceptability of biased answers.

And so, we took effort to minimize that, including emphasizing confidentiality of the survey in both written and verbal aspects of delivering the survey. We

also have ensured that it was the person who - it was not the person who provided the counseling who delivered the survey to the individual. It had confidential ways of returning the survey either using an envelope or a secure box.

However, that said, we definitely understand that it is possible that these items are going to be - have created responses, positive responses as a result of this bias. So therefore this is really the best case scenario and that would make this more right shifted in terms of the positivity of responses. And I think the fact that we still found variability that we did and found reliability of the survey despite that bias is actually a very important finding and indicate that there is absolutely room for improvement.

Tracy Flanagan: And just one more question along the same line which is could you - and maybe - I just don't remember seeing it in the detail, written versus email…

Christine Dehlendorf: Yes, thank you. You have asked that, I apologize.

Tracy Flanagan: Yes.

Christine Dehlendorf: So we used it and validated it using both paper and electronic version of delivery at the point of care, and we did both labeled it in testing presuming the these were equivalent with our - and is part of our validity testing interviews in focus group. And also there was one clinic and that switch in the middle from paper to electronic and had exactly the same responses of 86% positive with after they switched which support the equivalence of these two modalities of delivery.

Tracy Flanagan: Thank you.

Martha Carter: This is Martha Carter again. I want to say that I really think this is a good measure, and that balancing and making sure that there isn't coercion in contraceptive counseling is really important. I had a question about how the clinics that you've worked with were able to aggregate and report out their data.

It looked - when I read your material, that looked like you were providing them the report and I wondered if you tested it where they actually did the whole process, you know, collected the survey data and crunched the numbers and disseminated the result to their staff. And if not, you know, I'm worried that that's a barrier to implementation because there's cost involved in that. So could you talk a little bit more about that please?

Christine Dehlendorf: Yes, absolutely. So in the subset of the site, you're absolutely right, we were the ones who collected the data and aggregated it. And this was a study that was designed to test the validity and reliability so we put a feasibility perspective asking the providers - the clinics to do this when it wasn't endorsed measure. Was there something that was considered feasible at that time?

That said, in the process of doing this pilot testing, we did also engage with the Oregon Health Authority and they on their own, in fact, implemented this in their clinics and they - the Oregon Health Authority side sort of listed in our - that are only at the facility level. They actually collected and aggregated the data themselves and did the reporting.

So, to me, that demonstrates the feasibility and of course, we will continue to evaluate that ongoing if this measure is endorsed as part of maintenance, and that is part of our plan specifically with the National Association of Community Health Centers with respect to working with their healthcare

controlled networks around developing standardized processes for collecting, aggregating and reporting this data.

Tracy Flanagan: This is Tracy Flanagan again. You know, coming from a large integrated healthcare system, my comment which we'll get to later is how you identify patients who come in. Because in a typical larger setting, other than a family planning setting, identifying people who are talking about - wanting birth control and actually getting it is often embedded in lots of other kinds of visits. And so could you comment a little bit on how you thought about that?

Christine Dehlendorf: Yes, absolutely. So we did, as I mentioned, work with non-family planning specific sites as part of the process. And as a family physician, I certainly recognize the importance of that - the care that's not specifically at a family planning-centric site.

And we worked with - and that was part of our implementation process and our implementation learning with helping those sites to identify when - and they should deliver the survey to people. And that included a variety of mechanisms which we have developed in implementation manual to help with first sites to implement it, including things like ICD-10 codes, including logging a specific type of visit, including provider identification. So there's a range of ways that that can be done.

It's not going to be perfect. I absolutely agree it's not going to be 100% of patients that get contraceptive counseling are going to be identified. But, of course, what is important is that it is not biased. And what we found again in our test with clinics when we visit them and see - and do chart reviews to see if there was bias identification, we found that when patients were identified or not, it does not have to be with the patient or rather had to do with clinic level

factors such as what was happening in terms of clinic flow on that particular day.

Tracy Flanagan: Let me add a follow-up question, I'm really stuck on the denominator and - because, for example, I'm just going to talk in our own system, we have almost no visits that are targeted as contraceptive only.

And so then the question is do you identify based on exit - you know, exit coding? And if so, how do you then even decide what the survey is and what your denominator is? So I guess I'm still confused about that and would love some clarification on some of your testing on that.

Christine Dehlendorf: So the denominator is assigned to everybody who received the survey so - and who did the survey. And what we have emphasized…

Tracy Flanagan: Who gets the survey? Who gets the survey? That's the question.

Christine Dehlendorf: Absolutely, and so what we have emphasized in our implementation processes is airing on the side of giving the survey to more people even if there's not - it's not written that the contraceptive counseling did occur because we do include in the survey a question about whether or not people receive contraceptive counseling so that people can self-identify out, clearly people will self-identify in.

And it's going to be context-specific, like I said the nitty-gritty detail of how people are identified and I think that this will be again an ongoing conversation if endorsement happens in terms of, you know, there are new, for example standardized electronic data elements for contraceptive counseling having occurred that (OPA) is working on. So those could be implemented and those are things that we're looking at with the health center controlled

networks for - with our project with the National Association of Community Health Centers.

So absolutely not everyone, as I said, is going to be identified and that is what we found. The key is that it is not biased and that is (unintelligible).

Kimberly Gregory: This is Kim Gregory again. I think that Dr. Flanagan and I have sort of been thinking on the same concern or issue. Okay, even if you over - if you give this survey to more people, there needs to be some type of validation that, okay, I said that contraceptive counseling didn't occur, but that wasn't why I was there. So is there some reason to - is there some way to correlate contraceptive counseling occurred and contraception was given?

Christine Dehlendorf: So again this is not designed - and maybe I'm misunderstanding, but this is not designed - the people for whom contraceptive counseling didn't occur and because they were there for something else did not count against the provider with the measure. They are just excluded from the denominator.

Kimberly Gregory: But how would you know if you gave them a form and I checked out on the form that I didn't get contraceptive counseling, then that - what do you mean you would exclude that person?

Christopher Koopman: In the aggregation, you would not count their survey responses.

Matthew Pickering: So this is Matt from NQF, sorry to interrupt or interject, I do want to make sure that we try to keep to the evidence criteria and I think some of the discussions are starting to lean more towards some of the scientific acceptability types of discussions.

If we could try to come back to the evidence and thinking about is the evidence appropriate and maybe testing on that criterion. Some of these questions around the denominator and test exclusions, if the committee does feel that we need to raise those, I think those are best set, or suited, or designed to be scientific acceptability portion. So maybe if I can turn it back to our co-chairs to sort of continue on?

Carol Sakala: Yes, so thanks, Matt, and thanks to all for just starting very robust discussion and the thoughtful answers from Dr. Dehlendorf. This is Carol and I know we started with kind of general questions and then we are going through our area criteria. So some of them have been answered already, some of the questions that you will have, but let's go through the specific criteria.

The first area, I'm going to look at the importance to measuring report and scientific acceptability and then turn it over to Kim. So the first criteria under importance to measure and report, first criterion is evidence, whether there is an empirical demonstration that the - between the outcome and at least one healthcare structure, process, intervention, or service.

So I'm going to start with Amy Bell and ask if you have any specific comments about that because you gave a wonderful background to the measure as a whole. And then we also have Angeline Ti who has volunteered to complement that, and then we'll open that to any other committee members who may wish to discuss specifically the topic of adequate evidence. And we do need a pass here in order to move forward.

Amy Bell: All right, so just to give a summary of the comments from the committee, it was rated high as an opportunity for improvement. The overall comments reveal that the committee does believe this is an important measure.

Several members commented that this seems to be more of a process measure and not a true outcome measure. Overall, committee members state that there is a performance stat currently. There are various system practices and we believe we have demonstrated disparities in care. And with that, I'll have Angeline to chime in anything else.

Angeline Ti: Yes, and I did want to kind of just post at the outcome versus present measure question and I know that in the presentation of this measure, it was highlighted that NQF does define essentially the patient experience as an important outcome in and of itself.

But then in looking throughout kind of some of the committee comments, I did see sort of people wanting to have this linked to things like production unintended pregnancy. And so I just wanted to I guess make sure that everyone is comfortable that this is not meant to necessarily be linked to pregnancy rates or other things. But this is truly looking at the patient experience in contraceptive counseling in and of itself, and make sure that everyone is comfortable with that.

Carol Sakala: Great, thanks to both of - go ahead, not yet. Now, we'll open it up for other committee comments on this specific topic of evidence.

Jennifer Bailit: So this is Jennifer Bailit. I just want to comment on the last speaker talking about what was said about the comments. I appreciate that this in and of itself the patient experience is an outcome in the way that the NQF is defining it. I do think this is a measure that when we talk at implementation people in our own areas or nationally, that this is a measure that would be well paired with something else. That’s not to say that it can’t stand on its own, but that its value may be to be paired.

Carol Sakala: And I think we heard previously that this is intended to work in both ways.

Diana Ramos: Hi, this is Diana Ramos. I would just want to comment in terms of it does feel like it's a process measure and I'm not sure that the evidence is there to make it strong enough point.

My biggest concern is the fact that adequate counseling could be made, is there going to be availability to provide them with what the contraceptive method is desired. And then oftentimes the biggest dilemma is that many times the counseling is limited to what is available there immediately. So I'm a little concerned.

Carol Sakala: So, Dr. Dehlendorf, could you speak to that? It sounds like that issue may be out of scope for your particular method.

Christine Dehlendorf: Yes, absolutely, I think that - I can speak to that absolutely. I think that that's an important point in terms of that this is not designed to address all aspects of quality related to contraceptive provision and family planning care. And it is, in fact, as we display in our conceptual model by (Lori Daven) in our application, it is part of an ecosystem of how we think about (priority) contraceptive care.

One aspect of that is covered by the currently endorsed contraceptive method measure around contraceptive method provision. But Dr. Ramos is correct, if that doesn't necessarily address the structural question of all methods available at a given facility. And then it's definitely something that I have heard mentioned in terms of a structural measure that could be considered as a performance measure.

But it is not what we are specifically addressing here which is the quality of counseling and I strongly believe that you need to have - we need to have both, to have quality patient-centered contraceptive counseling and our methods available when someone selects a method. So this is one essential piece of the quality puzzle.

Carol Sakala: Thank you. Other committee comments, or questions, or concerns related to the adequacy of evidence? Okay, so thank you. I think now we will have a vote shifting to our new technology there and I will pass it over to Hannah for that process.

Hannah Ingber: Thanks so much. I will now be opening the voting. Voting is now open to the measure. Your options are A for pass and B for do not pass. We're still waiting on a few more votes.

Suzanne Theberge: While folks are entering their votes, we are hearing some feedback from someone's line. If you could put your phone on mute if you're not speaking, that would be great. It sounds like there's some kind of line cross or something like that. Thank you.

Hannah Ingber: I'm registering 15 votes. If there are any who are having trouble voting.

Sheila Owens-Collins: Hi, I voted, did you get it?

Hannah Ingber: Sorry, who was that speaking?

Sheila Owens-Collins: Sheila Owens-Collins.

Hannah Ingber: Okay, just one minute.

Woman: That would be by text, right? That's what you're asking. So what we want everyone to see for the folks who are on the computer is a darker blue shaded vote for importance to measure and report 1A evidence.

Matthew Pickering: Just to confirm, it looks like we've had someone who asked to leave. Rajan, are you still on the line?

Rajan Wadhawan: Yes, I am on the line, but I'm going to have to leave now.

Matthew Pickering: Are you leaving now? Did you vote on this last…

Rajan Wadhawan: I did.

Matthew Pickering: You did, okay.

Hannah Ingber: Okay, thank you.

Jennifer Bailit: And this is Jennifer Bailit. Unfortunately, I need to leave too to go to the airport. So I voted already on this, but I'm afraid I have to drop off.

Matthew Pickering: Okay, thank you.

Kimberly Gregory: Are we now below our quorum?

Hannah Ingber: We will - I'll just announce the results of the voting before we discuss that if that's okay. So we have - sorry, we have 14 counts for pass and 2 counts for do not pass. This means that the measure passes. We're going to discuss quorum in just a minute.

Suzanne Theberge: Okay, so our quorum is 16 and I think we have now dropped to 15, unless anybody has joined who missed roll call. One person did say they were going to be joining late, but I'm not sure if they've made on yet.

What we can do is do another track once we get to our voting for the next criteria. We'll just do a check and see if we're at quorum or not. But should we lose quorum, what we would do is to continue and discuss all of the criteria. We would share a survey and you can vote on the survey on the call, and we'll share that survey with your colleagues who were unable to attend today, and they'll be able to vote over the weekend.

We would not announce any results if we don't have quorum. But we would just let you complete the survey now as you go through this to make it easier for you all. But for now we will continue to gap and we'll take a count and see where we are once we get to voting on gap.

So with that, I will turn it back to the chairs to take us through the discussion of gap.

Carol Sakala: Great, so the second aspect about importance is a demonstration of quality problems in the provision of care and the opportunity for improvement. So this could be shown by data demonstrating considerable variation, overall less than optimal performance, disparities in care across population groups, and concerns along those lines.

So I think I'm going to start with Amy, if you have any comments about the gap and disparities issue, and Angeline, and then anyone else on the committee.

Apryl Clark: Okay, so specifically going into reliability and validity, it did receive high ratings for those.

Carol Sakala: Excuse me, Amy, we're going to get to that later so this would be that 1B, opportunities for improvement, and it's fine if you, you know, want to just open this up to others.

Amy Bell: Yes, that's fine, we can open it up.

Carol Sakala: Okay, Angeline, did you have any comments on that specific criterion?

Angeline Ti: No kind of specific criticism or anything. I guess - I think that the developers demonstrated a performance gap overall with their data as well as some distinct disparities by raising ethnicity as well as language, and so I think that demonstrates a need for a measure like this.

Carol Sakala: Thank you. So anyone else on the committee comments on the issue of performance gap and inequity issues?

Matthew Austin: So this is Matt Austin. I am drawn to the statistic that I guess averaged overall percentage for (CAP box) versus 83.9% for English speakers and 68.2% for Spanish speakers. Was that in - for the Spanish speakers, is that conducted using the Spanish speaking or the Spanish language version of the survey?

Christine Dehlendorf: Yes, those were responses to the Spanish survey, exactly.

Carol Sakala: Okay, any other questions or comments about this aspect of importance? Okay, so in that case, Hannah, we'll turn it back over to you for a vote with the members who we have on this call at this time.

Hannah Ingber: Thank you. Okay, I will be opening up momentarily. Okay, voting is now open for the measure. Your options are A for high, B for moderate, C for low and D for insufficient.

Carol Sakala: And I could say that insufficient means that we haven't been given the information that would allow you to give another rating.

Sheila Owens-Collins: Can you clarify the relationship between the text that's on the screen and the response options? The text on the screen is written from a - I'm going to call it negative perspective overall less than optimal performance. Am I responding that I affirm that there's less than optimal performance, or am I - I guess I don't know how to choose the answer based on the way the text is written.

Hannah Ingber: If you think there is room for improvement, then you would vote high or moderate, and if you think that the measure is top-down and there's - you know, everybody is doing the best they can then you would vote low, does that help?

Sheila Owens-Collins: Yes, thank you.

Carol Sakala: So consider it as to how important it would be.

Hannah Ingber: So we have 13 votes right now. We're waiting for a few more votes.

Sheila Owens-Collins: Could I just ask a question? I'm seeing a "clear last response." Do we each need to do that if we get a new screen up or will our vote go through if we haven't said clear?

Hannah Ingber: I'm not sure I understand your question. You're saying - don't clear your last response.

Sheila Owens-Collins: My - the - I did not clear my last response, but I got a new screen and voted. Have you received my vote, or do I need to say clear last response in order for my vote to be transmitted to you?

Hannah Ingber: No, each vote is its own new screen so we'll see your vote.

Sheila Owens-Collins: Okay, thank you.

Suzanne Theberge: Okay, it looks like we got 14 votes which our count means that we have lost quorum on this call. So as this time, we will take voting offline. We will - in a few minutes, we will send out a survey on SurveyMonkey to everyone and we would ask you to just fill that out.

We'll have to vote on gap on the survey. I think you will probably have to vote on evidence as well, so just put your vote in there, I know we've already done that one. But that would just allow us to move forward to the survey. Enter your vote on gap so that we have that and we'll have all of your votes collected there.

As we go through, we will discuss every criterion. And then for the folks that aren't on the call, we'll share the recording and ask them to vote, and we'll have the final results early next week, probably by Tuesday or so. And we'll collect votes via the survey until we have a quorum. So are there any questions on the process?

((Crosstalk))

Woman: Did someone just join? I'm hearing a…

Suzanne Theberge: I'm sorry.

Woman: Did someone just join the call or did not?

((Crosstalk))

Suzanne Theberge: Yes, you begin…

((Crosstalk))

Sheila Owens-Collins: This is Sheila Owens-Collins. I'm going to have to get off in about 15 minutes so I'll let you know. Thank you.

Suzanne Theberge: Okay, we are a few below quorum so I think we're - you know, we're - and unless we get a bunch of people suddenly rejoining, I think we're out of luck here. We will email that survey out in the next few minutes so you'll have that and you can complete that as we discuss. But again we will not be voting on the rest of the call.

Carol Sakala: Suzanne, I just have one clarifying question. For some of these coming up reliability and validity, we have a two-phase voting process where we first decide whether we want to accept the recommendation of the scientific methods panel. And then if there is any concern about that, we go to our own voting and rating. How will that work with the SurveyMonkey process?

Suzanne Theberge: That’s a great question. I think you can just skip that question and enter your own vote. That’s not a required question on the survey so you just be able to just jump over it and answer how you would like to rate the scientific acceptability for the measure.

Carol Sakala: Great. Okay, thanks everyone for hanging with this process. I know we have - we're dealing with some people who are facing weather issues, travel issues, major meetings in our field, et cetera, so we'll get there. We are now going to turn - yes?

Kimberly Gregory: I'm sorry, Carol. I just have a little angst about the part of the benefit of this is the discussion that happens, are we shortchanging the opportunity like should we consider rescheduling the call till we have a quorum I guess is what I'll ask.

Suzanne Theberge: Yes, we - you know, what we typically ask is for the people that were not on the call to, you know, listen to the recording, review the transcript which we'll make available, and you know, we would welcome written input from them as well. It is - you know, we agree it is not ideal not to have a quorum.

However, given the scheduling challenges and the timeline that we work with it, it can be tough to reconvene people in a quickly enough fashion. It would have to be, you know, sometime next week really or possibly right - you know, early the week after that in order to kind of get through the process.

So this is our standard process for when we lose quorum is we take the voting offline. And of course, the committee will reconvene in the spring after the commentary end to discuss at that time any additional input.

Carol Sakala: And is it the case that everyone has access to the comments that have already been submitted, everyone did have an opportunity to provide written comments, so yes.

Suzanne Theberge: Yes, those are all in the preliminary evaluation, and preliminary evaluation comments are all in the preliminary analysis document.

Carol Sakala: Great. So thanks, everybody. We're going to move to scientific acceptability and this is the area that has been reviewed by the scientific methods panel. It has two elements. They both must pass.

One is reliability and that refers to the measure as specified, not as what you might like it to look like. We have to stick to what we have received and whether it produces consistent results about the quality of healthcare delivery and then we'll move to validity.

So, Amy, I think you did have some comments about reliability, is that correct?

Amy Bell: Yes, I do. So we did receive high rating for reliability. Comments were all from the committee. They really appreciated the use of the Cronbach's alpha, concerned about the literacy level of the questions, but thank you to the committee or to the developers for addressing that early on today. And for also the use of other languages, so thank you for addressing that as well.

We do need to ensure there's a correct method for collecting race and ethnicity data across the country, and we've observed that in multiple areas where that is a concern overall for the committee. And that's the quick summary, I mean, there was a lot of just agreeing and that kind of thing in there as well. But those are the overall concerns that were raised.

Carol Sakala: Thanks, Amy. Angeline?

Angeline Ti: Yes, and this is Angeline. I don't have anything kind of beyond what the methods specialist have added, but I think I did want to respond a little bit to

some of the committee concerns about language and you know, to interpret results if - and certainly modifying the verbiage or the reading level.

And I think I want to make sure that we're looking at the reliability and validity of the measure itself and whether it might be some modifications when it comes to implementation that does not specifically what we're looking at here. So, overall, I agree with the methods panel and I think I don't have any concerns with the reliability or validity of this measure.

Carol Sakala: Thank you. So, opening it up to other committee members for discussion on this criterion of reliability. Okay, so think of how you want to vote when you get to that opportunity in a little bit, and we'll move on to the second criterion for scientific acceptability which is validity and this is a must-have.

And the idea here is that we're going to be getting credible or valid results about the quality of contraceptive care as it was provided by this person and in this setting. So did you have further comments, Amy, on this area?

Amy Bell: No, I had no major concerns here and I agree with what's being proposed there.

Carol Sakala: Thank you, and Angeline - and just to say that scientific methods panel gave us an overall vote of high on validity so that's what we're referring to here.

Angeline Ti: This is Angeline, nothing for me to add.

Carol Sakala: Thank you. So opening this up now, I know we touched on this a little in our opening, a very robust discussion. Do people have additional things to add? Okay, so thank you for that, and now I'm going to welcome Kim to talk through the remaining criteria.

Kimberly Gregory: Okay, we're talking about the feasibility. Does our primary reviewer want to add any comments or concerns about the feasibility? Amy or Angeline?

Amy Bell: Just a summary from the committee, you know, it was a moderate rating here from the team. But there were concerns in the comments about consistency and being able to collect the data, and how to upload information into an EMR if that's something that is supposed to happen.

Kimberly Gregory: Right, and I think that the issue of the denominator would fit here too.

Matthew Austin: So this is Matt Austin. I mean, I hear the concern about the identification of the denominator and my - the note that I made for myself was whether the measure developer was providing guidance or any guidance to facilities on how they can go about identifying that denominator population.

There are a number of other measures that are in sort of the clinical space, not specifically around contraception counseling, but where in some sense facilities whether that'd be a hospital, you know, in trying to identify which patients fall into the sepsis arm measure. Hospitals in some ways need to sort of make the decision that they're going to go broad and recognizing that some patients might actually fall out once you get down to actually applying the denominator criteria.

So I guess one sort of a question for the measure developer about whether any guidance is given to facilities on how to define the denominator, and then I guess the other is just sort of a comment to say I think this is a challenge that we face with other measures and I'm not sure that that should be a reason we don't infer with endorsement.

Christine Dehlendorf: Just to answer your question, we really worked with our sites to do implementation and including identification of the population information whether the survey we did as you said takes a broad approach of airing on the side of sensitivity and not specificity because we could exclude people after the fact.

And we have an implementation manual that we need to develop as part of that that will be included on our measure Web site. And we worked with National Family Planning Reproductive Health Association, NFPRHA, on that and also plan to continue to revise it in an ongoing basis in our interactions with the National Association of Community Health Centers and specifically our work with (SQA) team.

Tracy Flanagan: This is Tracy Flanagan.

Martha Carter: This is Martha Carter. Sorry.

Tracy Flanagan: Go on, Martha, and I'll follow you.

Martha Carter: There is an ICD-10 code for contraceptive counseling, did you work with that to help the practices identify the denominator? That is inconsistently reported.

Christine Dehlendorf: Well, I think that we took a broad approach so that is definitely one of the strategies that clinics can use, and I think some clinics use it consistently and others don't, it very much depends.

So I think that that is absolutely one of the strategies people can use. It depends often on whether providers have input their ICD-10 code by the time the patient walked out of the room or not, whether or not that can be used because we're not doing adjudicated claims. But that is absolutely a strategy.

And like I said, there's also potential for electronic - standardized electronic data elements that could be used, that could be more of a click box than an ICD-10 code. So that is definitely all, I think we take an inclusive approach to thinking about how a general implementation strategy that we can find at the facility level.

Tracy Flanagan: This is Tracy Flanagan. From the standpoint of feasibility, I have two questions, issues.

One is in a system like ours, we don't really have a checkout mechanism and in fact that would be an added burden on our system to do that. So I'm struggling with how this survey would actually happen on a checkout system unless it was introduced in the beginning. But how is it introduced in the beginning unless we know that they're for contraceptive.

And then if we're just using the denominators, all 15 to 42, are we giving it to everybody who walks in who has a visit? So I'm circling in mind on that one.

The second issue is we have to have a patient satisfaction survey that includes almost exactly these questions but to the visit, and so I'm concerned about duplication of survey that may be seen as confusing to the patients. And again, I recognize that we are not a family planning setting and that this may or may not be an optional measure, et cetera.

But we're speaking on behalf of a large healthcare system that values this, but really struggling to figure out how we do it from a feasibility standpoint.

Christine Dehlendorf: Thank you, Dr. Flanagan. I really appreciate those comments and we definitely have thought about this particularly in the context of Kaiser, you

know, working with one of the reasons not urban California, with one of the reasons to think about this and specifically around the possibility of administering this through the patient portal because Kaiser - as a Kaiser patient myself, it has a very high functioning patient portal, that this should be optimal for that administration.

That is not something we were able to do for the purpose of these reliability and validity assessments for this submission. But that is something that we plan to collect data for - again if this is endorsed for maintenance and ideally be able to have a modality of having this survey administered through a patient portal for systems such as yours.

And what we have (opted) with this other region, what we have discussed is absolutely taking a broad approach to what - who gets surveyed and again having people drop out based on their initial answer to whether or not they get contraceptive counseling.

So, yes, in general, this speaks to the point that implementation of this measure will depend on sites. And so some sites will be able to apply the ICD-10 code, CPT code, electronic standardized data elements to refine who the sites gets - the survey gets delivered to on a patient portal and that's something that we're working with this Kaiser region on.

And then - but also have the fact that people can drop out based on self-identifying it's not getting contraceptive counseling. So that can be something that we can work with - we will work with individual sites on as we move forward for sites that do not want to do it on the same day.

And then I think your other point was about - your other - other patient survey, so that again has come up with this other Kaiser region as well. I

think that one of the motivations behind developing a contraceptive-specific measure was that contraceptive counseling is a unique aspect of care.

And we talk to our patient stakeholders in our - and in our qualitative interviews and focus groups with patients, the target population, that they very much felt like having questions specific to birth control and contraceptive sampling were very important. And we ask them specifically to compare it to the CAHPS survey on communication and they felt that this is something different for them in terms of this aspect of care.

Also, the CAHPS survey is not visit-specific so, you know, you can go up three months, but it's not designed to be a visit-specific measure and we thought it was very important for contraceptive counseling. I recognize that there are - having received many of these surveys myself from Kaiser, there are visit-specific non-NQF-based endorsed surveys that individual sites use and again it will have to be site-specific, whether they decide to use this measure and how they use this measure if this is endorsed.

Tracy Flanagan: Thank you.

Kimberly Gregory: Any other questions or comments?

Matthew Pickering: So this is - yes, hi, this is Matt from NQF. I know that we have moved on to feasibility. I just want to ensure - because I think we kind of went through scientific acceptability fairly quickly, so I just wanted to ensure that the committee doesn't have any other questions or comments regarding the validity aspect in particular.

So thinking again are the data elements correct, is the score correct, does the committee have any concerns regarding exclusions, those types of

considerations. Does anyone have any thought there? I hate to kind of skip that, but I know that we went through science acceptability kind of quick, so I just want to ensure that we have some time to talk about that. If not, we can continue on with feasibility.

Tracy Flanagan: Matt, this is Tracy Flanagan. And maybe this is only my own question, but maybe the rest of the people have the same question. I guess I'm a little confused - you know, I'm still confused about the denominator issue and I think that doesn't affect reliability and validity, but I - could you answer that from a PhD perspective?

Matthew Pickering: So are you asking me or the developer about the denominator?

Tracy Flanagan: No, I'm asking you. I think I don't understand as a physician who, you know, thinks about measures. But for this particular aspect, I don't know if it affects science reliability and validity as the denominator keeps changing every time you do it and you try to get a facility score.

Matthew Pickering: All right, so - and I welcome the developer as well on this. But the denominator does affect your reliability depending on - the number of patients that you have in the denominator can affect your reliability and your reliability scores.

The issue with the denominator as well as validity aspect is just to ensure that the data elements are correct and accurate, and they're not getting any missingness within that - within those data elements that are feeding the denominator as well as any exclusions, which I'm not really sure if I'm adequately addressing your question. But I don't know if the measure developer has any additional thoughts as to this specific measure.

Christine Dehlendorf: I would just say that in terms of this mess-up with denominator shifting, I think it includes in the denominator in terms of patients will obviously be different with every administration. We just confer all measures. But the goal of our implementation of this is to again standardize the process within the specific context of individual clinic. So this wouldn't have an impact on individual clinic scores or facility scores, or provider scores.

Tracy Flanagan: Thanks.

Martha Carter: This is Martha Carter. This is my first measure review so I'm unclear about the process of recommending a measure, approving a measure that isn't fully developed, that really isn't going to capture all sub-groups, sub-populations, you know, in a standard diverse clinic setting.

You know, we've heard that there are plans to translate into other languages to figure out how to, you know, use interpreters or sign, whatever, I guess for blind people, whatever would be done- read to them by somebody in the clinic. So it's not universally applicable yet or usable yet and I don't know whether that's here in validity or someplace else, could somebody with more experience talk to me about that concern about not being able to use it for the whole population at this point and is that okay?

Angeline Ti: This is Angeline - go ahead.

Matthew Pickering: Yes, go ahead. Go ahead, Angeline.

Angeline Ti: I don't have more experience. This is my first measure. But, Martha, I guess wondering if you would be more comfortable with like essentially a linguistic exclusion that this applies to patients who read English and Spanish, is that what I'm getting at?

Martha Carter: Well, perhaps, but how does this usually go? Maybe somebody who's got more experience could help me out here.

Carol Sakala: So, Martha, this is Carol. I'll jump in just as a member of the committee now and I will say that there's a frequently sided NQF mantra that not letting the perfect get in the way of the good because that really is almost impossible to develop a perfect measure.

And also to point out that there's a difference between a new measure and then maintenance, and it's almost - there's kind of a chicken and egg issue that until we get an endorsed measure that really has a broad range of experience out in the world, it's very difficult to answer some of these questions, and some of these details could apply more to a few years henceforth when we would be maintaining this measure.

Martha Carter: Thank you, Carol. That's helpful.

Matthew Pickering: So I want to kind of also focus again, if there are any other sorts of concerns or issues regarding the validity component so that we capture those with this group and then maybe we could keep moving to feasibility. Okay, well, I appreciate sort of kind of coming back to that just to ensure because we did go kind of quickly through it, so just to ensure that there's any comment that we share.

Kim, I do apologize for interrupting that component, the feasibility piece, but we can sort of get back to that. We wouldn't mind picking up where we left off.

Kimberly Gregory: Sure, I think there were some concerns on feasibility, basically relating back to the measure. But, overall, the staff review was a pass on this. And are there any other concerns that the committee would like to raise?

Okay, hearing none and realizing that we do have our time coming up, I would like to talk about usability. Amy or Angeline, would you like to make comments here?

Amy Bell: So, overall rating was moderate here. Some of the comments from the committee concerns about it not yet publicly reported, but potentially could be in the future.

Some believed that this measure could discourage counseling overall and there needs to be a place for patients to express concerns about their experience and how would that - how would that come back to the providers or the practice leaders. Angeline, I don't know if you have anything to add there.

Angeline Ti: Nothing, nothing specifically. I think, overall, there - I didn't kind of - and looking at the comments and in my own reading of it, I don't have big concerns with usability. I think a lot of these kind of implementation questions are not unique, and kind of implementation concerns are not unique to this measure.

I think in looking at how we measure the patient experience and I think in any aspect of care, we're going to get into these issues. And so I think, in general, the usability - and maybe I'm also kind of talking about feasibility, but, you know, for simple questions on a lighter scale, I think these are really reasonable.

Suzanne Theberge: And a couple other comments I did want to add as well, you know, there were concerns about really no harm to the patient for doing the survey, but potential harm to a practitioner if the survey is not implementing correctly. The provider could be mislabeled as a poor performer. I mean, that data may not be accurate.

Other concerns that were raised are about the problems of using the survey in junction with very similar surveys on satisfaction. So it may be - you know, we need to make sure it's not going duplicating anything that's going on with that. And then some practices may not have the resources to perform the functions accurately and timely. There are some concerns about that from the usability perspective.

Kimberly Gregory: This is Kim. I had a question to the developer. Does it specify which practitioner that they're evaluating?

Christine Dehlendorf: So it is linked to an individual provider, yes. As indicated in our submission, in some places that we've done at both the provider and a facility level. And in other sites, it was only done at the facility level and I think that there's been a lot of discussion about where the best approach to quality improvement is.

And I think my assessment of that is that ideally, it would be being able to identify both performance on the provider level and on the facility level. But I also get the concern about individual providers and I think that, in general, the reporting by the provider, what we could do something as we move forward was thinking about use. It would be something that we would recommend.

Kimberly Gregory: Well, I didn't know that a lot of - even like NFPRHA training is - the person doing accounts is not necessarily the provider who's doing the prescribing.

Christine Dehlendorf: Absolutely, as part of our implementation process, in fact, is really getting at who is actually providing the counseling, not the method provision. And as we described in our application, specifically for that reason, because of the nature of how family planning care is provided in this country, we included unlicensed providers and counselors in our definition of a provider for the purpose of this measure.

And we also incorporated team-based care when that was relevant, when there were more than one individual that was providing a counseling service, and that would be evaluated on that team level as opposed to an individual level.

Tasha Cooper: This is Tasha. I'm also new to the committee so I have more of a repressive question and if it's not the right time, let me know. I am just curious, you know, if we just passes and even talk about usability and a lot of the other topics, do we then get additional feedback from providers to understand what worked and what didn't work, and we continually improve on it on the measure, or once it's released, that's it?

Christine Dehlendorf: So I will let NQF answer the general question. But I will tell you that from our side, that is absolutely our plan, it's to kind of figuring out how to optimize implementation, interpretation and use of this measure both on its own and then send them with the current NQF method provision measure as well.

Tasha Cooper: Thank you.

((Crosstalk))

Tasha Cooper: From NQF, is there a different response or…

Kimberly Gregory: Yes, go ahead, Dr. Flanagan.

Tracy Flanagan: No, I was going to change the subject once you finished the answer.

Kimberly Gregory: No, I was - for sure, it comes up under maintenance review and the opportunities to revisit some of the discussions especially if you've experienced some of the experience of implementing it does come up.

Tasha Cooper: Okay, thank you.

Tracy Flanagan: This is Tracy Flanagan. Yes, again, in the usability bucket, there are two issues. One is because we send the survey out, we could do afterwards on the visit and ask about respect and involved in care, you know, similar, some almost identical and a few not. I think there would be a lot of concern about two surveys that look similar. I'm just going to say that again.

But the second issue is, you know, when we get to provider level data within our own organization on that kind of a survey which we do on a routine basis after, you know, we sample a lot of visits for every provider, we wait till somewhere between 50 and 100 responses before we consider a live or valid. So I'm really wondering where - how you manage that at the provider level for reliability and validity.

Christine Dehlendorf: So in terms of the first comment, I think that we definitely recognize, as I said, that there may be alternative approaches that people use in our different systems' use and that the same-day administration may not work for all

facilities and all systems. And so that's definitely something that we would - we optimize this currently for the context in which we were testing it for reliability and validity, and what we've heard from our partners that we were working with for the process of reliability and validity.

And I think that, as I said, we are interested in working with the Kaiser system specifically to figure out how they work in the context of your system. We did - as I said in the application, we did very much want this to be something that was acceptable, of interest and usable for providers and clinic administrators.

So this is why we give the validity testing using hypothesis with them from providers and clinic administrators recruited around the country. So that doesn't mean that it's relevant to everybody, but it does mean that we have done a validity testing with a broad range of stakeholders.

In terms of the choice to use the number 30 for the limit minimum number for account side, that was based on our signal/noise reliability ratio which is based on the intraclass correlation and the standard errors around that measurement. And so that would be a minimum based on our assessment of what the adequate level of uncertainty is.

As you could see in our application, the standard errors were actually really quite narrow. Of course, that's therefore a statistical answer in terms of what we know from this measure reliability and validity testing. Of course, at individual sites, they wanted to collect more because they felt that that was their standard practices irrespective of the statistical issues. That is absolutely an individual system decision.

Tracy Flanagan: Thanks.

Kimberly Gregory: Okay, so everyone will cast their vote on usability. And I just want to mention that related and computing measures which are the contraceptive care most and moderately affected method.

It was an NQF measure, contraceptive care, access to LARC which is an NQF measure, and then clinical includes - well not HCAHPS but CAHPS. So there are measures out there and this is sort of proposed to be on the (Medallion) as a balancing measure.

So if there are no further comments, I'll just mention that you'll have to - based on this discussion, and your vote, and the feedback from the committee and the scientific methods committee come with the decision for the overall suitability for endorsement.

Now, again, I'm not sure how that's going to work with the SurveyMonkey and that it must pass the first two in order for us to be eligible to even get this far in the voting stream.

Suzanne Theberge: Sorry, Kim, this is Suzanne. I can jump in and provide a little bit more info here if that's helpful.

Kimberly Gregory: Thank you.

Suzanne Theberge: So the way that we have this vote is we send out a survey. It has all the criteria and we would ask you to vote on each criterion. If a measure did not pass one of the must pass criteria, so if it failed on gap, we would just - we would have all of your votes, but we would not include them.

The measure would be considered to have stopped if it fails anywhere along the way and those votes are just not recorded in the report that we put out. That said, we - since we don't know what's going to happen, we ask you to vote on everything and then we'll share those results as soon as have them.

We did get a request in the project box to kind of talk through the questions and explain them a little bit, so I'm going to go through that quickly now and definitely let me know if you have any other questions.

So the first question that we want you to vote on is evidence. I know the committee already voted on this and passed it, but please just enter something in there because I think that's a required question. So you'll just need to put in an answer.

For performance gap, we got a lot of those on that, but we're asking you to vote here because we didn't have quorum at that time. And again, what we're looking at here is whether there's considerable variation in performance across provider, or provider groups, or whether there's overall gaps in here, other disparities. Is performance better for some groups other than others?

You know, that's what we're looking for and if you think there is, you would vote high or moderate. If you think that the gaps is - like there's no room for improvement, everyone is doing as well as they possibly can, they you would vote low. And if you feel that you don't have a good data to respond, you would vote insufficient.

For reliability, you would look at are the specifications precise and is the testing appropriate. And again, the methods panel voted high. You can either, you know, kind of agree with that and vote high yourself, or you can say you think it's moderate again, or low would be you don't think the testing -

you think the specifications are unclear, or you think the testing is not sufficient. And then insufficient would be if you don't have enough information to answer the question.

Validity looks at a number of things. Validity looks at was the testing done, appropriate method of testing. And are the results adequate? You know, are they showing the measure is valid? And then you also hear considering threats to validity which include our population, the right groups of patients included or excluded. We had a lot of conversation about that.

What do you think about the risk adjustment for the measure? Is the measure able to demonstrate meaningful differences in performance? You know, is there a missing data that might bias - a systematic missing data that might bias the result, that kind of questions.

Again, your choices here are high or moderate which would mean that you think that the measure is good and has done a good job with the validity testing and the results are solid; and low or insufficient would be if you disagree with that.

((Crosstalk))

Woman: Again, can I ask a question in the middle here?

Suzanne Theberge: Yes.

Woman: So the SurveyMonkey says Question 6, do you accept the scientific method panel's rating of high for validity? But that's not actually how they scored it. There was a mixed score in there of high and moderate. So I didn't know how to answer that question.

Suzanne Theberge: That's a great question. So what we do for the method panel is we take kind of the overall recommendation. So I think it was like four people voted high and one voted moderate, so we would call that a high based on their results. That's just kind of how they had voted that.

So I'm just scrolling through the - confirm those were the right numbers, so, yes, you know, you can vote high, you can vote moderate if you think it is good enforcement and valid enough to be used either as pass. And ultimately, you know, if you think the measure should pass the validity testing, you can vote either high or moderate, and it will pass.

Woman: Do we have access to how many people - I'm on Page 17, and it doesn't tell me how many people voted high and how many voted moderate so you…

((Crosstalk))

Suzanne Theberge: Yes, we have that in - we have that in here, give me a moment to know exactly where it is.

Woman: It's on 9.

Suzanne Theberge: Thank you. It's on Page 9.

Woman: Page 9.

Suzanne Theberge: So up to the very top of the methods panel summary, you get the scientific methods panel votes, measure passes. Validity is high. Five voted high, one voted moderate, zero voted low and zero voted insufficient. So our (unintelligible) is high.

Woman: Okay, thank you.

Suzanne Theberge: And then just continuing through the survey responses, I believe - and Hannah, please feel free to correct me if I'm wrong. I believe you can just skip the questions on the scientific methods panel rating. I think those are not required, whereas the other ones may be.

And then the feasibility, that just looks at how feasible is it to generate the data and collect - and how feasible is it to implement data collection. Again, high or moderate is a pass and you would just look at how feasible is it for any one provider or clinic to implement this measure.

And then for usability and use, first, we look at use. This is a new measure as we just discussed, so we're looking at whether there is a credible plan for use and whether feedback on the measure by those being measured was considered and whether there's a pass for that.

And then, finally, usability looks at - since this is a new measure, if there are credible rationale that this measure can show opportunity or show improvement in care and kind of improve care, and that there is no evidence of unintended negative consequences; or that if there are negative consequences, they are outweighed by the benefits of using the measure.

And then, finally, we would ask you to vote on your overall recommendation for endorsement, you know, whether you think the measure meets our criteria and is suitable for use as an accountability or public reporting measure.

And so that's kind of our - are the voting criteria that we've laid out in the survey. We'll share the recording. I think we'll get that this afternoon, so we

can post that on SharePoint and we'll share the transcript as soon as we have it. Probably it won't be till Monday or maybe Tuesday, but we'll share that as soon as we can.

And I'll pause here and see if there are any other questions before we all go to public comment.

Tracy Flanagan: This is Tracy Flanagan again. When we vote overall on this from the standpoint of usability, really what we're holding in our head is could this be used by some or many, but not necessarily all healthcare systems, is that correct?

Suzanne Theberge: Yes, yes. All right, if you have questions, you know, you can email the perinatal box and we'll do our best to help you and resolve these questions as you're voting, so just reach out and let us know.

With that, we are almost at time so we do need to open the lines for comments if anybody, any NQF member, or member of the public wishes to make a comment, now is the time. Please feel free to speak or submit a comment via the chat box. All right, hearing no comments, I will turn it over to Hannah to move through our next steps. Hannah?

Hannah Ingber: Thanks so much, Suzanne. So our next steps will include our commenting period on our draft report which will run from March 18th to April 16th. Then we'll hold our committee post-comment web meeting on May 8th from noon to 2:00 Eastern Time.

As Suzanne mentioned, as for your voting, please send any questions to the project box here, perinatal@qualityforum.org and we will be sending out the materials that Suzanne mentioned shortly.

Are there any remaining questions? All right, hearing none, I'll pass it back to Suzanne or Matt just for any closing comments.

Matthew Pickering: No, so I just want to thank everyone for their time today. I appreciate you following up that survey. Please feel free to reach out with any questions as Hannah has mentioned.

And I want to thank our co-chairs as well, Kim and Carol, for your engagement with us today and keeping the discussion going, as well as our lead discussant and discussant, so thank you all very, very much.

Danielle Hessler-Jones: I want to say thank you from the UCSF Team for your consideration.

Matthew Pickering: Great, thank you all very much. Have a great weekend.

Suzanne Theberge: Thank you. Bye-bye.

Hannah Ingber: Thank you.

Operator: Enter remote access code.

END