NATIONAL QUALITY FORUM

Moderator: Kim Patterson
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10:00 am ET

Matthew Pickering: Okay. Well, good morning to everyone who's on the line at this point. My name is Matthew Pickering here at NQF. We'll get started here in about another minute just a little bit after the top of the hour, just allow folks to dial in, so we'll get started here in a little bit. Thank you.

Okay. So good morning everyone. My name is Matt Pickering like I mentioned previously, I'm at with NQF and I want to welcome you all to our Perinatal and Women's Health Spring 2020 Measure Review cycle. It is a pleasure to have you all on the call as well as our developers, our Standing Committee members and the public as we go through the measures that came through for spring 2020.

In addition, if you see the agenda, we also will be trying to - also the fall 2019 post comments on this call. If we are unable to get to both of those items today. We do have a meeting on Monday to accommodate any of that time needed to go through post commentary finishing either measure discussions that we are unable to get to today.

Before I proceed if you do - if you're not speaking, we would ask you to keep yourselves or your phone unmute just to prevent any background noise. I will most likely iterate this once again as we move forward, but I would like to just say welcome we do understand this is a very busy time for folks and other competing priorities that are going on outside of the work within NQF.

And we very much appreciate your time and efforts both today, but also the efforts of our co-chairs, Committee members, developers as well leading up to where we are today both for doing the analyses of these measures submitting them and also the review from our Standing Committee participants as well. We very much appreciate your time during this busy period for folks.

I will like to, sort of, give the opportunity at this moment for our co-chairs to welcome the Committee. Carol and Kim, I'll open it up the floors, so maybe Carol if you'd like to go first and maybe Kim just to welcome our Standing Committee today.

Carol Sakala: Great. Yes, welcome everyone as Matt said we're so grateful for your time. We understand it's a challenge and it takes a village here. So, the NQF staff, the developers are voluntary discussions and of course our Co-Chair Kim. It's been several years since we've done the regular measure maintenance work of our Committee and I personally I am really happy to be at this place and then we'll look forward to reconvening in the fall cycle to continue this work.

Kimberly Gregory: Hi, this is Kim Gregory and I echo what's been said already. It's been a pleasure working with Carol and the NQF team and the Standing Committee and it's exciting to see that we actually have some real work to do today, so I look forward to, I have the exchange.

Matthew Pickering: Okay. Thank you, Kim and Carol. So it's just a few housekeeping items for those who are on the web platform here you can the screen, but those who maybe have the slides in front of you not on the web platform currently Slide 3. Just some housekeeping items here. So, we are using the Century web link platform and allows you to view the presentation of our PDFs of these slides sent out to you earlier.

Please mute your lines again if you were not speaking just to prevent any background noise and we kindly ask you not put us on hold. If you have to step away, please do not put us on hold. We also ask you can submit questions through our chat box, there is a chat box features in the web platform, so you can submit your questions there. We will be monitoring that as well as our co-chairs have access the monitoring as we'll make sure to try to recognize those questions as they come in.

We also ask that you used to raise hands feature in the CenturyLink platform as well. So, this allows us to just see who has a question and also tries to prevent a little bit of jumping over one another as we are trying to move through the discussions today. So either one of those raise hands and we'll make sure that identify even calling you or if you have a question you can certainly raise it in our chat box as well.

And I just want to give a brief mention here and allow others of the team to introduce themselves just briefly. So again my name is Matt Pickering, I am the Senior Director here at NQF overseeing this portfolio and working with this great team listed here. Erin, would you like to introduce yourself.

Erin Buchanan: Sure. Good morning. My name is Erin Buchanan. I am a manager on this project.

Matthew Pickering: Thank you, Erin. And Hannah?

Hannah Ingber: Good morning everyone, Hannah Ingber. I am an analyst on this project, really excited to be speaking with you all today.

Matthew Pickering: Great, thanks, Hannah. And Robyn?

Robyn Nishimi: Hi. Robyn Nishimi. I am a Senior Consultant with NQF I think, you know, most of you from our previous iterations working with Susanne on this strategic issue. So I'm happy to be helping out on the project with measures.

Matthew Pickering: Great, thank you Robyn. And we're very much looking forward to working with you today and continuing on this cycle. So just a brief overview of the agenda listed here. So before we get into our discussions today. We'll do introductions and disclosures of interest. So you all have received various different requests.

I'm sure filling out some disclosures of interest and it will have an opportunity for you to disclose any of those potential complex as well as introduce yourself here to kick us off. This will be led by Apryl Clark, who's our acting Vice President.

And then we will highlight the measures that are under review for this cycle and then we will introduce the evaluation process sort of the flow of what's going to happen. And then we will do the voting process as well as the voting test. And so I stated here as well is that you probably received a link to the voting platform, which is Poll Everywhere.

So that is what will be using today for voting if considering we maintain quorum but that link should either be in your inbox as an email or also within

the calendar invite as well. So we will go through that, but you can try to identify that now and we also do it again during the voting test.

So after all of that we'll then dive into the measures for spring. So, Spring 2020 Measure Evaluation and then we would have public and member comment after those proceedings are done as well as next steps and you see adjourn here. This is not necessarily adjourn the call, but it's really to adjourn the spring 2020 discussion.

There is again a second piece of this, which is the fall 2019 post comment and so if you have seen previous communications from us, we have extended that post-comment period for fall 2019 for 6 to 60 days originally with that 30. So, those discussions are now going to be appended to the spring measure 2020 discussions.

If we are unable to get to that portion of the call today, we do have a meeting on Monday that's reserved for any sort of spillover if we needed for either the spring 2020, but also the fall 2019 post comments. We're hopeful, we can get through it all today, we understand that we want to respect people's time and not have to come back for another meeting but we do have that meeting on your calendars for Monday if we still need it.

Are there any questions at this point before we go into introductions and disclosures of interest? Again if you could use the hands, raise hands feature. Okay, seeing none, not in the chat box either.

Okay, I will go ahead and turn it over to Apryl Clark, you will do the introductions and disclosures of interest. Apryl?

Apryl Clark: Thanks, Matt. So I would just like to also offer my thanks to everyone for being with us for a whole day on Friday in the summer. So appreciate the time that you are giving me really appreciate that you are all volunteers and we couldn't do our work without you. So appreciate the time you're spending with us.

We are going to combine introductions with disclosures of interests, so let me just give you a little bit of background. You received two disclosure of interest forms from us: one is our annual disclosure and the other is disclosure specific to the measures we are reviewing the cycle. And those ones, we are seeing a number of questions about your professional activity.

Today, we'll ask you to orally disclose any information you provided on either of those forms 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 said on this group as an individual, you do not represent the interest of your employer or anyone who has nominated you for this Committee. We are interested in your disclosures of both paid and unpaid activities that are relevant to the work in front of you.

Finally, just because you disclose does not mean that you have a conflict of interest. We do oral disclosures and the spirit of openness and transparency. So, starting with our Committee co-chairs, I'll call your name, please state your name, who you're with and if you have anything to disclose and I will apologize in advance if I mispronounced your name.

So starting with our co-chairs Kimberly Gregory.

Kimberly Gregory: I'm Kimberly Gregory. I'm at Cedars-Sinai Medical Center and I have nothing to disclose.

Apryl Clark: Great. Carol Sakala?

Carol Sakala: Hi, this is Carol Sakala. I'm with the National Partnership for Women & Families. And I did report that I serve on advisory Committees to NCQA and CMS, but there's no overlap in measures and I don't consider this a conflict of interest.

Apryl Clark: Great. Jill Arnold? Matt Austin? Jennifer Bailit?

Jennifer Bailit: Hi, my name is Jennifer Bailit. I'm a Maternal-Fetal Medicine Specialist here in Cleveland, Ohio. I academically have interest in measuring and improving quality of care and I have no conflicts of interest. Thank you.

Apryl Clark: Great. Amy Bell?

Amy Bell: Hey good morning. This is Amy Bell, Assistant Vice President for Performance Improvement at Atrium Health and I have nothing to disclose.

Apryl Clark: Great. Martha Carter?

Martha Carter: Good morning. Martha Carter. I'm an Independent Consultant, I serve as a commissioner on the MACPAC. I do reviews for HRSA when we're able to view them in person and I have no conflicts for these measures.

Apryl Clark: Great. Tasha Cooper? Ashley Hirai?

Ashley Hirai: Hi, I'm Ashley Hirai. I am a Senior Scientist with HRSA's Maternal and Child Health Bureau. I think I did mention in the disclosures that I've worked on Committee selecting measures where the Title V Block Grant.

Performance and outcome measures some of which we actually elective delivery cesarean and proceeding with using different agent sources and not worked with financial developer and I need those measures. I do not consider that to be a conflict.

Apryl Clark: Okay. Great. Lisa Holtzclaw?

Lisa Holtzclaw: Good morning everyone. My name is Lisa Holtzclaw and I am currently the Women and Obstetrics Director for HCA. And I do not have any conflicts to disclose. Thank you.

Apryl Clark: Great. Mambarambath Jaleel?

Mambarambath Jaleel: Hi, good morning everyone. My name is Mambarambath Jaleel. I am a neonatologist at UT Southwestern Medical Center in Dallas and the Medical Director for one of their hospitals. I have no conflict of interests.

Apryl Clark: Great. Diana Jolles? Deborah Kilday?

Deborah Kilday: Good morning everyone. I work with Premier Health Care Incorporated and I'm a Principal leading Premier's Women and Infants Service Line. And I have nothing to disclose.

Apryl Clark: Great. Sarah McNeil?

Sarah McNeil: Hi, everyone. I am a family doctor out in the Bay Area to labor and delivery and abortion work. I have some grants that I'm supported by UCSF to study medication abortion - doctors that I disclose but it's not related to this work. And then some consulting that I do for the American Academy of Family Physicians for speakers on contraception on women's health care in labor and

delivery for family physicians, but not relevant to any of the measures coming up today.

Apryl Clark: Okay great. Jennifer Moore? Sarah Nathan?

Sarah Nathan: Hi, I am a clinical faculty at UCSF and my clinical practice is at La Clinica which is an acute fee in Oakland and I have nothing to disclose.

Apryl Clark: Great. Kristi Nelson? Sheila Owens-Collins? Diana Ramos? Sindhu Srinivas? Nan Strauss?

Nan Strauss: Hi, this is Nan Strauss. I am a Managing Director of Policy, Advocacy and Grantmaking at Every Mother Counts. And I have nothing to disclose. Thanks.

Apryl Clark: Angeline Ti? Rajan Wadhawan?

Rajan Wadhawan: Hey this is Raj Wadhawan. I am a neonatologist with AdventHealth in Orlando. No disclosures.

Apryl Clark: Great. And I know it looks like Jill Arnold is not able to speak. So, she has written into us that she has on the call and she has nothing to disclose. Same for Diana Jolles. She's also let us know that she's on the call and she's nothing disclose.

So with that, I'll ask if there's anybody else that joined the call late after we started our roll call. If they have got and providing disclosures.

Okay, great. Well, I'd like to let you know that if you believe that you might have a conflict of interest anytime during the meeting, please speak up. You

may do so in real time during this web meeting 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 bias manner you may point this out during the meeting, send a message to your chairs or to NQF staff.

Do you have any questions or anything you'd like to discuss based on disclosures made today?

Great, so just as a reminder NQF is a non-partisan organization out of resource for each other we kindly encourage that we make an effort to refrain from making comments, innuendos or humor relating to for example race, gender, politics or topics or otherwise maybe considered inappropriate during the meeting. No interest discussions that are open, constructive and collaborative that I'll be mindful of however (unintelligible) maybe perceived by others.

With that, I'm going to turn it back over to the team.

Matthew Pickering: Great, thanks, Apryl. So this is Matt once again. I will say that right now on the call. We do have 15 individuals. So for quorum we need 16. We will do another assessment just in case if you are folks may be dialing in a little bit late. We'll do another assessment during our voting test, which is in a few, later on this morning before we actually get into the measures.

So if we are able to get 16, we will proceed with the voting on the call here with the Poll Everywhere like I mentioned earlier. If we do not have a quorum on the call, oh sorry, if you're not talking would you mind putting yourself on mute. Thank you.

So if we aren't able to establish quorum, we will be sending out a SurveyMonkey link to you all, you are able to proceed in vote on your end using that SurveyMonkey link. However, we will not know the results of those criteria you're voting on. We will not be reading off any responses.

If we do establish quorum and maintain that quorum, we will use the Poll Everywhere link and then we will be reading off the responses as well. However, even after that if we lose quorum of survey link SurveyMonkey will be sent out as well. And also at the very end of this call, if we do not establish quorum, we would send out a SurveyMonkey link as well as the recording of the meeting, so that those who were not able to attend could also complete that survey.

So again we will see where we are at the voting test to see if anybody else is able to join that was joining late. Okay, so going into spring 2020. So we have six measures up for endorsement review this title as you can see listed here. Two of which are pair if not they are an eMeasure version of a sort of the paper-based version if you will of the other measure. Those measures are 0469 and 0469e and then we have 0480 and 0480e. So the e being the e Measure version of that paper-based measures.

I will say at this point that the evidence for those measures are the same. So 0469 has the same evidence as 0469e. If you saw that in your review of these during the pre-evaluation summaries or pre-evaluation comment period and then 480e has the same evidence as 480. And so when we get to those portions we would vote just once on the evidence and then we will ask for the other measure, the paired manager.

We would ask if there was any dissenting viewpoints that you have on the evidence. So the evidence would just carry over since those are paired and

also the evidence is the same and paired in this case maybe it's just the e measure version of that paper-based measure.

And then we also have 0471, cesarean birth and 0716 unexpected complications in term newborns. So we have these measures, six measures that will be going through maintenance endorsement. So maintenance, none of these measures are new measures. So just wanted to mention that as well.

So the scientific methods panel, one measure 0716 the unexpected complications in newborns went to our scientific methods panel. So, some of you're probably familiar with the kind of message panel but just a refresher. This panel is consisting about 30 individuals either these are methodology of statisticians, those researchers that are really experts in the area of reliability, validity testing. Those types of approaches especially the realm or the context of quality measurements.

They are here to advise the Standing Committee on aspects of reliability and validity. So the testing approach is, if you're thinking about risk adjustments as well, they advise on some of the approaches to that. So it really is just an advisory group and their inputs help with the deliberations on the call today, but overall your evaluation of the measure. Are those instances where the measure and the approaches that were used were just not appropriate and will not require a vote from the Standing Committee.

If anything we can discuss those measures, however, if the method is really inappropriate or needs to be - the developer needs to do additional work on that. There will be no opportunity for vote, however, the Committee can discuss it. That is not the case with 0716, the scientific methods panel passed 0716 on both validity and reliability. It's all we get to the questions for that

you will be asked if you would like to accept the scientific methods panel rating of that criterion both reliability and validity.

If you do not accept, if the Standing Committee more than 60% do not accept. The scientific methods panel you are able to, the Standing Committee is able to provide their own assessment and vote. So voting on high, moderate, low or insufficient.

So again, they're passed on both reliability and validity. The question will be do you accept their rating if more than 60% of the Standing Committee does accept the rating it moves forward with more than 60% of the Standing Committee does not accept it the Standing Committee would have to revote and provide their own assessment of high, moderate, low or insufficient on reliability and validity.

Okay. So, I'm going to hand it over to Erin, who's going to walk us through the overview of the evaluation process. Erin?

Erin Buchanan: Hello everyone. So like Matt just said before we go into the measure discussions would like to lay some ground rules and give an overview of the evaluation process. So as a reminder of your role as part of the Standing Committee is to act as a proxy for NQF multi-stakeholder membership. Work with us the NQF staff to achieve the goals of this project.

You will be evaluating each measure against each criterion. So you indicate the extent to which each criterion is met and run along with rationale for the rating. You know, so I ask that you make recommendations regarding endorsement for - to the NQF membership. And part of this Standing Committee to oversee the portfolio of Perinatal and Women's Health Measures.

For today's meeting, yes, you'd be prepared, having reviewed the measures beforehand. You should have received an email from us with all of the details of these measures. Please base your evaluation and recommendations on the measure evaluation criteria and guidance. We ask that you remain engaged in the discussion without distractions and we recognize that's difficult given that it's online.

But please, if both of you can please attend the meeting at all times and let us know in the chat box if you need to leave a minute meeting at any point, so that we can monitor quorum. Please keep your comments concise and focused as you saw we have several measures to discuss today and we would like to get to as many as possible and please allow others to contribute.

So, the first process for the measure discussion and voting. The discussion will start with a brief introduction by the measure developer. Then lead discussants will begin the Committee discussion for each criterion by explaining the information on the criterion provided by the developer. Then there will be a - they will also provide a brief summary of the pre-meeting evaluation comments.

Emphasizing areas of concern or differences of opinion, so also notes any, if you need any preliminary rating by NQF staff. And this rating is intended to be used as a guide to facilitate the Committee's discussion and evaluation. The measure developer will be on the today's call to response to any questions that the Committee might have for them. And then the full Committee will discuss, then vote on the criterion, if needed, before moving on to the next criterion.

And Hannah we'll goes through the following slides.

Hannah Ingber: Thanks so much Erin. Okay, so I will now review our endorsement criteria, how we vote on it. Our rules for quorum and then we'll conduct a voting test before we discuss our first measure. So our criteria are five votes. We have importance to measure and report, which looks at whether a measure can help drive improvements in care and it's a must-pass criteria.

You have to pass into some criteria and importance, which are evidence, is there evidence underlying the measure and evidence of providers to make changes and improve the care and gap are there disparities and care, is there room for improvement in general performance on things like that.

The next most pass criteria is scientific acceptability and it's made up of two sub criteria, which are reliability and the measure be implemented consistently for comparability and validity. Can the measure affect quality of care through the measure elements or score? These are also must-pass. Then we'll look at feasibility, how easy is it for providers and facilities to report on a measure.

And then we'll look at usability and use, how is the measure being used and how is feedback given to people being measured as well as to the measure developer and the measures to it so that they can improve that measure. Now as of fall 2017 used is a must-pass criteria for maintenance measures, which is all the measures that we're looking at today.

So you will be voting on each of this criteria each and every measure and you'll discuss them and then vote on each. We sent an email just a few minutes ago with a link to the voting site and it also in the meeting invite. So we'll be doing a voting test shortly and ask that you just start to pull up that link. Well, we're getting ready for that.

No related and competing measures were identified today. So we won't have to discuss whether the measures address harmonization or which is the best measure whether they're just like it is. Then if every must-pass criterion has received a passing vote, we will vote on the measure's overall suitability for endorsement. If at any point a measure fails must-pass criteria, then we simply finish the discussion there and then move to the measure.

And in this case, because these are all maintenance measures, if the measures don't pass, they will lose endorsement if the CSCA approves the Committee's recommendation. So we have quorum on the call when 66% or more of active Committee members are on the call. For ask that 16 out of 23 members and for this reason it's really important that you let us know if you have to leave for any reason or when you come back as Matt mentioned.

So measure passes when greater than 50% of the votes are for high and moderate or for pass and consensus is not reached when 40 to 60% of the votes are for high and moderate or pass. And the measures is not pass if it gets fewer than 40% of net flows. We continue voting on this consensus not reached measures and resolved I'm going to post comments call in September if that happens. But if a must-pass criteria fails we stop measure discussion as I just mentioned.

Okay. So again please let us know, if you need to in this part of the meeting if you need to step away and come back. Just note that discussion may occur without quorum. And if you leave, but we still have quorum and we'll continue to vote on. But we do not vote in that results without quorum as Matt mentioned. So if we lose quorum our contingency plan is to send that SurveyMonkey in the team as he mentioned.

So before we move forward with the voting tests. Are there any questions about this? Okay, seeing none and hearing none and anything on the chat box. So if you click the voting link that we recently this morning, which is in the meeting invite you'll see that I open the voting test and it says a test thank you and your answers are yes and no.

Please select yes, so that we can make sure that, you know, everything is working properly and you don't need to clear your response or anything once you vote, just stay on that same page and it will change whenever I operate it on the backend.

So just give us one minute while we check things out. Now, we have nine votes. Okay. We're seeing 11 votes, please just let us know if you're having any trouble on voting. I'll give it a few more minutes.

Matthew Pickering: Meanwhile, Hannah, doing that I just checked, has anybody joined the call that was not on at the beginning or the start of the meeting.

Hannah Ingber: Okay. I'm seeing 14 votes.

Matthew Pickering: Missing one vote there for 15. And we look like we did get an email confirmation from one Standing Committee member that they will be coming in at 11:30, which will move us over 16 if the 15 is still on the call right now. But so we may have to revisit quorum voting once the Standing Committee member comes back on.

So the Poll Everywhere would still be something we could move forward. Hannah, do we have 15 captured?

Hannah Ingber: No, we still only have 14.

Matthew Pickering: Is anybody having difficulties with the Poll Everywhere vote?

Kimberly Gregory: This is Kim, is that possible we can have another test question.

Hannah Ingber: I can navigate, yes.

Matthew Pickering: Navigate.

Hannah Ingber: Sorry, go ahead, Matt.

Matthew Pickering: No, it's okay. So what happens once it's - once the vote - when somebody voted Hannah what did they see?

Hannah Ingber: I think they should just see that your response has been shaded and that you responded.

Matthew Pickering: Okay. And then - sorry, what was that?

Kimberly Gregory: I say I was recorded at the top.

Hannah Ingber: Okay. Thank you, Kim.

Matthew Pickering: Okay. So Hannah, maybe it's - maybe we can see who's actually voted.

Hannah Ingber: Right.

Matthew Pickering: Hannah, so yes. Well at this point at least it sounds like we don't have the quorum if we only have 15 or even just 14, but we only have 15. Like I mentioned, we may have another under Standing Committee member come in

a little bit later this morning so we'll have to revisit that. We may just only get through this first measure and not have the Poll Everywhere vote.

So what I'll ask Hannah to do, Hannah, if you could send out that SurveyMonkey link?

Hannah Ingber: Uh-huh.

Matthew Pickering: So for those on the call you will be getting an email with the SurveyMonkey link you are welcome and encouraged to follow along and answer your votes through that link. But since we right now currently do not have quorum, we will not be displaying any of the votes. So you can vote on your end.

We will discuss the measure of the developers on the call to answer any questions and once we established quorum with this other Committee member and who is calling out and it's going to be quite obvious when they joined. But, yes, we will see if we can reestablish quorum and proceed with the other measures accordingly.

So let's just use the Survey Link just for this first measure since it's maybe about an hour or so before the other person comes back on. And then maybe Hannah, we can see who maybe hasn't voted in this and or having some difficulties with the voting poll. But I'd like to continue on with the call today. So if we could, I'm going to hand it over to Kim, we're going to be doing the first measure today.

So Kim, I'm going to hand it over to you for 0469 at the PC-01 Elective Delivery.

Kimberly Gregory: Great, thank you very much. I'm going to get remind everyone that PC-01 Elective Delivery is assesses the patients with elective vaginal and elective caesarean birth at greater than 37 bureau and less than 39 weeks. And I will turn it over to Martha regarding, I'm sorry, the joint commission who will talk about updated evaluation of this measure.

Woman: Hi, this is (unintelligible) from the joint commission. I'm a Project Director in the Department of Quality Measurement. Can you hear me, okay?

Kimberly Gregory: Yes.

Matthew Pickering: Yes.

Woman: Great, thank you. Yes, as Kim mentioned, the elective delivery measure description was listed there for you to see. This measure has been collected for the joint commission since 2010 and the rationale is supported or the measure is supported by multiple guidelines that require 39 weeks gestation prior to an elective delivery whether that's vaginal operative.

The studies have shown that most elective deliveries are done for convenience and that these can result in longer maternal length of stay. They can have significant short-term effects on the neonate including things like adverse respiratory outcomes, mechanical ventilation, sepsis, hypoglycemia.

So it's an important measure for both the mom and the baby. The joint commission continues to require this measure for accreditation for hospitals with 300 or more live birth per year and we feel it's a very important measure.

Well, many hospitals have been successful in reducing the rates. We see that there are still a number of hospitals that are a lot of layers and this was

described in our testing document. Our technical advisors also have expressed that there's concern that hospitals if they stop collecting and measuring monitoring this measure. It's quite possible that the rates could slip back into a pattern of allowing early elective delivery, so we feel it's important.

To continue to collect this measure for a period of time yet to assure that the practice is ingrained in the field. So we also have to retool the measure as an eCQM, which we will talk about in a little bit. But we recognize that all hospitals don't have the capacity yet to collect measure as an eCQM. And so we offer the chart-abstracted measure currently until we can get to a point that everyone can be collecting with the electronic version.

And we have worked very closely in aligning the two measure specifications to the extent possible. They are allowing to me continue this effort each year with annual updates as we make updates to the measure specifications and we'll talk more about that later we get to the electronic measure portion of the discussion.

And with that, I'll turn it back over to the Committee.

Kimberly Gregory: Great, thank you. Are there any questions? Okay, hearing and seeing none, I'm going to turn to Martha Carter who will lead the discussion for this measure and the additional review works with Tasha Cooper, Ashley Hirai and Sarah Nathan. Martha?

Martha Carter: All right. Thank you. So this is a process facility base maintenance measure that we're entertaining today. The developer did update the evidence, which supports the evidence that was previously presented in particular they presented or submitted the ACOG Practice Bulletin, which was published in 2019. This evidence was not graded, but it was reported as a Level 2

recommendations. The staff preliminary analysis rated the evidence as moderate, which if you remember is the highest possible grade.

The ACOG guideline reiterated that late preterm and early-term children have lower performance scores across a wide range of measures compared with their full-term peers. And also said that amniocentesis should not be used alone to determine gestational age and as the rationale for delivery because of other non-respiratory morbidity are increased in early preterm birth.

The other, I thought, interesting point was that there were different ways it's possible for handling enforcement of this measure and the most effective as you could imagine was in facilities use a hard-stop policy, which prohibits non-medically indicated deliveries at the hospital level. So the pre-evaluation comments, so that most people indicated there was no additional evidence beyond what was submitted.

One reviewer suggested that the background and justification for the measure be updated due to results from the arrive trial, which shows that C-section rates are not higher in the elective delivery. So I think that's all that I had do the additional reviewers have any other comments and evidence to discuss.

Kimberly Gregory: Okay, then hearing none, I'm going to turn it over to the NQF staff. We will begin the vote as we have a quorum and we'll be talking about criterion once.

Matthew Pickering: Correct. Right. And so just to say again at this point we don't have quorum for this measure, so you should have received the Survey link. If there are no other questions or discussions with this, we can move on to performance gap and you are able to vote within the Survey link on your own.

But there won't be any report out of those results at this time just because we do not have a quorum.

So if there's no further discussion around evidence. Please go ahead and use the Survey link to rate what you feel is for evidence and we will move to performance gap.

Kimberly Gregory: I'm sorry Martha, can you perform the – discuss the performance gap?

Martha Carter: Oh, sure. Sorry, I thought we were taking a minute to vote. And I was realizing I was wrong. So on this, there is – you can actually have a high, moderate, low or insufficient rating. So, I'll track that.

All right. Performance gap, recent data from 2018 were submitted. Performance rates show improvement across hospitals. While the mean of 1.7% shows performance is improving, and may mean that this measure is topping out. I think it's notable that

And of note, the performance rates on eCQM differ significantly from this measure with a mean of 17.6%. The staff preliminary analysis rated this as moderate. Pre-evaluation comments, the general consensus was that while performance has improved over time, there are still gaps in performance and variability in compliance and within patient characteristics. One reviewer did question if this measure was still needed, however.

I think we're also looking at disparities in this part of the discussion. And, you know, they were comments noted that there are disparities, particularly, by age. And they require further investigation. And one reviewer wants to know the significance of the variation based on age, race and ethnicity. So, additional reviewers, other comments?

Matthew Pickering: This is Matt, again. I just want to encourage – I'm sorry, I just want to encourage you, if you have a question, please feel free to use to raise hand feature, that way we can just identify you, as well.

And while you're doing that, I also wanted to mention that Sarah McNeil just commented previously. So sorry, Sarah, for not catching this commented previously. I believe for evidence that she was in agreement with the addition of the ARRIVE trial. So, I just wanted to recognize your comments, Sarah. So, thank you.

So, if there is a question, please for performance gap, please go ahead and use the raise hand feature.

Martha Carter: Kim, would you – this is Martha. Would you like for me to pose the question? Is there a gap in care that where, you know, disparities that warranted national performance measure, is that really what we're…

((Crosstalk))

Kim Gregory: So, we've got pretty significant national response with most institutions being less than 5%. And I think 82 hospitals still have not met that benchmark. I will say that it's one of those ones that you're very good at, and you stop paying attention to it, and it does sometimes seem to drift. So I think – I don't know, as a chair, I should have an opinion, but I think the calling to question whether it should be still maintained as an important question.

So, if there's no other – does anyone – oh, I see comment here. (Diana) has said to clarify the ARRIVE does not relate to this measure. This measure is

for less than 39 weeks and ARRIVE is greater than 39, greater than or equal to 39.

Martha Carter: Thanks for that clarification, Diane. This is Martha. So, you know, since there's such a difference between the electronic version of this measure and the original version of the measure. I think it's important to keep it until everybody really is able to report the electronic measure. After looking at all the evidence, I think that it's an important national measure.

Kimberly Gregory: I appreciate your recommendation. And I will ask if we're ready to call for vote. All right. So, we're going to vote on our SurveyMonkey.

Matthew Pickering: Thanks, Kim. And this is Matt. I do want to recognize Sarah McNeil has her hand raised. Sarah, do you have a comment or question related to the performance gap?

Sarah McNeil: Yes. The reason why I think that it's important to add the ARRIVE trial to the evidence around the measure is that the ARRIVE trial speaks to the states, give induction at 39 weeks. And so, this measure is focused on encouraging hospitals to not allow induction from 37 to 39 or discourage induction from 37 to 39 but including the latest data to say that induction in that large trial was successful at greater than 39 is relevant.

I also think that I want to put in a plug for continuing this measure because I think that while it has shown great success and change, we know that without measures hospital, things start to drift. And I think that there is still a lot of utility in continuing this measure.

Kimberly Gregory: Okay. I'm going to ask everyone to go to SurveyMonkey and vote on, is there a gap in care and/or disparities (unintelligible). We would now move on to scientific acceptability.

Okay. So, there was some new empirical reliability testing, score level reliability testing using a signal-to-noise ratio, reported a mean 0.76. And the developer notes said in general a score of 0.7 or higher suggests adequate reliability.

Pairwise comparisons from ICD-9, ICD-10 were found to not have a statistically significant difference for the numerator. But the denominator was found to have a statistically significant difference. The developer reports that the difference of 0.68 is not clinically significant. The staff preliminary analysis related reliability as moderate. And pre-evaluation comments, most reviewers have had no concern regarding reliability.

One reviewer commented, because of the – some of the indicators for delivery are subjective and not well defined, for example, logistic or cycles, social indications. There's a risk that some deliveries will be labeled medically indicated when other clinicians would not code them with a medical indication. And that was a concern for – across a couple of the questions that we're looking at today.

And so, the question for us is, are we satisfied with the reliability custom for the measure? (Natasha), Ashley, Sarah, do you have any other comments?

Ashley Hirai: This is Ashley. I don't I think there's more of a potential issue with the validity. Thank you, Martha.

Martha Carter: Okay. I'm hearing no comment. Can we vote on, are we satisfied with the reliability testing for this measure?

Matthew Pickering: Kim, this is Matt, once again. Just referring back to the SurveyMonkey. If you could just go in there and put your vote in, that would be great.

Rajan Wadhawan: Hey, Matt. This is Rajan Wadhawan. I do not see any option of being able to vote or anything beyond the test question in the SurveyMonkey that came through. I've tried to use them…

((Crosstalk))

Woman: You should be on Number 4 Q&A, Reliability.

Rajan Wadhawan: I'm not changing…

((Crosstalk))

Matthew Pickering: Hi, Raj. You may be still in the Poll Everywhere. Is the test, just a Yes, No?

Rajan Wadhawan: Yes, that is correct.

Matthew Pickering: Yes. So, there was a separate email sent out to you and the Standing Committee, just a little while ago. It should be a SurveyMonkey as opposed to the Poll Everywhere link that you're using. Did you receive that email?

Rajan Wadhawan: I did not.

Matthew Pickering: Okay. So, we can send that directly to you. This is what we're using to capture votes for this measure. We could potentially switch back to the Poll Everywhere, which is that test questions to see, once we establish quorum. However, for this measure, we're going to have to use a SurveyMonkey capture Standing Committee vote.

So, I will have our team follow-up with you with that email which is link to the survey.

Rajan Wadhawan: Thank you.

Matthew Pickering: Yes. Sorry for any of that inconvenience there.

((Crosstalk))

Matthew Pickering: Sorry, I was just checking. Anybody else have any issues or difficulties? Okay. Thank you, Raj for raising that. So, we'll follow-up with that.

Kimberly Gregory: Thank you. Martha, would you like to discuss validity now, please?

Martha Carter: Sure. So, this is validity testing potential threats to validity and risk adjustment. So, new empirical validity testing of the measure score was provided using construct validity to correlate the measure against other measures in the Perinatal Care or PC sets.

The developer noted that except for the correlation between (PCO-1) and (EPCO-5), the correlations were in the expected direction. I've pointed out that these measures really evaluate two different populations, mothers and babies. And therefore, two different aspects of prenatal care, which are apparently not correlated.

The staff noted that perhaps a stronger approach to correlation analysis would have been with a more global measure such as CMS's Five-Star System or (HCAHPS). And Invesco staff preliminary analysis rated validity as moderate.

And the pre-evaluation comments, most reviewers had no concerns regarding validity. One review noted that they would like to notice the rate of medically indicated deliveries has changed overtime. Had there been a shift from not medically indicated to medically indicated that belies some of the stated improvement.

There was a concern that some of the conditions which we heard earlier that possibly justify elective delivery and those are exclusion are subjective and vague and maybe selected by the coalition to justify, and otherwise non-medically indicated delivery. And I think maybe we need to hear from the developer on whether there's been any balancing of the data, measuring the medically indicated deliveries as a corollary to this measure.

Pre-evaluation comments on exclusion and risk adjustment, most reviewers had no concerns. One reviewer commented with our current knowledge of Institutional Racism and Implicit Bias, I'd like to see a deeper analysis, the data around social risk factors. For example, patients with no prenatal care excluded from the measure population that leaves the hospital from accountability and designing services that are accessible, all to meet them.

So, the question that we're looking at is are we satisfied with the validity testing for the measure, especially, the magnitude and the correlation? Did the additional reviewers have any comments? I'd suggest we've just said they have some concerns on validity. So, who was that, if you want to comment?

Ashley Hirai: Yes. This is Ashley Hirai. I think that – yes, there's a note from the NQF staff about correlation, the CMS Five-Star. It seemed like the other indicators, there's weak, to no correlation. And I kind of wondered why there wasn't a correlation, that was PCS specs unexpected applications of term "newborns". If this is supposed to reduce, you know, adverse neonatal outcomes.

And I would just – that I think that there's mixed evidence in the literature about state and hospital policies actually leading to improvements and outcomes. And I think, another pre-review comment mentioned that certain conditions, may be subjective or poorly coded, leading to an apparent shift in EED, when it really maybe just better documentation of conditions versus true improvement.

And I think there was also, like a hospital level analysis in New York City by (Elizabeth Howell), and that is in (unintelligible) lot of these indicators just didn't correlate well with maternal or neonatal outcomes. And yes, like the delivery was among those.

Martha Carter: And back to you, Kim.

Kimberly Gregory: All right. So, would developer want to respond to that? Okay. Does anyone else want to respond to that?

Matthew Pickering: This is Matt. I just wanted to see, is there developer on the line?

((Crosstalk))

(Susan): Yes.

Matthew Pickering: Sorry. Go ahead.

(Susan) Sorry. This is Susan. Just to respond regarding the PCO, the new measure that we did add, the unexpected complications in terms of newborn, term "newborns" measure. But that was added in January of 2019 So, we did not have that data available to us when we were doing the work for the submission for this time period.

And then I don't know…

((Crosstalk))

Woman: The unexpected term "newborn" by definition, 39 weeks. So, you wouldn't be comparing the same denominator.

(Susan): If it's 37, terms. Yes. So – you're right. For PCO-6, it's 37, unless that are excluded for the expected, unexpected term "newborn".

Woman: Okay. (Unintelligible)

Woman: So, what about the CMS Five-Star, that was mentioned by the NQF review, is that a possibility that you can perform that correlation?

Woman: Yes. (Susan), can you speak to that?

(Susan): (Steven) or (Dave), can you unmute and speak to that correlation?

(Dave) Yes. This is Dave. Yes, we did not see the correlation (unintelligible)

((Crosstalk))

Woman: You need to get directly into the mic, we're not able to hear you.

(Susan): Yes. So, this is Susan. My apologies, I don't know if they're having trouble with their – of their audio. But in a message, instant message, it was the correlation with the Five-Star rating, that it was not correlation with the Five-Star rating, which was why they did not include it in the testing document. So, they looked at Five-Star rating and there was no correlation, they did not include it.

Woman: I guess, I'm just struggling with the validity here, if there's very little correlation with other indicators, there's no kind of gold standard applied. Yes, how this could be moderate validity.

Kimberly Gregory: I think it goes back to some of the earlier work where they were able to show the impact on reducing NICU admission. So, it's not being correlated directly with the measures. It's being correlated directly with newborn outcome.

Do any other Committee want to respond to that?

Diana Jolles: Can you hear me? This is Diana Jolles.

Woman: Yes, we can hear you. Thank you.

Diana Jolles: I just would agree with Dr. Gregory. This is a very valid measure that it linked to NICU admissions and harm.

Woman: Yes. It just seems like in the documentation validity that it wasn't presented there. And there has been evidence with more recent hard stop policies. And

I think it is a question of whether we've already achieved the maximum and the topping out here.

Woman: This is (unintelligible). So, my work is in rural United States. I work in Texas and Florida. And we've definitely not topped this measure out.

Woman: There's a comment also in the chat box that is also moderate because it was directionally correlated with some of the others.

Kimberly Gregory: So, I think we can call this to a vote regarding the validity. Are you satisfied with the validity testing for the measure, specifically, the magnitude in correlation? And you're voting on your SurveyMonkey. Passed.

Matthew Pickering: Thanks Kim. This is Matt, once again. (Raj), I just want to make sure you're able to access that SurveyMonkey?

Rajan Wadhawan: Yes, I am. Thank you. I got the email.

Matthew Pickering: Great, thank you. I also want to just check in to see if anyone else has joined the call, that was unable to join at the very beginning of the meeting. I think Diana Ramos.

Diana Ramos: Hi. Yes, Diana Ramos is on.

Matthew Pickering: Excuse me, Diana Ramos. Thank you, Diana, would you mind just stating your name, your affiliation, and if you have any disclosures of interest today?

Diana Ramos: Diana Ramos with the American College of OB-GYN, as well as with the California Department of Public Health, no interest, no disclosures.

Matthew Pickering: Great. Thank you. So…

Woman: Hey, Matt.

Matthew Pickering: Yes.

Kimberly Gregory: I was wondering if we should finish this measure on SurveyMonkey, and then do the next one with the (unintelligible)

Matthew Pickering: Oh, Kim, you and I in the same wavelength, I very much agree with you. I was just going to say that. So, Diana, there was a SurveyMonkey that was sent out. We sent that out because we didn't have quorum. However, with you on, we should have 16.

So, I would ask if you have any votes that you would like to provide for the criterion that you're listening in on that you use that survey link for this measure, it's 0469e that we're on.

After this measure is done, we will do another voting test. So again, going to the Poll Everywhere to say just to make sure that we have 16. And then we'll determine if we have the quorum. But with Diana on, we should have 16. And we're still waiting, maybe for a couple folks that maybe hopping on. So hopefully, we can push that number up to higher than 16. So, thank you. I'll give it back to you, Kim to continue forward.

Kimberly Gregory: Thank you. All right. So, we should have all of those voted on our perspectives about validity for this measure. And now Martha will take us through feasibility.

Martha Carter: All right. Just a little overview, the data for this measure are collected, generated and collected by healthcare personnel during the regular provision of care. They're coded by someone other than the person obtaining new original information usually, although, not always, I would say and abstracted from a record by someone other than the person obtaining the original information.

The developer indicated that, although, EHR Electronic Health Records regularly capture these data. There are some hospitals still who need this measure because they rely on paper records review. The staff preliminary analysis rated feasibility as moderate and the pre-evaluation comments on feasibility, there were no outstanding concerns.

Additional reviewers, any questions or comments? Okay. Back to you, Kim.

Kimberly Gregory: Okay. Are there any Committee members who have comments? All right. Well, then I will call the vote to vote on feasibility using the SurveyMonkey.

Woman: Are we using SurveyMonkey or…

((Crosstalk))

Kimberly Gregory: Yes. SurveyMonkey for the rest of this measure.

Woman: Got it. Thank you.

Kimberly Gregory: And then, last well, (unintelligible) do that. We're going to talk about usability and use Martha Carter, can you help me with this?

Martha Carter: Sure. So, the developer stated that the measure is publicly reported and used in an accountability program. Hospital Inpatient Quality Reporting, which is a payment program, CMS uses it, value-based purchasing program to CMS, of course, the Hospital Accreditation Program through Joint Commission, and the Perinatal Care Certification to the Joint Commission.

The developer noted that minor modifications to the measure were made in response to feedback, but they don't actually indicate what the modifications were. Although, when I looked at the history of this measure online, I could see a lot of changes over time that were made. And I suspect response to feedback.

The developer noted that there's minimal change from 2015 to 2018. And the staff recommended pass on use and moderate on usability. I think we have two separate votes here. But there were no concerns in the pre-evaluation comments regarding use.

One comment regarding usability was that hospitals with complex, high risk patients that are not included in the exceptions may appear to have a higher rate of election – excuse me, elective induction less than 39 weeks, when in fact, they're providing good care. However, this commenter said it was unlikely that it would cause the hospital to be an outlier because they would also be hospitals with large denominators.

So that more of a comment and not, I think anything that needs to be answered by the developer. So generally, there were no real concerns on usability and use. Did the additional reviewers have any other comments?

Kimberly Gregory: Does the Committee members have any other comments?

Matthew Pickering: So, Kim, Hi, this is Matt. I just wanted to just provide a little bit more information around the use and usability. So, we've been hearing use and usability, they should be part of a two separate criterion used being a must pass for maintenance.

And so, with NQF, in our criteria, we really look at use, specifically, as if it's used within an accountability program within three years of additional endorsements and publicly reported in six. So, this gets to this transparency element of the measure, right, to see if we're able to actually see results from this and providers actually able to improve on those results. So, really trying to see if actually using some of these programs.

And there's also a feedback component with use. So, as it's used and publicly reported, can the accountable entities actually provide feedback to the developer and that that feedback is somehow incorporated, potentially, it helps to improve the measure. So those are aspects of use.

Now, we'll get into the usability portion. Usability is looking at the – how well the measure is improved overtime. So, is the measure actually doing what it's intended to do, essentially. And so, we're looking at, sort of trend data with some of those components, and explanations around benefits and harms.

So, I just wanted to just clarify that a little bit. So, when we think about use and usability as we move forwards today. Use is going to be thinking about if it's actually using the program, publicly, reported and transparent for any feedback the developer has mentioned. The usability portion is thinking about the improvement, has that measure shown improvement over time. And then, are there any benefits and harms that we should be made aware of.

Sorry, I'll just – I'll turn it back to you, Kim. Thanks.

Kimberly Gregory: Sure, thanks Matt. Thank you for focusing on that.

Martha Carter: Yes, I agree. That was very helpful.

Kimberly Gregory: So, I'm going to ask everyone if there are no other comments from our Committee to vote on both use and usability with - as I understand would use you're deciding whether you want it to pass or not pass and usability, you're rating it in terms of high, moderate, low or the amount of information.

And then finally, the overall suitability for endorsements for making that vote and open it up to the Committee to see if there are any additional comments that people want to share. Hearing none and seeing nothing in the chat box, please vote on overall suitability for endorsement. This is a yes or no voting.

Matthew Pickering: Great, thanks Kim. This Matt again. So, we won't be reading off the final results of this measure for the overall. Again, we have to look back in the votes. Again, some of these criteria in a must pass so we just needed to make sure that the votes don't lend itself to not passing.

And then obviously overall vote would be not pass. So, we have to look back at those votes in Survey Monkey and also if we needed to capture any others from those that were not able to attend the call to establish quorum on that measure.

So, if you just go ahead and make your votes for your decision on this measure, we can move forward to a voting test just to see where we are with quorum. So Kim, I'm just going to ask Hannah to pull up the Poll

Everywhere again. And what we'll ask the Committee to do now is to go into that Poll Everywhere link.

It's different from the Survey Monkey link. Again, we tried to do this earlier with the voting test. So, if you can go into that Poll Everywhere, we'll do a quick voting test just to see where we are with the quorum numbers. And Diana, this Poll Everywhere link was also sent out in an email prior to this meeting.

But also it can be found in the calendar invite as well as the Poll Everywhere. You should see, this is like a test and then a yes and no option. So, if you go ahead and fill that out, and I'll turn it to handouts to see where we are with numbers.

Kimberly Gregory: Thanks, Matt. Yes, we're at 11 so far, so keep waiting two minutes just so people get that pulled up.

Hannah Ingber: But you didn't tell us to vote. So, I'm not sure.

Kimberly Gregory: This is the test vote. It should be open. There's a Poll Everywhere and if you could select yes.

Hannah Ingber: Okay.

Matthew Pickering: And if you're having difficulty…

Kimberly Gregory: You cannot change your mind once the response is recorded.

Hannah Ingber: Sorry, can you say it again Kim?

Kimberly Gregory: You cannot change your mind once your vote is recorded.

Hannah Ingber: I believe that you are able to - are you clear? Okay, got it. I see it. Thank you. Working right now.

Matthew Pickering: If you have or you're having difficulties voting, just let us know. If you have not voted - and then again this is the Poll Everywhere link now. We're trying to see how we are with quorum. It's not the Survey Monkey. switching back to that Poll Everywhere link.

Rajan Wadhawan: Hey Matt, how do we submit the results of the Survey Monkey because we're only doing one measure on that?

Matthew Pickering: Only doing one measure. Yes, only doing one measure, so it should be captured. Is that correct Hannah? Just doing one measure should already be captured, do they have to go to the end and actually hit submit?

Hannah Ingber: No, it should already be captured.

Matthew Pickering: Right.

Kimberly Gregory: But we should keep it until the end of the meeting because we may be going back and forth.

Matthew Pickering: That's correct. Right. So, we'll keep your Survey Monkey open just in case we lose quorum once again. But for now, we will switch to Poll Everywhere if we have quorum here. Thanks Raj, great question. And Hannah where are we at now?

Hannah Ingber: We are still at 14.

Matthew Pickering: Okay.

Kimberly Gregory: Should we do a roll call?

Matthew Pickering: Yes, I was actually going to do that. Thank you.

Hannah Ingber: Mortality, you've got and so, if we didn't go through for some reason, that would highlight a problem.

Matthew Pickering: Hannah, are you able to pull those names up?

Hannah Ingber: I am, I'm able to do it either way, whatever works best.

Matthew Pickering: Okay. And Jolles has a question only the test page shows up, so that's correct Jolles, it should just be the test. It should be yes or no for the test page, if that's what you're referring to. So, Hannah, let's go through the names just to see who we have.

Hannah Ingber: Sure. Okay. I have Kim Gregory, Diana Ramos, Diana Jolles, Carol Sakala, Amy Bell, Raj Wadhawan, Mambarambath Jaleel, Sarah McNeil, Sarah Nathan, Ashley Hirai, Nan Strauss, Jennifer Bailit, Deb Kilday, and Martha Carter. Is there anyone who is trying to vote whose name wasn't called?

Kimberly Gregory: We still don't have quorum yet.

Matthew Pickering: No, it doesn't look like we still have quorum. We must have lost someone and maybe.

Matthew Austin: So, Matt Austin just joined.

Matthew Pickering: Oh, hi Matt.

Matthew Austin: Moments ago, hi.

Matthew Pickering: So, that's enough to….

Hannah Ingber: Fifteen.

Matthew Pickering: … give us over the top, so that put us at 15, Matt, thanks for joining. And Matt while we're while with you or while we're working on the voting, can you just announce your name, affiliation and if you have any disclosures of interest?

Matthew Austin: Sure, Matt Austin, the Johns Hopkins Armstrong Institute for Patient Safety and Quality and I have no disclosures to offer, thank you.

Matthew Pickering: Great. And Matt could you just mentioned about your involvement with the SMPs a measure that's been under reviewed and that you will be recusing yourself?

Matthew Austin: Yes, I'm a member of the interior scientific method panel. And there is one measure from which I've already reviewed and voted on the reliability and validity. And I don't have my computer right in front of me. So, I can't remember the number of the measure.

But I think the unexpected complications in newborns, if I remember correctly, so I will not exaggerate on the reliability and validity of that measure.

Matthew Pickering: That's correct. Great. And just so the Committee knows that that won't affect quorum. What will happen for that is that Matt's recused from validity and reliability voting, our denominator drops down to 22. So, we just need 15 people as opposed to 16.

And it looks like with Matt, I think we're still trying to get one Standing Committee member to vote here maybe having some difficulties, it puts us at 16. If we can just figure out what's going on with the Poll Everywhere. So, I will say maybe we can continue forward as we're working through this.

Matt, if you are also able to vote on the survey link just so that we're capturing you as well. This is the Poll Everywhere link. Matt, you're probably familiar with that. It's a test question. I's just a test of yes or no. If you can just click yes just so that we're capturing you.

And then we'll still work on this other Standing Committee member just to make sure that they're getting the response and that will put us at 16. So, that would be quorum, so we will proceed going into 469E and see if we can try to get the Standing Committee member through.

For that person who was unable to - having difficulties with Poll Everywhere, you can always chat it directly to the team in the chat box and we can capture it that way if needed. Okay, so we'll move forward. We'll go to 469E before I turn it back over to Kim and the lead discussant.

I will say that we also have one of our consultants on the call with us today Chris Millet, who will be providing a little bit of more information on the testing aspects for this e measure. Chris is very much involved with our E measure evaluations here in NQF providing his expertise.

And he will raise any of the major issues or concerns that maybe the Committee should be discussing as well as see if there's any questions that we received - see if there's any of those concerns the developer would like to address.

So, when we get to the scientific accessibility, I'll go ahead and let Chris, maybe do a little bit of an intro before the lead discussant, and then we can go forward with lead discussant with the Standing Committee. So Kim, I'll turn it back to you. Thank you.

Kimberly Gregory: All right. So, the good news is we should be relatively familiar with this measure as a concept. But now we're going to look at it from an electronic perspective. So, the measure is the exact same, which is elective early delivery between 37 and 39 weeks, which we would like to avoid.

And I guess, Chris, you will lead the discussion about e-measures before turning it over to the result.

Matthew Pickering: So, actually Kim. Well, I was actually having Kim maybe. Well, no, that's fine. But Chris, if you'd like to talk a little bit more about the e-measure piece that's fine to be here, yes.

Chris Millet: Oh, sure. I can speak a little on the context for that now. As you mentioned that this is a 469E is that an ECG electronic clinical and quality measure and uses the HR data. So, the fact that it's an eCQM means that a calculation is meant to be automated.

So, when we do the review for this measure, we look for a few extra things to support that. Primarily, we look at the feasibility scorecard which highlights

capability issues. But for this measure it also highlighted some feasibility issues with data elements related to accuracy.

And because it builds on accuracy, we'd like the Committee to consider the data elements of accuracy issues and whether or not there's any impact to the validity of using data elements to automate the measure. This is something that when we get to it, the sort of developer can elaborate on more on the vision. And yes, I'll stop there.

In the document, if there are any other questions, I'm happy to speak well on that.

Kimberly Gregory: Okay, the questions request are perhaps we'll get the Joint Commission input and then regroup. Okay, so the developer for the Joint Commission would like to address this measure please.

(Marilyn Franson): Hi, this is (Marilyn Franson). I am one of the measure developers on ePC-01. This eCQM does closely align with the charts directed measure which was just previously covered. And we continue to harmonize and update on an annual basis to bring that alignment closer together.

Using 2018 data, we performed a comparative analysis between the chart of structured measure in the eCQM and we found estimated gestational age to have a high missing data rate which was found to be due to timing. In 2019, we updated the timing attribution in the logic for better alignment with the chart-abstracted measure.

Also, due to the transition from ICD-9 to ICD-10, some of the related data elements from the initial reliability testing were removed and replaced to support the changes within the standards.

Stillbirth is an example where there is a slight deviation from the chart obstructive measure, where the eCQM identifies this data element using a SNOWMED code versus a manually extracted data element of history of stillbirth for the chart-abstracted measure. So, those are few examples of where, you know, we're trying to explain the differences between this chart-abstracted and the eCQM.

Kimberly Gregory: I'm sorry. So, you're saying that this is diverse, would be a reason for an exclusion but that's not an ICD-10 code?

(Marilyn Franson): I know it's not, haven't been longer.

Chris Millet: Interesting. Okay. Yes. So Kim, it was included in a code. And when the ICD-10 was originally put in place, and then coding guidance changed and so it was added as a separate data, chart-abstracted data, elements in the chart-based measure, but in the eCQM, it can be captured through SNOWMED codes.

Kimberly Gregory: Okay. All right, are there any other questions for the developer?

((Crosstalk))

Woman: Sorry, just a question for the developer exactly right. In terms of the difference, if you know if there's any information on, you know, what explains the discrepancy between e-measure overall rates compared to the, I guess paper version.

Is it, you know, different hospitals contributing? Is it a coding issue or is it stillbirth issue that you just mentioned? What are your thoughts on when explained that difference?

Man: This is (unintelligible) from the Joint Commission, everything okay?

Kimberly Gregory: Yes.

Woman: Yes

Man: Okay. Well, there's two considerations. One having to do with the numerator and one having to do with the denominator. So, the denominator, we really talked about was the gestational age of being able to capture that in the eCQM. And that's pretty much a hospital issue, so either a hospital can do it or they can't do it. So if a hospital can't do it, they pretty much don't have a population for that measure.

For the numerator, it's a matter of being enabled able to exclude it through the eCQM. And a lot of potential exclusions were not captured in the eCQM but were captured in paper measure or the chart-based measure.

So, it's been able to capture those exclusions and having enough of a denominator size. That kind is the difference between the rights, mostly the former issue of capturing the right exclusions.

Kimberly Gregory: This is Kim. Do you anticipate that ICD-10 will evolve to be able to capture that?

Man: Yes. And in fact, even between 2017 and 2018, we've noticed an improvement in their being able to do that. So, it's kind of like with our chart-

based measures of getting used to measure being able to capture the right data elements that improves over time and we're seeing the same thing with these eCQMs.

Kimberly Gregory: Okay, Martha, would you like to comment?

Martha Carter: Sure. So just as an overview, this is a maintenance measure. It's not yet publicly reported. And through the comments, we'll see there was a lot of concern about the lack of good reliability between the two measures. Although there seems also to be an opinion that this is an important measure to continue to develop may not be ready for primetime in terms of being publicly reported.

Shall I go on to evidence? We can dispense with that one pretty quickly, I think.

Kimberly Gregory: Actually, we can take this opportunity to say that we accept our votes for evidence…

Martha Carter: Okay, good.

Kimberly Gregory: …on the e-measure, I mean on the first measure and then move to….

Matthew Pickering: So sorry, yes...

Martha Carter: Do we still need to vote?

Matthew Pickering: …we would, because we actually didn't get the Committee to vote, right? So now that we have quorum, we would actually have to vote on this. We

can't carry over the Committee's recommendations necessarily because we didn't capture them all.

Martha Carter: Got it.

Matthew Pickering: So, maybe we could just vote on this e-measure for evidence. You can just keep in mind, everyone that the evidence is the same from the paper-based measure. So, if you were within those conversations around that, please keep in mind that the evidence is the same.

I know there are some new folks on the call that weren't involved in that previous conversation. So, we didn't have quorum to discuss any of that or within a quorum to establish those votes. But if there's an opportunity or if you'd like to raise any questions you have an opportunity to do it now for those that weren't around for the evidence, discussion or quorum.

But if not, we can move to vote. So, we will be voting on evidence here for this e-measure.

Martha Carter: And this is Martha, I want to add that the staff preliminary analysis rated the evidence as moderate if that helps anybody.

Kimberly Gregory: Okay. Are we voting on the vote anywhere?

Matthew Pickering: Right. So, it will be Poll Everywhere. Right.

Kimberly Gregory: Poll Everywhere, okay, thank you.

Matthew Pickering: Yes, so many, right?

Kimberly Gregory: So, it would Question 10 on Poll Anywhere. Important to measure…

((Crosstalk))

Kimberly Gregory: …1A evident.

Martha Carter: That's a Survey Monkey tool, so we need to wait for…

Kimberly Gregory: Okay.

Martha Carter: The Poll Everywhere to come up for us.

Kimberly Gregory: Oh, I'm sorry. You're right.

Matthew Pickering: So, if there's no other questions yes, we can have Hannah open up the Poll Everywhere vote.

Hannah Ingber: Yes, I'm ready to activate it if there's no other question.

Martha Carter: I don't know where mine, which…

Hannah Ingber: Perhaps someone… go ahead.

Matthew Pickering: So, yes, I was just - so this is the not the Survey Monkey because we now have 16 people for quorum. This is the Poll Everywhere link. This was the test question that we just did just a little while ago, so it's that link now. And I still see, I don't see any hands raised or questions in the chat box.

So, Kim I think we could move to vote.

Kimberly Gregory: Okay. So, there should be a Poll Everywhere and it's not numbered. But the options are: A high, B moderate, C low, and D insufficient. So, please record your response in the Poll Everywhere on evidence.

Matthew Pickering: And Hannah, maybe I could ask to share your screen with folks so they can kind of see what…

Hannah Ingber: Yes, I will once we have all the votes in, we're counting 15 right now.

Matthew Pickering: Okay.

Hannah Ingber: Waiting on one more. Okay, we have 16. I'm going to lock in the votes by deactivating and I'll share my screen. Just bear with me one moment. Okay, it's very small because the question is very long. But you can see that we have three votes for high and 13 votes for moderate with a total of 16.

So, this measure passes on importance to measure and report.

Matthew Pickering: And here we have zero for low and zero for insufficient.

Hannah Ingber: Yes, correct. Thank you

Matthew Pickering: Great.

Hannah Ingber: Okay, I'll hand it back to you all.

Matthew Pickering: So, yes. And so, great. Thank you, we have captured the votes. I will ask this one question. Are there any dissenting comments or views if we carry over this rating for evidence to the 0469? That's the paper-based measure, same evidence.

Kimberly Gregory: I know that we do that.

Matthew Pickering: Okay, great. Hearing no other comments or dissenting views on that, we will do that. So, that evidence will carry over, great. So, thank you very much for that and we will move forward with performance gap. Thanks, Kim and (unintelligible).

Kimberly Gregory: Okay, so now we're going to talk about the gap before the e-measure, Martha?

Martha Carter: Sure, thank you. So, we're looking at performance gap and disparities. The developer submitted the most recent data from 2018 and the rates do show an improvement across hospitals. However, there's a pretty significant difference between the rates shown on this e-measure and the original, what we're calling the paper-based measure.

The mean on this measure was 17.6% with a standard deviation of 21.6% and the original measure was 1.7%. So, there's quite a wide variation on especially by age and race. The staff analysis rated this as high in the pre-evaluation comments.

Well, we notice a significant gap in care that this measure seems to report and questions, of course, why there's such a difference between this measure in 0469, some of which the developer has addressed. There was also another request for analysis of the significance of the variation based on age, race, and ethnicity.

Any other comments from the additional reviewers? The question for us is, is there a gap in care and/or disparities that warrants a national performance measure. Back to you Kim.

Kimberly Gregory: That I don't know, I would say that most of this difference is probably related to coding. And once we start measuring it, that coding will improve. But it is more than noteworthy that the difference is supposed to match between the e-measure and the (unintelligible) measure.

Martha Carter: I agree and that there are so many differences in age and race categories in particular, which seems to be running a lot closer in the original measure.

((Crosstalk))

Kimberly Gregory: The Committee is very quiet. Is there any comments from my Committee?

Ashley Hirai: Hey Kim, this is Ashley. I'll just say I mean, I think here, there's obviously more of an improvement gap because the percentage is higher, but then we're not clear how to interpret that. If it's because I'm not having these codes for exclusions, but I just feel like a lot of people probably think that this percentage is probably more accurate somehow.

Sorry, I think there's just this fundamental tension on the validity here and whether maybe there is some over-coding of conditions and somebody mentioned in the previous comments like subjectivity. So yes, I mean, I think we want to believe that the performance gap is closer to this percentage but then it seems like it's because of not including all the necessary exclusions.

Matthew Austin: So, this is Matt Austin. I guess I have a, maybe a technical question for NQF, which is the discrepancy between the paper version and the electronic

measure. Is that really sort of a validity question or reliability question more than a performance gap question? Because if we look at the electronic version on its own, we do see that there's a gap and there are disparities.

And if we ever saw the paper version, we would sort of, I guess, come to the conclusion that we do have a gap in disparities. I guess I'm trying to figure out where we are correctly to sort of give the feedback about the difference between the two.

Matthew Pickering: Yes, it's a great question Matt, and this is Matt. So, I think you know, taking the performance gaps and trying to compare them, you do see that discrepancy. I think what you're getting that is correct. It's like what could be underlying reasons for this.

Is it more of potential issues with the reporting of the measure if that's happening potentially across the two, some validity concerns regarding exclusions? Some of the things that the staff have noticed as well as the developer has provided some rationale around some of the feasibility and data elements with the e-measure that we'll get into.

So, I think we notice the discrepancy in the performance gap. But I think some of the underlying questions related to why it's going to be where we're getting into the validity and reliability aspects of the measures. So, and Matt I appreciate you trying to be focused and focusing your comments to the related sections.

So, if they're starting to get into, well, is it more of the reasons around some of those critical data elements that the developer has mentioned in their testing, then I would reserve those comments for those aspects of our

measured valuation today. So, the validity criteria and reliability criteria. Does that seem to answer your question Matt?

Matthew Austin: Yes, that does. Thank you.

Martha Carter: This is Martha. It seems though that we really don't know, which is, I think actually a good reason to continue this measure. We don't know if the disparities that we seem to be seeing here are accurate or whether there are results of data collection problems or a combination.

So, I think, you know, my take on this is as the developer further refines the measure and as hospital systems and the EHR systems get better at extracting these data, we may see a change in the performance gap and disparities, but right now we can't really know.

But my interpretation is we're seeing a performance gap and disparities. And therefore, I would concur with the staff that there's a high rating on this one.

Kimberly Gregory: And, can I confirm who is this present?

Martha Carter: I'm sorry, this is Martha. I apologize for not introducing myself.

Kimberly Gregory: No, no, no, I should recognize your voice by now because it's just you and me talking. But I just want to add that, essentially it meant it says the same thing that we need to collect the data better to understand interject to the chat box. So, other people agree with your assessment thing.

Martha Carter: Well, I'm going to call the votes in. The Committee should vote on is there a gap in care or disparities that warrant a national performance e-measure for this PC-01 and we'll be voting using Poll Everywhere.

Matthew Pickering: Okay, so I'll turn it to Hannah, but I believe the voting poll is open.

Hannah Ingber: Yes, thank you Kim. Thank you, Matt. Yes, voting is now open on importance to measure and report 1B. I'm still waiting on two more votes. Sorry, I'm going to unmute. Okay, we have 16 votes, so I will lock in these responses and share my screen.

Okay. So, you can see here a little easier to read that the responses for importance to measure and report, we have nine votes for high, seven votes for moderate, zero votes for low, and zero votes for insufficient for a total of 16 results. Therefore, the measure passes on importance to measure and report.

Kimberly Gregory: So, that brings us to the exciting topic of scientific acceptability. Martha?

Martha Carter: Thank you, Kim. So, is this where we get Chris to come in and talk to us more about the specification?

Matthew Pickering: Yes. Chris, are you still on the line?

Chris Millet: Oh, yes, I'm still on.

Kimberly Gregory: Chris, this is Kim, could you also add in the context of this is not the first e-measure out there and is it usual to see this type of discrepancy when you go from paper to be?

Chris Millet: Sure, this is - yes, this is definitely not the first eCQM. What is usual from what we've seen in our review is that - let me back up.

When we do a technical abuse in eCQM, we look for a few things, because eCQM must be automated, we check, we require that the developer provides this feasibility scorecard, which typically is used to identify feasibility issues for calculating reporting the measure.

However, what is typical is that sometimes we notice that there are issues around being able to use the data elements that feed the measure. So, well, there use to be due to different domains which pretty calls them in the scorecard.

One of the – the domain of our workflow, availability, standards and accuracy. And this measure, we put all this quite a bit of the data elements and issues around accuracy. And that is the case in those eCQM as well and developer usually can speak to their experience of trying to use the data elements in the fight of acceptability here as well as their experience of testing.

And the question then we would ask is, based on the developers' rationale, how important are these issues for determining, using these data elements for automatically calculating these measures. Is there an issue with using these data elements?

So, I hope that provides a little context for the kinds of things that we're highlighting around the data elements use in this measure.

Kimberly Gregory: Okay. Thanks, Chris. So, I think we first look at vote on specifications. Matt, helped me out here.

Matthew Pickering: So, what we are going to do is…

Chris Millet: Yes, we have to vote on measure specifications, whether the specifications for the measure are consistent with the evident.

The specs have been updated since the last NQF review says the developer to improve alignment with the chart-abstractive measure. They are so Committee concerns that several exclusion elements may be difficult to obtain and that reliability is impacted by accurate coding of exclusion criteria. So, I don't have anything else on specification.

Kimberly Gregory: So, this is Kim, I can see mechanistically where this is a problem. For example, a patient gets admitted at 35 weeks or whatever. A week later in the coding, somebody has to update that they are now 36 weeks. And then a week later, they have to update that it's 37 weeks. And the person doing that updating is the clinician.

I don't know to what extent the medical record coder goes back after delivery to confirm the gestational age at delivery and then updated again. Does anyone know that process?

Lisa Holtzclaw: This is Lisa Holtzclaw and I apologize. I don't know the process to that. You really brought up a great point.

I think in the delivery summary though, the delivery summary states the gestational age upon delivery because it's usually updated in the physicians' delivery note to my recollection.

Martha Carter: This is Martha. If this is all abstracted from coding then the clinician delivery note wouldn't be used. So, to Kim's point if the coding isn't updated it may not get captured. I guess the coder goes back and looks at the - we need a coder on this call.

Lisa Holtzclaw: Yes, I agree.

Martha Carter: If the coder goes back to look at the actual dictated note.

Lisa Holtzclaw: I thought I did. I can't stick to their process.

Man: That is the process, Lisa, at our institution for the quarter to look at all the physician notes and then code accordingly. So, I would think it would get captured, if it is either documented in the physician notes or some systems may have electronic data capture where it is going to automatically update the gestational age of the pregnancy as the pregnancy versus after it is put in by nursing that couldn't be at the time for admission.

Lisa Holtzclaw: I agree.

Kimberly Gregory: This is Kim, I also think most places do not code until the discharge has already occurred or right around the time of discharge. So, they are not putting it in multiple times.

Lisa Holtzclaw: Correct.

Kimberly Gregory: Okay. Thank you for that. Well, I guess being sort of - do our lead reviewers have any comment or suggestions about data reliability or the scientific acceptability?

Martha Carter: I think Kim, we are actually - this is Martha. We are looking - we have a couple of votes in this section. So, we are looking right now at specifications only, measure specification. Are the specifications consistent with the evident?

Kimberly Gregory: Great.

Matthew Pickering: Right. So, I'll add to this piece as well. So, with this measure specifically, the developer did a validity testing at the data element level. So, this can replace what we would see for reliability testing at the data element level.

And so, it gets to the specification piece, but if there's validity-based parents who have guidelines. This approach of doing validity testing at a data element level can sort of replace that reliability tests. It actually can show and demonstrate reliability.

So, the highest really possible rating in the absence of score level, reliability testing is moderate. So again, the developer had performed data element, validity testing, which for NQF guidelines which of course can demonstrate the reliability testing. But in the absence of reliability testing, the score level, the highest we can go is moderate.

So really, we are looking at a lot of what we've been discussing right now is just, you know, the data elements being there. Critical data elements and agreement with those as replacing those pieces.

Kimberly Gregory: So, can I ask…

Matthew Pickering: Sure.

Kimberly Gregory: …would you either do the e-measure or the chart measure or would you do both? Is this like a data test for the e-measure, wouldn't we, what's our vision of how this is going to be used?

Woman: This is Joint Commission (unintelligible)?

Kimberly Gregory: Please.

Woman: We encourage our organizations to use both. Both are available. And then that allows us to do some of the statistical work that we spoke of comparing the measure and find opportunities where we can address some of the issues and concerns were raised by the group.

And, you know, we've made great progress there. And I'd also like to defer to Mia Nivera who's one of our lead Informaticist on this measure. Mia, can you comment on a couple of things that were mentioned?

Mia Nivera: Yes, absolutely. Hi, this is Mia Nivera. And so, one of the things of the eCQM is that these data elements are typically in a discrete element, and that's how they are captured within the EHR.

And specific to the question regarding the ETA calculation. Well, there're several ways a site could do that. And we allow for the capture of a discrete element using a coding concept where they have a specific location in the ER where they document ETA.

Also based on some of the calculations that we could use from ACOG to determine ETA, there are discrete elements that use that calculation so that it would not rely on assessment but a calculated number for the EGA assessment. Does that help with the question that was asked earlier regarding how EGA was captured?

Kimberly Gregory: Yes.

(Tricia Elliot): And this is (Tricia Elliot) from the Joint Commission also, the one thing that I like to point out with these types of measures particularly as we kind of have both, the attracted measure can be sampled. So, organizations would use sample methodologies to review the petition whereas obviously the eCQM would be a 100% of those that meet the criteria of how the measure is specified.

Kimberly Gregory: Okay. This is Kim. I think we are – are we ready to vote on reliability? Well, we are in the scientific accessibility phase and we'll be voting on the data element, scientific reliability.

Martha Carter: This is Martha. I think you are ahead of us. I think we are still in measure specifications in the SurveyMonkey tool. We actually have a vote on specifications. It sort of overlaps with the next one on reliability because of the way the testing was done.

So, we actually have three votes in this section on specifications, reliability, and validity. Is that correct, Matt?

Kimberly Gregory: I'm looking at the actual poll where Poll Everywhere and…

Matthew Pickering: Right.

Kimberly Gregory: The question of scientific acceptability of measure property to a liability, including precise specification, testing, whether we are using the appropriate method and scope with adequate results.

Matthew Pickering: Yes. Thanks correct.

Martha Carter: This is Martha. It confuses me because the SurveyMonkey actually has a separate vote for expectation.

Kimberly Gregory: Right. And we didn't actually talk about reliability in detail.

Matthew Pickering: Right. So, right, Martha, yes. So, Martha great questions. So again, this measure, the reliability testing for this measure was not conducted in the sense that, you know, you would see for like score level reliability, data reliability was that they did the validity testing at the data element level, which per NQF guidelines that validity testing can demonstrate reliability.

And so that aspect of reliability is demonstrated through the validity testing of the data element level. And so, the highest score that we can actually get there would be moderate.

So, within the Poll Everywhere, that's where we are starting - that's where we have this question of the specifications, all of these for reliability. But what you have to take into consideration is, is the validity testing sufficient for the reliability testing?

Ashley Hirai: And the NQF staff review has not changed, I mean the initial assessment there was insufficient for reliability.

Matthew Pickering: Right. Who is that? I'm sorry.

Ashley Hirai: This is Ashley.

Matthew Pickering: Hi, Ashley. Right. So, the NQF staff, our preliminary rating, we had rated as insufficient for this piece. And this is just because of what we felt was some of the missing data or some of the data elements that the developer

said that they could not capture, which were some of the things that we've been discussing on the call. So, we have read that as insufficient.

Now, please, you know, this is where the Standing Committee based on your discussions and deliberations and your expertise provide your own rating. The preliminary rating, we have as insufficient because of some of the critical data elements that the developer had mentioned could not be assessed for accuracy.

So, that's why there was an insufficient rating there.

Kimberly Gregory: And this as well, I just want to add to that. I'm sorry…

Ashley Hirai: Go ahead…

((Crosstalk))

Ashley Hirai: No, no go ahead.

Robyn Nishimi: I just want to add to that content, to that insufficient. Part of the issue for NQF staff on rating it insufficient is we aren't able to make a clinical assessment as to whether those data elements are really important or not. And that's why we rely on you to make that assessment and that may well change your rating significantly.

It's just that, you know, that's the purpose of the Standing Committee at this point.

Martha Carter: This is Martha if I can add to that just, so the developer found there was an err of the staff, actually found that there was near perfect agreement for three of six critical data elements, but moderate to poor reliability for the other three.

The developer thinks that those are not as critical. The three elements that have a poor Kappa are medical induction of labor, active labor, and prior uterine surgery. So again, to Robyn's point, does the Committee feel that this is a significant problem and thus earns the rating of insufficient or can we live with the poor correlation in those three elements?

Kimberly Gregory: So, this is Kim and I would say, I would agree on prior uterine surgery, that being able to tell that that person was an active labor it's critical because they are an active laborer. It wasn't elected.

(Heidi Bosley): Hi, this is (Heidi Bosley), a consultant for with Joint Commission on these measures. I just, can I provide a little clarification and may ask the Joint Commission team to clarify the testing that you are reviewing. I want to make sure that you understand what's in front of you if that's okay.

Kimberly Gregory: Okay.

(Heidi Bosley): Okay, I'll keep going then. Because I know we are going to hit your lunch break pretty soon. So, the testing that Joint Commission's provided for this eCQM is a comparison of what was produced from the electronic extract of the measure against what was then produced from the chart extraction.

It's really considered with some groups called Parallel Form, Reliability Testing. But NQF has always, from what I've seen considered it to be satisfying data element validity. In no way, did we try to identify or determine how reliable that data is.

All we were showing you was when we looked at a chart extracted data, which we considered, in essence, the gold standard, because it pulled everything from all fields, all notes, et cetera, against an electronic extract. This is what we found.

So, I want to make sure that that's clear. And maybe some of the Joint Commission staff were more statisticians and can dive in a bit more. But the other thing I think we should clarify too is the feasibility testing that you are reviewing is from the last submission. So, correct me if I'm wrong, but I do not believe it reflects current feasibility status for those data elements. (Mina), did I get that right?

(Mina Vera): That is correct.

(Heidi Bosley): Right. So, I think it's worthwhile. I wouldn't hang my hat on what you see for feasibility because it's probably, our hope would be updated. And I think that's where seeing what we found that the validity testing is probably a better thing to look at. David, Steven, anyone from Joint Commission? Did I miss something or anything you wanted to add?

Man: No, that's good. And with the additional comments, we've seen improvement over time in the two years we've looked at it in some of these data elements.

Kimberly Gregory: Okay, then I'm going to ask the Committee if they have any further questions or comments?

Okay, hearing and seeing none, I want you to go to your Poll Everywhere and the question before you is scientific acceptability of the measure property. And your options are high, moderate, low or insufficient.

Hannah Ingber: We have 14 results right now just waiting on a few more. We have 15 now, so just waiting on one more vote.

Kimberly Gregory: Did you see that one person needed to step away? Hannah, she's waiting. Okay.

Hannah Ingber: Okay. Bear with me just one more minute.

Matthew Pickering: So, Diana, I'm just checking, you are still on?

(Diana): Here, I'm still on. I'm here and I voted.

Matthew Pickering: Great. Thank you.

Woman: And I voted as well.

Matthew Pickering: Well, thank you.

Hannah Ingber: It looks like we have 17. So, someone has joined us. If you could announce yourself.

Matthew Pickering: So, someone joined that maybe had to come back didn't vote previously. I think maybe, is it Lisa? Lisa, are you - I think you might have step away and then are you back on and have voted? Lisa, are you there? Okay.

So, we do have the 16, so we have to - so yes. So, I think it was Lisa. Lisa, just checking. Lisa, are you able to chat? Are you there? Did you step away and come back to vote? Okay.

So, when you identify potentially who that person is. Just one more time, does anybody not vote previously and now is voting. And Lisa, are you there?

Okay. So, until we try to identify that person, I'm afraid we may need to just proceed without reading off the votes. So, we are going to be working on that on the back end. So, I would hope to turn back to the Standing Committee to discuss about the validity portion of this measure. So, back to you Kim.

Kimberly Gregory: Okay. Actually, back to Martha, would you like to take on the validity discussion for at least that for us, please?

Martha Carter: Sure. So, thank you. We are looking at validity testing, potential threats to validity and risk adjustment. So, for data element validity testing, the developer stated it believes that the most critical data elements required for the measure show validity. Fifteen items were not assessed for accuracy and two data elements were not included in the feasibility assessment that comes from the staff.

For score level validity testing, the developer correlated this measure with other PC measures and reported and accepted the correlation between this measure and the exclusive breast milk feeding PC-05. The correlations were in the expected direction.

The staff preliminary analysis voted validity as moderate. And in the pre-evaluation comments, there was concern for the effect of coding and lack of testing for accuracy of certain data elements and I think they want the developer to address the importance of the items that weren't assessed for accuracy.

Also, there was concern given the significant difference compared to the non-e-measure. And it was noted that the developer reports that missing rates for data elements is decreasing over time but obviously hasn't been fully resolved. Any additional comments from the additional reviewers?

Ashley Hirai: And this is Ashley, I guess, in looking at the detailed correlations, and this is on Page 42 of the document, the PDF on the measure. If you look at the empirical measures for validity section and the correlations there's a zero - basically a zero correlation with this paper version of this measure. So, if there's absolutely no correlation, how could it be valid?

Martha Carter: Does the developer want to address this question?

Man: Yes, this is (unintelligible). Hello. I mean, the low correlation could be because we have small numerator sizes. So, it doesn't take much to be not very highly correlated. In the race and to be very small as well. So, there's not much room for variability.

Martha Carter: And you are doing, I wonder if there's a difference between like Pearson and Spearman rank correlation here? Is this - can you tell us which correlation?

Man: Yes, on the chart-based side, more than half of the reporting values are zero. So again, very little room for variability.

Martha Carter: Okay. I'm going to call for votes in using your Poll Everywhere. Hannah, can you help us?

Hannah Ingber: Yes, sorry, one second. Okay. So, we are voting…

Martha Carter: So, using your Poll Everywhere, we are voting on scientific acceptability of the measure properties to be validity and your options are high, moderate, low, and insufficient.

Hannah Ingber: Okay. We are at 11 results. Okay, people a few more minutes or seconds to vote in and just don't hold your response there when we declare it.

Martha Carter: How are we doing?

Hannah Ingber: Bear with me while I'm just figuring out the adjudication of this result. Okay, I will display the result. Just give me one minute. Excellent, clear. Okay.

We have 16 votes now. Please just leave your voting. No need to clear it. That way I can display the results. Thanks.

Matthew Pickering: So, we are still waiting for that 17 person, Hannah?

Hannah Ingber: Yes.

Matthew Pickering: So, whoever cleared their vote…

((Crosstalk))

Hannah Ingber: …in the chat box that someone for that last vote they voted and then cleared and voted again?

Matthew Pickering: Yes. I didn't notice that. Thank you. So, we did clarify what was happening in the last vote. So, we'll read off those results after we capture all the votes here. So, we just need you to vote. I think somebody had cleared

the vote right now for validity. So, if you could just put your vote back in. Hannah, how are we doing? We only have 16?

Hannah Ingber: Uh-huh.

Robyn Nishimi: Well, since we have quorum, why don't we just close the vote?

Matthew Pickering: Yes, let's just close it.

Hannah Ingber: All right, I'm closing the vote here, responses are further locked in. Let me share my screen. Okay, you can see here, scientific acceptability of measure properties 2b, we have two votes for high, 12 votes for moderate, two votes for low and zero votes for insufficient. Therefore, the measure passes on scientific acceptability of validity.

Matthew Pickering: Okay. And then Hannah, can you display and read off the results for reliability?

Hannah Ingber: Yes, I can. Give me just one minute to get back to that. Okay. So, for reliability, we have one vote for high, 10 votes for moderate, four votes for low and two votes for insufficient. No share of the vote received greater than 60%. So, consensus is not reached on this on aspect of the measure.

Matthew Pickering: Okay. So, just to tell the Committee what happens now with the next steps here. So, since consensus was not reached on this criterion, this measure, we will have to move the discussion and the consideration of this measure to the spring post-comment periods whose consensus was not reached on reliability.

We will proceed on voting – sorry.

Robyn Nishim: I'm sorry, Matt. But wasn't there a high, one high?

Matthew Pickering: One high.

Robyn Nishim: And 10 moderate, so that's 11 so that's 64%.

Matthew Pickering: Hannah, can you confirm that? That's right.

Hannah Ingber: Yes right, I will display the percentages and then we can see it that way. Okay. You were right, Robyn.

Matthew Pickering: So, apologies there. So yes, now we have - this does pass on reliability. Apologies for that so we can scratch that. So, it does pass for reliability and we will proceed moving forward. So, on the feasibility.

Kimberly Gregory: Okay. So, this is Kim and we have two votes left. I want to do a reality check for everybody. We are at 925. We were supposed to go to lunch five minutes ago. But I think that I would like to finish this measure before we do that. So, I'm asking for permission and taking the chair prerogative all at the same time.

So, we are going to move to feasibility, Martha?

Martha Carter: Sure. Thank you. Few comments, all data elements are in a defined field in EHRs. The staff preliminary analysis rated feasibility is high. One reviewer supported this measure saying, "Although there are discrepancies between the paper and the data formats. It's critical to keep improving electronic data collection systems." And that's all I had for that. Any additional comments from the other reviewers.

Okay, hearing none and seeing none in the chat box, I'm going to call the vote. So, if you could put the question out, Hannah?

Hannah Ingber: So, feasibility. Yes. So, voting is now open on feasibility. I will wait until we get a few more. We're at seven right now.

Woman: I'm just so frustrated. No, I'm just talking in general.

Hannah Ingber: Please be on mute. Yes. 15 - just turned to 17. I will lock in the votes. And you can see we have nine votes for high and eight votes for moderate on feasibility. Nine votes for high, eight votes for moderate, zero votes for low, and zero votes for insufficient. So, total of 17 votes. Therefore, the measure passes on feasibility. Okay. And last but not least, usability and use. Martha, can you share?

Martha Carter: Sure. And remembering that great description last time and the difference between use and usability. This measure is reported – was this reported publicly, no. The original measure is reported publicly but this measure is not yet reported publicly.

But it is used in some accountability programs, by CMS's Hospital Inpatient Quality Reporting Program and Joint Commission Hospital Accreditation Program and public reporting is planned. So, I guess it is publicly reported. It's reported but not in general, to the general public.

In terms of feedback, the developer notice that minor modifications to the measure were made in response to feedback. We don't have this performance data from the 2016 version, so we can't compare to assess the improvement,

and this is from the staff. And if the staff wants to elaborate on that it would be helpful.

If you recall, there was a pretty big difference between the paper and the electronic versions, in terms of performance. So, the staff preliminary analysis recommended path on use and insufficient on usability because of the data problems that we've already noted in this discussion.

From pre-evaluation comments, since this measure is not yet publicly reported, reviewer of questions the timeline for public reporting and how this will be reconciled with the related measure 0469.

And another reviewer commented that it seems that accuracy of maternal health data has been a lower priority for EHR vendors than say, chronic disease management. And that vendors need to be held accountable for accuracy of maternal health data in order to improve usability of this measure.

So, I think we have some mixed reviews on use and usability. Any additional comments from reviewers?

Matthew Pickering: So, this is Matt from NQF. Thank you, Martha for mentioning the usability component. Again, we're voting on these separately. So, I know we're talking about it together, but we're voting on this separately that difference I've mentioned previously.

The usability component, I wanted to elaborate on that, as well. So again, usability is looking at improvement over time. And looking to see if there's actually change in the measure score. The measure is actually doing what it's intended to do.

What we noted is that we didn't see any data presented over time in the 2020 submission. It was only for the period 2015, 2017. So there really wasn't a data, enough data for us to really determine improvement up to the point of where we are today. There wasn't enough performance data for us to merely make that determination based on the data that was submitted, which is older data.

There was no improvement from 2014. And so, we rated this as insufficient on usability, just because we weren't able to adequately make a determination as to just from what was presented to show that there was improvement. So, we look to you all to deliberate on that and come to a rating for this criterion.

(Susan Kane): Hi. This is (Susan Kane) from the Joint Commission. May I make a comment?

Woman 1: Please.

(Susan Kane): On page 15, we do show the data that we received in 2017 and 2018 and to the comparison there showing that the rate has improved. And then we also just wanted to point out that the collection for the eCQM data, we did not receive at the Joint Commission, we had a pilot, I believe it was in 2016, but 2017 was the first year we received data. Do I have that correct (Steven)?

(Steven): Yes, that's correct. In 2016, there were only a handful that reported for that particular year. So you really wouldn't want to use it for a comparison anyway.

Woman 1: So this is voluntary for hospitals report now?

(Steven): That's correct. Hospitals choose a number of eCQMs to report to the Joint Commission and that measure is on the list.

Woman 1: Okay. Then I'm going to ask my committee if they had any additional questions. Hearing none and seeing none, I'm going to call for the vote on usability. Hannah?

Hannah Ingber: Sorry, I was just getting off mute.

Woman 1: Okay.

Hannah Ingber: We're voting on use first and then usability that we (unintelligible).

Woman 1: Yes, please.

Hannah Ingber: Yes. The vote is open now on use. Your options are pass or no pass. We're at 12 responses.

Woman 1: Okay, so - there is, okay.

Hannah Ingber: Just waiting on two more people. We still have only 15 votes. Okay, we have 16 votes now. We're just waiting for one more.

Robyn Nishimi: This is Robyn (unintelligible) last time we're at quorum, I say we should look to close the vote.

Hannah Ingber: Okay, all right. I will lock in the votes. Let me share. Okay. So for use, you can see we have 16 for pass and 0 votes for no pass. Therefore the measure passes on use.

Woman 1: And we'll now vote on usability.

Hannah Ingber: Okay, thank you. Yes, the vote is now open on usability. Your options are high, moderate, low or insufficient. We're at nine votes. I'm just waiting on one more. Okay, we're at 16 votes, so I'm going to lock in and share. Okay, you can see here the results for usability and use there, we have two votes for high, 10 votes for moderate, three votes for low and one vote for insufficient. Therefore the measure also passes on usability.

Woman 1: Beautiful. Okay, so that brings us to lunch and I will turn it over to NQF to give us…

Matthew Pickering: We actually will vote on the overall first.

Woman 1: I'm sorry.

Matthew Pickering: Yes.

Woman 1: One last vote which is the overall endorsement of the measure - suitability for endorsement. And this is a yes or no question.

Hannah Ingber: Thank you, yes. The voting is active. We have 12 responses so far, waiting on two more. Okay, we have 16. I'm going to lock in those votes and you can see the overall suitability for endorsement, we've received 16 votes and 0 votes for no. Therefore the committee recommends this measure for endorsement.

Woman 1: Congratulations committee. We got through two measures and now I will ask NQF to give us our return instructions.

Matthew Pickering: Okay. So thank you very much. We got through the first two measures on the agenda. Now, we will be breaking for lunch. And so will the committee be okay if we still reconvened maybe not at 1:20, but at 1:30? Will that be sufficient for you all?

Man 2: Yes, that sounds good.

Woman 1: Yes, it'll be fine, yes.

Matthew Pickering: Okay, all right. So we will reconvene at 1:30. You want to welcome to lead the platform up. We will keep it up and we will reconvene at 1:30 and go through the rest of the measures. So thank you all very much.

Woman 1: Thank you everyone for your participation and helping us work through the bugs and we will see you back at 1:30. Thank you, bye. Everybody is on lunch break right now. We will be back at 1:30.

Sheila Owens-Collins: Okay, thank you. This is Sheila Owens-Collins. I'm sorry that I'm just joining. But I'll be back at 1:30 then, thank you. Good bye.

Matthew Pickering: Okay. Hello. This is Matt Pickering from NQF. I think we're going to get started. Just to check, can anyone hear me?

Hannah Ingber: This is Hannah with NQF, yes, we can hear you.

Woman 1: Yes.

Matthew Pickering: Great. Okay, excellent. So I do want to thank everyone for coming back to this meeting as we're going through spring 2020. So hopefully we'll have time for fall 2019 discussions. I do want to quickly do a roll call just to

capture - again to see if we have quorum and make sure that we have those folks on the phone who are on previously.

So I'm just going to go through the list here. And if you could just say present or here as I call your name out, that will be just fine. So I'm going to get started. Kim? Kim Gregory, are you there? Okay, maybe will come back. I know like Kim had to step away closer to 2 o'clock, but okay. Carol?

Carol Sakala: Yes, hello.

Matthew Pickering: All right Carol, okay. Jill? Matt Austin? Matt, are you there? Okay. Jennifer? Amy Bell?

Amy Bell: Yes, I'm here.

Matthew Pickering: Okay. Martha?

Martha Carter: Yes, I'm here.

Matthew Pickering: Thank you. Tasha? Ashley?

Ashley Hirai: I'm here.

Matthew Pickering: Thank you. And Lisa? Okay. Mambarambath?

Mambarambath Jaleel: Yes, I'm here.

Matthew Pickering: Thank you. Okay. Diana Jolles?

Diana Jolles: I'm here.

Matthew Pickering: Thank you. Deborah?

Deborah Kilday: Hi everyone.

Matthew Pickering: Thank you. Sarah McNeil?

Sarah McNeil: Here.

Matthew Pickering: Thank you. Jennifer Moore? Sarah Nathan? Nan?

Nan Strauss: Hi, I'm here.

Matthew Pickering: Thank you. Sorry, I jumped up a little forward there. Kristi? Okay. Sheila?

Sheila Owens-Collins: Yes, I'm here. Thank you.

Matthew Pickering: Hi Sheila, welcome.

Sheila Owens-Collins: Hi, yes.

Matthew Pickering: Sheila, I know that you were on - yes, thank you very much for joining. Would you mind stating your name, your affiliation and if you have any conflicts of interest to disclose?

Sheila Owens-Collins: Okay. My name is Sheila Owens-Collins, no conflicts of interest and I'm with Mednax Pediatrics and Neonatal & Perinatal Consulting.

Matthew Pickering: Great, thank you. And Sheila, I believe there may be a conflict of interest form that we still need from you. So what I'm going to do is one of our team members…

Sheila Owens-Collins: No, I've…

Matthew Pickering: You received it and filled it out?

Sheila Owens-Collins: Yes, and I sent it back.

Matthew Pickering: Okay.

Sheila Owens-Collins: It would have been yesterday or the day before, but I have sent that out.

Matthew Pickering: Okay. So we'll confirm with…

Sheila Owens-Collins: But let me know if you haven't got it out, I will send it out again.

Matthew Pickering: Great, thank you. And so we'll confirm with the team and then follow-up accordingly. But thank you very much for joining. Okay. Diana Ramos? Sindhu? Angeline? And Rajan?

Rajan Wadhawan: Yes, I'm here.

Matthew Pickering: Okay. So I'm just going to go back to just to confirm. Jennifer Bailit, are you here?

Jennifer Bailit: Yes, I'm here.

Matthew Pickering: Okay, thank you. And Lisa? Lisa Holtzclaw, are you there? And Kimberly Gregory?

Kimberly Gregory: I'm here.

Matthew Pickering: Great, thank you. And Sarah Nathan? Diana Ramos? Okay. So I count - I think we are less than quorum at this point. So I don't think we'll be able to proceed with the voting. I believe we're at 14 people. And Matt Austin, are you - you're here. Are you there, Matt?

Matthew Austin: I am here.

Matthew Pickering: Okay. So I still think we're less than 16. Okay. So at this point since we do not have quorum since some people - well, I'm sorry, my team is mentioning in me here. So Sarah Nathan and Jill Arnold, are you here?

Jill Arnold: Yes. Jill Arnold is here.

Matthew Pickering: Great. And Sarah Nathan? Okay. So - Sarah, are you there?

Woman 1: Sarah is chatting out. We're getting a lot of feedback on someone typing. So if they could mute their lines, thank you. Sarah is chatting…

Matthew Pickering: Okay. Yes, thank you.

Woman 1: …that she is present…

Matthew Pickering: Great, awesome.

Woman 1: …so I'm not sure (unintelligible).

Matthew Pickering: So we are at quorum then. Thank you Sarah and we can proceed. So we will now proceed to the next set of measures which is 480e and then 480. So we're doing the e measure first. And I'm going to turn it over to Carol here in a second. But the reason why we're doing the e measure first is that (Chris) who is again our consultant for our e measures will need to leave the meeting a little bit earlier.

So that's why we're putting the e measure up first. So if we can just go to that e measure real quick and then I will turn it over to Carol who will introduce the e measure. Okay, Carol, over to you.

Carol Sakala: Great. Well, thanks everybody for hanging in there. This is a challenging process to do this day long remote and I'm back to everybody.

So this is one of the perinatal care, Joint Commission measures, PC-05 Exclusive Breast Milk Feeding and that number is 0480e. And this is a measure of the rate of babies that are discharged from hospitals who have only been fed breast milk during their hospital stay.

And I just want to check in about the best time for (Chris) to weigh in. Well, I'm not sure, (Chris) if you'll be able to be with us for this whole discussion or when would you like to share information?

(Chris): Hi. I could make a brief comment now. So the findings that we - that I've had on reviewing this measure is similar to the previous measure. The only difference mainly being which elements had the issues in terms of feasibility issues that may have had some accuracy issues. So that's the main difference. I can hang on the line until about 2 o'clock evening.

Carol Sakala: Okay, great. Thank you very much. Okay, so do we have Susan or someone else from the Joint Commission who can give us some overview of this?

Susan Yendro: Sure. This is Susan and I'll go ahead and start with the clinical and time portion of it and then I'll have the eCQM person jump in with just a few brief comments as well.

So as it was stated, this is a measure that looks for exclusive breast milk feeding for the newborn's entire hospitalization. The measure is supported by a number of organizations who have set the goal for exclusive breast milk feeding for the first month of life including AAP, ACOG and WHO.

Studies have shown that breastfed children who have at least six - that breastfed children have at least six times greater chance of survival in the early months when compared with non-breastfed children.

The breastfeeding also drastically reduces deaths from infections such as respiratory infections from diarrhea and other infectious diseases. WHO and UNICEF recommend breastfeeding, they recommend that it's initiated within the first hour of life and that it's done exclusively for the first six months. Studies also show that there is a number of maternal outcomes that are improved by breastfeeding including decreasing postpartum blood loss as well as a more rapid, you know, involution of the uterus.

And I will skip the chart-abstracted comments and tables for later and turn it over to the eCQM comments. Yanyan, are you…

Yanyan Hu: Yes, I'm here. Thank you, Susan. Hi, this is Yanyan Hu. I'm the Measure Lead for PC-05 eCQM. The eCQM - PC-05 eCQM is closely aligned with

the chart-abstracted measure. And so we continue to (unintelligible) and update on annual basis.

Using 2018 data, we performed the validity testing of data elements for the same patients on both the eCQM and the chart-based measure. The data element agreement rates are above 97% which are well within acceptable level, yes.

Carol Sakala: Great. So anyone else on the Joint Commission? Okay, one person…

Susan Yendro: Answer questions however you need.

Carol Sakala: Thanks. Great, Matt and Hu. So this time around, Ashley Hirai is our lead discussant. So we'll let her kick us off with the question of evidence under importance to measure and report. We'll then offer the additional reviewers who are Matt Austin, Lisa Holtzclaw or Diana Ramos an opportunity and then open it up to the entire committee before we go on to the voting. So Ashley?

Ashley Hirai: Thanks Carol. I guess I do have a disclosure that I'm currently exclusively breastfeeding. I have almost five-month old and a toddler. So having an infant and a toddler in a pandemic, it has been very challenging. I appreciate your support as I – for discussants to jump in. I don't think I reviewed the e measure as well. I thought we would (unintelligible) reversed.

But the evidence I think hasn't changed and since the last submission there was an update to the AAP recommendations that was noted. I think, you know, the Joint Commission could also reference an update from the Cochrane review, there is the 2012 update, I think the 2002 cited.

There is also a newer Lancet review in 2016 that could be (decided), but the evidence really hasn't changed and that it hasn't been graded although the Cochrane review does discuss some evidence from the community (tile). So we can't randomize individuals to proceed or not, but we can randomize communities to receiving breastfeeding, encourage it.

And both trials confirm the major benefit on reducing respiratory infections and gastrointestinal disorders. But longer-term benefits, we're not seeing in terms of child obesity or cognitive development. And I think that the maternal benefits on breast cancer are probably the strongest. So I feel that there is, you know, consistent support for this measure that the staff rated it as moderate and preliminary. And I'd welcome any other additional comments from the co-discussants.

Matthew Austin: Yes. So this is Matt Austin. I would concur that the evidence is very strong about the value of breastfeeding and in terms of both health for the newborn and health for the mother. I do hear concerns about this measure, specifically the lack of exclusions specifically around, you know, when the infant is suffering from malnutrition or dehydration and the mother stop producing the milk.

I guess there is some other, you know, concerns about contraindications for breastfeeding for moms who are HIV positive, mothers who are using illicit drugs. So I'm not sure this is necessarily an evidence question for the measure developer, but at some point, will be interested in sort of hearing the thoughts around the very small limited number of exclusions.

And I guess the other sort of potential exclusion I will be concerned about is sort of mother's choice and where does that sort of come into play. And this is in no way to argue with the overwhelming evidence that breastfeeding is

obviously helpful and fantastic and I voted one in (pro breastfeeding), but I do have some concerns about sort of the lack of exclusions for some of these other cases.

Carol Sakala: So before we go to other comments, I would welcome somebody from the Joint Commission to respond including the question of what will be a target rate here, because I think it's always more challenging when we don't have a 0% or a 100% aim which I know is the case in this measure.

Susan Yendro: Sure. Hi, this is Susan Yendro again from the Joint Commission. Yes, so one of the things with the exclusive breast milk feeding measure that we have targeted is a rate of 70%. We feel that that's an achievable benchmark. We do have hospitals that are achieving that.

We don't expect it to be a 100%. We do mention that whenever we're talking about the measure to make sure that folks now that we're not looking for a 100%. And certainly that would sort of cover those people who choose not to breastfeed or can't breastfeed for whatever reason within that 30% difference there.

One of the things that we did try in the past, some of you who have been around a while with this measure might remember the PC-05a measure which took out those instances of - with maternal conditions as indicators who're breastfeeding as well as mother's choice.

And what we found was that the burden for collecting that and the emphasis that was placed on documenting that the mother receives to breastfeed, triple way a lot of the organization's energy from focusing on those moms that wanted to breastfeed and focusing on helping to support the moms who want

to breastfeed as oppose to focusing on documenting how you try to get someone breastfeed who didn't want to.

So that measure we retired and we're working for this measure as, you know, more of the outcome of the actual exclusive breast milk feeding as oppose to taking out a lot of exclusions which again as I said sort of pulled the focus from when it should be.

Carol Sakala: So I guess…

Matthew Austin: So this is Matt.

Carol Sakala: Yes go ahead, Matt.

Matthew Austin: I just had a sort of a quick follow-up question and I can appreciate that there is a value of sort of a more simple measure. I guess my only concern is, are there hospitals out there that care for patients that have higher rates of these contraindications? And are we sure that 70% is achievable is for every hospital? Can the Joint Commission kind of speak to that what are they have been able to look at that?

Susan Yendro: Well, I can say, in talking with some of our clinical experts, in California they did look at combining the initiation of breast milk feeding with exclusive. And they found that the difference between those two measures wasn't great and that the real meaningful difference was shown in the exclusive looking at the exclusive breast milk rate. So we haven't, you know, initiated the look at that at this point, again, kind of reflecting back on the experience that we had with the PC-05a measure.

Matthew Austin: Okay, thank you very much.

Carol Sakala: Okay. So I'm not sure if Lisa has been able to join us, but I'm wondering if Lisa or Diana has a further comment as additional reviewers a question?

Diana Ramos: Hi…

Lisa Holtzclaw: Hi, this is Lisa. Go ahead.

Diane Ramos: No, I was just going to say I think Matt pretty much covered the outstanding questions that I had. So no other questions from me, this is Diane.

Lisa Holtzclaw: And this is Lisa. I as well, I guess I have some of the concerns as well about some of the exclusions, so thank you for bringing that up. And so my question has been answered.

Carol Sakala: Great. On that topic or on the general criterion of evidence, other questions or comments from committee members?

Mambarambath Jaleel: Carol, this is Jaleel here. Can you hear me?

Carol Sakala: Yes.

Mambarambath Jaleel: Yes. So I have a question or a concern about this measure. The intent of this measure is to encourage breastfeeding and to encourage exclusive breastfeeding which is wonderful, but that is mother's own milk. So what has happened with this measure is that it doesn't clearly specify whether this breast milk feeding is mother's own milk feeding or donor breast milk? And what has happened in several hospitals is that there has been increase of the usage of donor breast milk and there has been a significant increase.

While there is evidence for definite advantages of donor breast milk in preterm infants with the reduction in necrotizing enterocolitis and et cetera. There has been no evidence of any benefits of donor breast milk in term infants.

And so what this measure is doing is taking away the supply of donor breast milk from the preterm infants and there are many hospitals which are using donor breast milk. And since the measure does not specifically say, I think the distinction has to be made between mother's own milk and donor breast milk.

So I would like to hear a comment or a response from Joint Commission or the measure developer or if anybody else has a clarification on that.

Carol Sakala: Great. It's really an interesting point. Susan or someone else from the Joint Commission.

Yanyan Hu: This is Yanyan. Currently the breast milk, the value set. We contain breast milk and also express the breast milk. So…

Mambarambath Jaleel: So donor breast milk is considered breast milk?

Yanyan Hu: Exactly. So this is what I'm saying. I was on mute. Yes, so that's inclusive. Does that express or explained your concern, to raise your concern? So I hope so.

Mambarambath Jaleel: Sorry, I think you were on mute and probably we missed out on some of the things that you were saying.

Susan Yendro: Yes, I think which - yes, this is Susan from the Joint Commission. I think what Yanyan is saying is that the codes are not specific enough to say that it was donor versus breast milk within the - a value set for the eCQM.

Mambarambath Jaleel: Yes. So I think this would lead to a concern, because there is a definite disadvantage, a negative effect of this is people are using donor milk much more in these term infants and late preterm infants without any evidence for its benefit and possibly taking it away from the preterm infants. So how would you address that going forward?

Susan Yendro: We have not looked at that. We have allowed even in the chart-abstracted measure for a case to pass if they use donor milk.

Rajan Wadhawan: Hey, this is Rajan Wadhawan. I like the opportunity and I'm also a neonatologist and I have the same concern. While the intent of this measure really as Dr. Jaleel mentioned is to promote maternal breastfeeding by a mother. And what it inadvertently doing is that, it is also including all of those neonates that maybe receiving donor breast milk without any evidence of benefit for those infants.

So I'm on the same track as well that I think we need to think through and what could be in this measure that actually (floors) the donor breast milk term neonates or getting donor breast milk preterm is all different story as we know about the benefits there.

But in term infants excluding those are not including those, because that's actually creating potential harm and not potential advantage based on what Dr. Jaleel just mentioned.

Mambarambath Jaleel: Thanks Raj.

Tricia Elliott: This is Tricia Elliott with Joint Commission. If you have evidence to share on that donor issue, we would love to take that into consideration.

Mambarambath Jaleel: Well, there is evidence in the preterm infants that yes it benefits. There is no evidence to say that it benefits term infants. So I'm not sure if there is anything in literature which still says that yes, there is a beneficial effect.

Tricia Elliot: Okay. And I think clarify…

Carol Sakala: And could I just - I'm sorry, go ahead.

Tricia Elliot: Yes. I was going to make the comment that I don't think the (exporting investor) has caught up to that particular - shall we say area. So as - because Yanyan had meant that it includes mother, you know, feeding and then express milk as well. So it does include those. But currently we do not see in the coding any way to note that it was donor.

Lisa Holtzclaw: And I just like to make - ask for a clarification. Is this a gaming to perform well on the measure with the understanding that once the baby goes home, those babies are going to be fed breast milk substitute?

Mambarambath Jaleel: Absolutely.

Lisa Holtzclaw: I was (unintelligible).

Mambarambath Jaleel: One could - yes, go ahead Lisa.

Lisa Holtzclaw: And - no, I was going to say and I'm not to say 100%, but I would say without a doubt that has - and I'm not sure it's gaming the system, but it's to meet the measure, right. And so I think we've lost the intent that going back and I apologize to the neonatologist and I'm sorry, your name, I just - I had a 55-year old brain…

Mambarambath Jaleel: Jaleel, yes.

Lisa Holtzclaw: …right now.

Mambarambath Jaleel: That's right.

Lisa Holtzclaw: But no, I can say that they're using the donor breast milk and I have to also be a champion for the utilization of the donor breast milk in the most appropriate population it needed.

It is a very precious commodity and it's - we call it liquid gold. And, you know, at times especially right now I just have to think that we've had a - we had a hard time getting some breast milk, because with the COVID, we had a decrease in folks donating.

And so we had to almost - and I know we're not supposed to use organizations that has to remind them where they need to utilize the breast milk and where they shouldn't be at this point just because of - they left with limited resources that are out there. But I would say the whole intent was to have the mother really work on her breastfeeding.

So I think it goes back in that question that as (nurses) in the bedside, do we need more lactation specialists? How many more resources can we give to the mother to help her with feeding? Or what are some of the - you know, how

can we help her versus just giving donor breast milk? And that's one thing I really - I'm trying to champion where I work.

Carol Sakala: So this is really an interesting and important issue for the joint commission to take up and try to understand moving forward the extent of the problem and whether they want to try to make any adjustments for that. I don't think we can change the current specifications now. So I would ask if there are any other members of the committee who wanted to make a comment on the evidence. And then I think we have a quorum to move towards voting after that.

Mambarambath Jaleel: Carol, is there a specification that we can put in for Joint Commission to respond to this question, because this is a great concern. How do we do this? So once we pass this measure, it will not come back to NQF or us some more time, right, maybe three years, is that what the rotation is?

Matthew Pickering: This is Matt from NQF. Yes, that is correct.

Carol Sakala: And the other option for comments is that there was fully opportunities to put comments in the record after our meeting, so they can go in and I think very frequently those are included verbatim in the reports these days. Is that correct?

Matthew Pickering: Correct. That is correct. Any comments received…

Carol Sakala: Yes, so that…

Matthew Pickering: …we'll include verbatim, yes.

Diana Ramos: Yes, this is Diana and I just wanted to comment on the preterm babies that - and the donor breast milk. And I think this is important to capture and I agree especially with the preterm birth, because they disproportionately affect women of color higher and African-American women.

And I really think this isn't something that we - that I'm glad it was brought up because of the donor milk and this maybe something where the information maybe missed and some hospitals maybe (dinked), because they're the ones taking care of higher risk patients that may not be breast feeding whether the baby was preterm. And again, it just - it disproportionately affects women of color.

Carol Sakala: Thank you.

Susan Yendro: Hi. This is Susan from the Joint Commission. I just wanted to point out that this measure is specific to term 37 weeks or greater babies. So those preterm babies are excluded. So it sounds like we can certainly take back the recommendation to look at, you know, whether or not donor milk should count for term babies. However, the - I think we need to point as well the ability to tease that out in the eCQM may or may not be available.

Diana Ramos: And it sounds like there may be an educational component to hospital staff to understand that they're not improving their rates by giving the milk to preterm.

Matthew Pickering: I did want to recognize the question from Jill. And I'm not sure if anyone on the call would have any of this information or if the Joint Commission knew. But the question from Jill is just saying that, are there any data on the incidence of use of donor breast milk? If anyone can maybe provide some references there?

((Crosstalk))

Jill Arnold: Hi. This is Jill. Just like how widespread is the problem, because it doesn't seem we're changing unless we actually have something in the literature to say that this is a widespread problem.

Mambarambath Jaleel: Yes, anecdotally I can say that yes, it is happening in the hospitals, but…

Jill Arnold: At what rate?

Mambarambath Jaleel: I'm not sure. But you can see the concern. The intent of this measure is extremely good and we want to encourage that, but at the same time we don't want people to game the system.

Rajan Wadhawan: I believe there is huge variability in the prevalence of this practice. There are going to be a lot of hospital (unintelligible) almost 0%. I think there are certainly some that are using it more often. And the problem is there is no data on that that anybody have you all know about that. But I'm not sure anybody can answer how widespread this problem is.

Jill Arnold: Okay. So the burden of proof will be on, you know, how to figure out how widespread this is before people make big changes on this.

Mambarambath Jaleel: I don't understand why the burden of proof is (unheard). The burden of proof should be with the community, with NQF, with everybody else and with Joint Commission too, because - while the intent of the measure is good and we all support it, there is a possibility and a potential for abuse of this - negative effects of this.

Rajan Wadhawan: And I will just add to that. Even if the problem was not widespread or there is an opportunity for gaming of the measure should - does it not be (unintelligible) all of us to look at opportunities to improve that measure, but that is not a potential opportunity for anybody to that even if it's all may not be really widespread.

Mambarambath Jaleel: Because the intent is breast milk feeding mother's own milk, right? That's what we want to encourage. But we are not encouraging this by having the place where we can game the system.

Carol Sakala: And the recommendation is for six months, not for the first three days although there is definite benefits in that.

Mambarambath Jaleel: Okay.

Carol Sakala: Okay. Really interesting question and I have my finger crossed that we have a good quality of research next time we discuss this.

So could we now please move Hannah toward a vote on the first matter of evidence?

Hannah Ingber: Yes, thank you Carol. I've now activated the voting on importance to measure and report. Your options are high, moderate, low and insufficient.

Carol Sakala: And could we say what QQC stands for please?

Hannah Ingber: Yes. Quality - Quantity, Quality and - goodness.

Matthew Pickering: Consistency.

Hannah Ingber: Thank you.

Carol Sakala: And have those been submitted?

Matthew Pickering: So the - I'm sorry, the question on whether the Quantity, Quality and Consistency have been submitted for this measure?

Carol Sakala: Yes, wondering if high is an option or not for folks.

Matthew Pickering: So yes, it is an option - no, I'm sorry, excuse me. It would not be an option for this because of the QQC not being submitted for this measure.

Carol Sakala: Thank you.

Hannah Ingber: Okay. So the traces are moderate, low or insufficient. Okay, we're at 17. I believe we're on voting on one more vote, but we are at quorum. I'm going to lock in the responses and share my screen.

Okay, as you can see it's a little small on importance to measure and reports. We have one vote for high, 14 votes for moderate, two votes for low and zero votes for insufficient and the total is 17. So the measure passes on evidence 1a, importance and report.

Carol Sakala: Great. Thank you. So Ashley, do you have a comment on the question of performance gap?

Ashley Hirai: Sure. I can just send this seems to be a high room for improvement, substantial hospital variation both from the e and the paper measure. Here we're focusing on the e and it looks like 54% (need wide) in the cortile range

25% or so. And definite (unintelligible) with the African-American babies having half the rate of whites. So yes, it does seem like there is a strong high rating for opportunity for improvement and there didn't appear to be any report for the contrary in terms of other commenters or reviewer pre-evaluation comments.

Carol Sakala: Thank you. The other discussants, any comments or questions?

Matthew Austin: This is Matt. And for me, I would agree that there it does appear to be a gap there across different groups.

Carol Sakala: Okay. And anyone on the committee has anything more to mention or ask about performance gap? Okay. Hannah, it looks like we can move to a vote on this question.

Hannah Ingber: Thanks Carol. Okay. So I have activated voting on importance to measure and report 1b. Your options are high, moderate, low or insufficient. We're getting five. We're waiting on a few more. We're waiting on three more votes. Just one more. Okay. We have quorum. So I'm going to lock in the votes and share.

Okay. You can see here for importance to measure and report on performance gap, we have nine votes for high and seven votes for moderate, zero votes for low and zero votes for insufficient for a total for 16 votes. Therefore the measure passes on performance gap.

Carol Sakala: Thank you. So back to you Ashley on the whole question of scientific acceptability starting with reliability.

Ashley Hirai: Okay. So I guess we're still on e measure and so reliability could not be affect at the level I guess element reliability testing and so there is empirical gold validity testing. And that appears to be acceptable. Yes, general agreements, I think there is that issue of gestational age, the preterm.

But it was strongly correlated with the paper measure and correlates with other - I guess weakly correlated with some of the other prenatal quality measures, but moderately correlated with the - I think with the CMS rating, but that that may have been just for the paper version.

Carol Sakala: Okay, thank you. I think I would like to give (Chris) a chance to comment, but maybe we should hear first from the additional reviewers.

Matthew Austin: This is Matt. I don't have any additional comments at this time. Thank you.

Carol Sakala: Great. So (Chris), now we're sort of in the weeds here in your area. So do you have further things that you want to say about the specifics? You're maybe on mute.

Matthew Austin: I think he indicated he had to drop off at two, is that correct?

Carol Sakala: Yes, thank you. We had a robust discussion and so (unintelligible). Okay. Anyone else on the committee who would like to comment on this I guess combined area of scientific acceptability?

Sheila Owens-Collins: Hi. This is Sheila, can you hear me?

Carol Sakala: Yes.

Sheila Owens-Collins: Hello? Yes, you can hear me?

Carol Sakala: Yes.

Sheila Owens-Collins: Okay. I'm just trying to get in for about 45 minutes. I think you had me on mute. So this is basically a check. But, you know, I agree with what everyone else is saying that the gestational age clarification will be helpful. And I definitely agreed with the (epidemiologist) that donor breast milk should not be used in term infants, (unintelligible) then it could be much better used in the preterm babies. So, you know, that's my (bow) into it. So now I think I can vote and so I'm online with you guys.

Carol Sakala: Great. I'm sorry about that challenge Sheila.

Sheila Owens-Collins: Okay, yes.

Carol Sakala: And - okay. And just wondering, (Chris) is gone, but anyone else from the Joint Commission who wishes to comment on the specifics here of the elements, please do so now. Okay. So I think what we can do is open it up - yes.

Susan Yendro: Hi. This is - I'm sorry, this is Susan. I believe perhaps (Mia) was trying to get into the - are you able to speak?

(Mia): Yes. Hi, yes, so sorry. This is (Mia) from the Joint Commission. And I just wanted to clarify that the assessment, the feasibility assessment that was presented was from the initial assessment. And I believe that we had - we would replace what you would see in those data elements in the - I'm sorry in the reliability.

Carol Sakala: I'm not quite sure I understand what you're saying. Are you saying that - when you said initial, when this e measure was first developed and now you have, I think better updated data, assessing data?

Susan Yendro: So I think what we're trying to say is - sorry, this is Susan again, that the feasibility scorecard that was initially submitted when the measure was first reviewed in 2016, those data elements overtime have changed - the value sets have changed the - I'm sorry, I'm not the informatics person, but the language has changed around some of that, so some of those data elements have actually changed.

And what we did was the comparison - I think we talked about that a little bit - earlier with the other measure is the comparison between the chart-based measures and the eCQM measure, the one-to-one match and we're able to match those data elements and we had a very high rate of match between the chart-abstracted and the eCQM on a data element to data element comparison.

Carol Sakala: Thank you. If there are no further comments from the committee or developers, I think Hannah we can go to a vote on all the scientific acceptability items.

Hannah Ingber: Thank you Carol.

Matthew Pickering: And just a reminder, since this is the reliability testing, they did the data element validity testing in replace of that, so the highest we're going to be going for on this vote will be moderate. Again, since the validity testing at the data element level is here in place of the reliability testing, the highest that we have is moderate.

Hannah Ingber: Thanks Matt. Yes, so voting is now open on scientific acceptability (2a) reliability. We have 14 votes in so far. Just waiting on three more. Just one more. Okay. I'm going to lock in the votes. We have quorum and I will share my screen.

Okay. So you can see here, scientific acceptability of measure properties for reliability, we have 15 votes for moderate, one vote for low and one vote for insufficient with a total of 17. So that means that the measure passes on reliability.

Carol Sakala: Okay. Now, do you have validity?

Hannah Ingber: Yes, give me one moment.

Matthew Pickering: And so does the committee have any other discussions on validity at this point?

Lisa Holtzclaw: This is Lisa, I do not.

Diana Ramos: And Diana likewise do not.

Hannah Ingber: Okay. Then…

Matthew Austin: This is Matt, real quick. There is a note about that some of the elements were not able to be assessed. If there were seven items that (we're going to) assess for accuracy, would the measure developer talk a little bit about that in today sort of can I understand what the impact is of not knowing the accuracy of those like from the (sensitivity) analysis?

(Mia): Hi. This is (Mia) from the Joint Commission. I'll be happy to answer that. So some of these as you mentioned had changed in the terminology and so they were not assessed for example in the standards. The physical exam performed; we have a different way of being able to express that in the updated specification for gestational age specifically. So those were not assessed for accuracy if that's helpful to understand what that is trying to communicate.

Matthew Austin: So just so I understand, it's the way the measure is being endorsed using the old sort of criteria or is it using the new criteria?

(Mia): The initial - the feasibility assessment that was reported was referring to an old feasibility assessment and for the submission we use the validity - data element validity to represent the updated specifications. We did not conduct another feasibility assessment, but rather a data validity comparison with the chart-abstracted measure.

Woman 2: Right. This is (unintelligible). Just to answer that a little bit more, what do you think? I mean I think the data element validity probably gives you a better sense of at least across the broad (class) of hospitals using different vendor systems, how accurate and well, valid the information is, right, which is in some ways I think we saw to precede it's feasibility, because feasibility is inherently I guess to a certain extent assumes, because we've got discreet sales they're pulling it from using the coding standards and modifying clinical workflows as needed. So it was just not something that was updated and provided because we had the other more detailed information on validity.

Matthew Austin: Okay, thank you.

Carol Sakala: Any other comments or questions? Okay, Hannah?

Hannah Ingber: Thanks. Okay. I will now open voting on scientific acceptability, validity. Your options are high, moderate, low or insufficient. We're at five responses. Just waiting on one more. Okay, wonderful. We're at quorum. I'm going to lock in these responses and just one second.

Okay. So now you can see here scientific acceptability of the measure properties, validity, we have three votes for high, 10 votes for moderate, three votes for low and one vote for insufficient for a total of 17. We have the measure passing on validity.

Carol Sakala: Okay, thanks Hannah. So Ashley, on to feasibility.

Ashley Hirai: Yes. So it didn't appear to be that there were any concerns about feasibility on the elements where any electronic health records and I believe yes, the preliminary rating for feasibility was high and no concerns from pre-evaluation comments.

Carol Sakala: Thank you. Other reviewers?

Matthew Austin: This is Matt…

((Crosstalk))

Carol Sakala: I'm sorry. I didn't hear who was also speaking with when Matt spoke.

Lisa Holtzclaw: This is Lisa. I mean I have no other comments.

Carol Sakala: Thank you. Okay. Anyone else on the committee with comments on feasibility?

Sheila Owens-Collins: This is Sheila Owens-Collins. I have no other comments, thank you.

Carol Sakala: Great. Okay. Hearing no one, I will ask Hannah to open up her vote on feasibility.

Hannah Ingber: Thank you. Yes. So I've now opened the vote on feasibility. Your options are high, moderate, low or insufficient. We're recording 12 votes right now. Just waiting on one more. Okay. We have quorum. So I'm going to lock these in and share.

Okay. You can see here, we have for feasibility, seven votes for high, nine votes for moderate, one vote for low and zero votes for insufficient for a total of 17 votes. Therefore the measure passes on feasibility.

Carol Sakala: Okay. So Ashley, moving on to you use and usability.

Ashley Hirai: Okay. So it is - currently the measure is being sued and publicly reported as part of the Joint Commission's Accreditation Program and it's also part of the CMS Hospital Inpatient Quality Reporting Program. So it is being used I think in terms of usability there were issues there. But do we need to - are we covering both now?

Carol Sakala: Let's just go ahead and talk about both of - both areas, yes.

Ashley Hirai: Okay. Sorry, and so I think with the usability, if we're talking about the e measure and there may not - in terms of improvement, I don't think there was a lot of data presented and for the paper measure there haven't been improvements in there either. But in evaluation comments, there was a note

that there is just a need to emphasize this measure in (ELB) (unintelligible) communities.

I think the larger concerns we've been talking about though are on the unexpected unintended possible harm in terms of respecting patient not have any choice. And also with medical need for supplementation. I think those are reasons why the target isn't 100%. And the recent discussion we had around the donor milk and also additional unintended consequence and it being used for term infants and (unintelligible) shortage or the true need in preterm infants.

Carol Sakala: Thank you. So other reviewers?

Lisa Holtzclaw: This is Lisa. I had no other comments.

Matthew Austin: So this is Matt. I do have one question for the measure developer and maybe I should have asked this back in the gap section. But there is a noted, you know, disparities by recent ethnicity around this measure. And has the Joint Commission seen hospital - or have examples of hospitals that have been able to reduce those disparities? I'm just kind of concerned that somehow maybe we're measuring other factors as part of this measure that - as opposed to just sort of focus on breastfeeding, so.

Susan Yendro: Yes. Hi, this is Susan. I would comment that in the literature there is a lot of literature on many hospitals who have been able to improve their breastfeeding rates, utilizing a number of different programs that are available out there. There is CDC (SM), AAP, Baby-Friendly for example and many hospitals have been able to make improvements on that.

We've also heard from our, you know, experts in the - you know, our technical advisory panel people that say that particularly for race and ethnicity with a good program they have seen improvements.

Matthew Austin: Improvements sort of hospital wide or have they been able to sort of close disparities or I guess that's what I'm…

Susan Yendro: I would say on a hospital level, but it was specifically mentioned that there was improvement in the disparities by races and ethnicity with good programs, targeted programs.

Matthew Austin: Okay, great. Thank you very much.

Carol Sakala: Okay. Any comments from the committee as well on usability and use?

Diana Ramos: No comments, this is Diana.

Carol Sakala: Okay. Hannah, I think we can move to the next vote for this here.

Hannah Ingber: Yes, thank you Carol. Okay. So I've activated the vote for usability and use for use specifically. We have options of pass or no pass. I'm seeing 10 votes so far. Okay. We have all our votes in. So I'm going to lock those in and share.

Okay. Here for use, you can see we have 17 votes for pass and one vote for no pass with a total of 18 votes. So we are - the result is to pass this measure on use.

Carol Sakala: Great, thank you. So can we move to usability then?

Hannah Ingber: If there is no other discussion from the committee. Okay. Hearing none, I can open the vote on usability as well. Your options for usability are high, moderate, low or insufficient. I'm having seven votes. Okay, all right. We have quorum. So I'm going to lock in these votes and share my screen.

Okay. You can see here for usability we have two votes for high, 14 votes for moderate, two votes for low and one vote for - or sorry, zero votes for insufficient for a total of 18 votes. Therefore the measure passes on usability.

Carol Sakala: Thank you. Now, I have a question for Matt Pickering. I have been now here about public comment, but we weren't doing that for the measures this morning. So just wondering if we're going to go to public comment now or vote for our overall view of whether this measure should maintain endorsement?

Matthew Pickering: You know, it's a great question. This is - that note is if we received any comments from pre-evaluation. So we did not for this measure, so we will be moving on to the overall consideration from the measure.

Carol Sakala: Great. And thank you. So Hannah, back to you again.

Hannah Ingber: Thank you, okay.

Carol Sakala: Unless if anyone has any last-minute comments on this measure, any aspect of it? Okay, thank you.

Hannah Ingber: Okay, wonderful. So I've now activated the overall feasibility for endorsement vote. Your options are yes or no. I've seen five responses. Just waiting on four more. Okay, just waiting on one or two more. Okay, we have quorum. So I'm going to lock in these responses and share my screen. Okay,

here you can see for overall suitability for endorsement. We have 15 votes for yes, and two votes for no for a total of 17 responses. So this measure is recommended by the committee for endorsement.

Woman: Okay, so now we're going to move on to the other half of this pair, 0480 which was the paper measure for exclusive breast milk feeding. And I certainly want to offer the Joint Commission an opportunity to again discuss this measure from the point of view of the paper version.

Susan Yendro: Hi, this is Susan Yendro again. I think the only thing that I would like to mention is that for the chart abstracted measure, we continue to offer this measure in recognition of the fact that a lot of hospitals are still working on the ECQM version and their ability to capture the data in through a ECQM version. And so we feel it's really important to continue to have endorsement for the chart abstracted measure as well. Thank you.

Carol Sakala: Great, thank you. I would like to ask Ashley and the other reviewers if they would like to comment on evidence and but before that, I think we should just ask if anyone from the committee wishes to have another evidence discussion or the alternative would be to carry over to evidence voting that we had for the ECQM measure since in theory, the evidence is the same. So would anyone like to have a new discussion about evidence at this point?

Jennifer Bailit: This is Jennifer Bailit. Just one quick comment. I'm very taken by the argument about the donor milk and the potential harm that this measure has been doing as an inadvertent overuse over what am I trying to say, people trying to meet the measure.

The paper measure does give you the opportunity to collect data on donor milk versus non-donor milk and or to exclude donor milk. And I would

encourage you to explore that in the next iteration, even if it's just sampling to see if you can get a sense of how big that issue is.

Mambarambath Jaleel: Carol this is Dr. Jaleel here again. As we were doing this, I was doing a quick PubMed search to see if there are any articles and there is one in breastfeeding medicine, which I quickly found and this is from Brigham And Women's Hospital in Massachusetts and Harvard Medical School along with Cornell University.

And in one of their units, they found an increase from 0.4% of the infants in 2014 to 4.7% in July 2015. The number of bottles provided per infant also increased from 0.6 bottles per infant to 4.6 bottles per infant. This is in a term infant nursery.

Most common indications were parent caregiver requests, 19% and excessive weight loss 17%. So they and the conclusion is that more research is urgently needed to understand the repercussions of this practice on resource utilization as well as short and long-term breastfeeding and health outcomes.

So I can send this article, I don't know where to send this to. Carol, should I send it to you or hope I send this to Joint Commission?

Carol Sakala: If you send it to the perinatal email, then I think they can send it around to everyone.

Mambarambath Jaleel: Okay, thank you.

Carol Sakala: Great, good work.

Woman: So, Matthew, we just, Pickering this is, do we move on to a vote about whether we want to talk about evidence or do we just give someone an opportunity to say they want to discuss evidence?

Matthew Pickering: Right, so thanks, Carol. So, we'll just leave it open. If there's any one from the committee that would like to discuss the evidence or excuse me revote on the evidence for this, we will allow you to do so. However if not, we will just carry over the votes from the e-measure against the same evidence, it would just be for the evidence piece that we would carry that over.

Again, the highest rating for that was the moderate. So, if there are no dissenting views on the evidence for this paper-based measure, we will carry that over with respect to the donor milk, I believe that would apply to both of the measures considering that the evidence is the same.

So, if there's no other differences, or anything else that should be considered for the evidence for the paper-based measure, then we will just carry those over. So, does anyone from the committee have any dissenting views and reasons for re-voting on the paper-based measure?

(Hannah): Hi, this is Hannah Roberts. I just have a question in terms of maybe this is a question for the Joint Commission. How which measure is being used more and do you anticipate eventually the paper one being phased out at some point in the future?

Carol Sakala: Yes, definitely the paper-based measure and yes. We would foresee that happening in the future.

(Hannah): Thank you.

Carol Sakala: Okay. So, if anybody wants to discuss the evidence, I think we could look now please Ashley at the performance gap data for the paper measure.

Ashley Hirai: Yes, I would just say in general, I don't think that there's going to be much of a change here between the paper and e-measure with the exception of the reliability and validity. So again, they're still on variation and racial ethnic disparities with high potential for improvement.

Carol Sakala: Thank you, other reviewers?

Man: No, additional comments. Thank you.

Ashley Hirai: No, additional.

Carol Sakala: Thank you. Any comments on the question of performance gap from other members of the committee? Okay, then I think Hannah, we can move to a vote and performance gap.

Hannah Ingber: Okay, thank you so much. Okay. So I've now activated the vote on importance to measure and report for one b performance gap. And your options are high, moderate, low or insufficient. We have nine results so far. Looking for two more. One more.

Okay, we've reached quorum, so I am going to lock in the responses and you can see here on the important to measure report for performance gap we have eight votes for high, eight votes for moderate, zero votes for low and zero votes for insufficient or total of 16. And this measure passes on performance gap.

Woman: Thank you, Hannah. For Ashley back to you. And the whole question of scientific acceptability starting with reliability.

Ashley Hirai: So unlike the e-measure, I think this Joint Commission could do signal to noise analysis and found very high reliability, their average score of 0.97 is a very tight range across hospitals. So it seems to be highly reliable and looking across the ICD-10 transition, there didn't appear to be a change in mean rates or paralyzed tests. Same hospital, so the reliability this appear to be very high.

Carol Sakala: Thank you very much.

Ashley Hirai: Separately, I think, sorry.

Carol Sakala: Yes, I know some of these are a little more intertwined. And so I'm sorry I've been skipping around but let's finish this one first, let's say. Any comments from other reviewers or the full committee. Okay, Ashley, I mean can I actually, Hannah, I think we can vote on this one to you.

(Hannah): Great. So, I've now activated the vote on scientific accessibility for reliability. Your options are high, moderate, low or insufficient. We have six votes waiting on three more, three more. So waiting on one last vote. So we have 15 votes.

Matthew Pickering: There it goes, okay.

(Hannah): Yes. Okay. Wonderful. So we have quorum, so I'm going to lock those in. Thank you, everyone. And okay, you can see here for some scientific acceptability for reliability. We have seven votes for high, eight votes for

moderate, one vote for low and zero votes for insufficient for a total of 16. Therefore the measure passes on reliability.

Carol Sakala: Okay, thanks. Hannah's back to you, Ashley moving toward for that.

Ashley Hirai: Okay. With the validity, I don't think there were any major concerns about threats for validity. And there were expected correlations met some of the other measures and a moderate correlation with the hospital five-star rating. That seemed to indicate acceptable validity. I guess in terms of the exclusion so this has kind of come up and since we have these neonatologists on board, I personally just wanted to ask is it necessary to make an exclusion to term newborns here because I think this is recommended for all infants regardless of gestational age.

(Steve): This is (Steve). I would definitely say term because that's where the whole thing is the mother body that the infant. And that's where you get the best cost benefit resource of it.

Man: So this is not awesome, at least as I read the denominator statement as a single term life form new reports. So the way I understand is that the term is part of the denominator definition.

Ashley Hirai: Yes, that wasn't my question. I think that if this is recommended for all infants breastfeeding as regardless of gestational age and so I just kind of wondered, why if we also are already capturing donor milk if it had to be like this big restriction to term newborns.

Carol Sakala: So is that a question for the developers as well? Why it's specified?

Ashley Hirai: Yes. I just expected maybe some of the new housing colleges, so weighing in on that as well, it just seemed like it was another restriction. That might create some burden but I can appreciate that not everyone, not all newborns can receive it.

Carol Sakala: Yes, so the denominator does only include term newborn. And I think there's a lot of variability. If you start to get into the preterm rest whether or not there to exclude any baby that's in the nick, it helps to hone in on that population that you would be expecting could receive oral intake and takes out all of those babies who may not be able to have oral intake of nutrition.

(Hammond): Hey, this is Dr. Hammond. I agree with the term neonates and especially if at some point that is going to be an attempt to address the previous discussion that we had around the donor breast milk. I think it would be important to leave the term infants because that's where this thing has the most relevance. Preterm infant has their own different set of issues and I think that other measures not met and those go in hand but there are other measures that people track when it comes to infant care.

(Steve): This is (Steve). I totally agree. It should be limited to term.

Carol Sakala: Thank you.

Ashley Hirai: Okay. I guess I was just curious because it is recommended and it converts like the necrotizing enterocolitis. I think that that's it would be a separate measure as neonatologists have commented.

Carol Sakala: So, do our other reviewers have anything to add? Okay and anything from any other member of the committee? Okay, Hannah.

(Hannah): Thank you. Okay, so we opened scientific accessibility for validity. Your options are high, moderate, low and insufficient. Got five results. Waiting on one more. Okay, wonderful. We have quorum, so I'm going to lock these in and just one second. Sorry, okay, okay. So for validity you can see we have five votes for high, eight votes for moderate, three votes for low and zero votes for insufficient with a total of 16 votes. Therefore the measure passes on validity.

Carol Sakala: Thanks, Hannah. Ashley, back to you for feasibility.

Ashley Hirai: Okay, that appears to have acceptable feasibility. It's more burdensome to do the manual chart review than the e-measure but it appears to be acceptable for feasibility.

Carol Sakala: Great and this is where not having a lot of exclusions is helpful. Other reviewers?

(Matt): This is Matt Austin. No concerns for me, thank you.

Carol Sakala: Okay, other members of the Committee on feasibility of the paper, exclusive that you mentioned.

Ashley Hirai: Tried to go through some charts from time to time to do this one, just to get a sense of it, you have to look at every feeding that the baby has. And that is difficult to do. Especially if you're the nurse, you don't always know what mom's given that's a turning issue. But also just the sheer volume of things that have to be gone through. So I actually find this it's doable, but it's burdensome.

Carol Sakala: So this is your call, is it automated in the EMR at all? Is it can I make it be automated?

Ashley Hirai: I think it's a wide-open question depends on your EMR, depends on how you chart within that EMR. Not an answerable quick answer.

Man: Okay, yes. And I understand that. But if you feel that you can query and you can just do quick query to make it easier, because it's valuable information.

Carol Sakala: Thank you. Any other comments on feasibility or questions?

Susan Yendro: Yes, this is Susan again from the Joint Commission, I would just comment that we have been able to pull this from discrete fields in the e-version of the measure. And so there again hospitals that even if they're performing the chart abstracted measure, they can utilize the same methodologies to look at querying fields within the EHR as well.

Carol Sakala: Thank you, Susan. Any other comments from anyone? Okay, Hannah.

(Hannah): Thanks. Okay, so we've now opened voting for feasibility. Your options are high, moderate, low or insufficient. I got six responses so far. Okay, one more, okay, great. We have quorum, I'm going to lock these in. And you can see here for feasibility, we have one vote for high, 14 votes for moderate, one vote for low and zero votes for insufficient for a total of 16 votes. So this measure passes on feasibility.

Carol Sakala: Okay, thank you, Hannah. And I'm going to separate now use and usability, so there's no confusion. So Ashley, if I could start with you, please.

Ashley Hirai: Yes. Very similar to the e-measure. And it's being used with the Joint Commission for the accreditations publicly reported and quality check. I guess the EU measure might have also been used as part of the CMS inpatient quality reporting, but it is used and seems to pass that.

Carol Sakala: Thank you. Other reviewers.

Man: None from me, thank you.

Carol Sakala: Okay, thanks. Other committee members? Okay, Hannah please.

(Hannah): Okay, so the voting is open on use. Your options are pass or no pass. Got 12, just waiting on three more. Okay, we have quorum. As you can see here for use, we have 16 votes for pass, zero votes for no pass for a total of 16 results. So this measure passes on it.

Carol Sakala: Thank you. Okay. Usability, please, Ashley?

Ashley Hirai: Okay, there's two components here improvements. It doesn't appear to have improved much since 2015. Actually, it hasn't changed. I would say that I did look at the data for just initiation of breastfeeding using other data sources like the birth certificate and the National immunization survey.

And they do some improvement over time and initiation that it is slower and so it may not be too unexpected, not too much of machines in a few years, but I think other reviewers have pointed out that it does indicate a need for improvement.

In terms of the benefits and harms, I think we have already discussed some potential harms in terms of patient autonomy and choice and potential medical

need for supplementation. It could be ignored, but I think that we've already discussed that the target isn't 100%. And then we still have that discussion on the donor milk and improving the measure moving forward.

Carol Sakala: Thank you. Other reviewers, other committee members. Thank you, Hannah, please.

(Hannah): Okay, I'm just going to open the votes for usability. Okay, now you should see your options are high, moderate, low or insufficient. Yes, seven results so far. Just waiting on two more. Still waiting for two more. We have 14.

Man: So I'm getting Diana says the poll is not showing for her anymore, Hannah.

(Hannah): I just got another vote.

Man: Okay, Diana, was that you?

Diana Jolles: I had already voted.

Man: No is Sheila, it is Sheila.

Sheila Owens-Collins: I keep coming out.

Man: It is taking a while.

Sheila Owens-Collins: I can log in and out, it says I'm logged in though.

(Hannah): Yes, I think that might be wise logging in and out, yes.

Man: So Hannah, what's the number that we have now?

Carol Sakala: 15.

Man: Okay, so maybe with Diana, we'll be back up. I do know that Baron Nathan has to leave. So we shall see where we are with the number.

Diana Jolles: And I voted.

Man: Thanks Sarah. I thought you said I'm sorry Sarah Nathan.

Diana Jolles: No, this is Diana.

Carol Sakala: Okay.

Man: Hi, Diana. So you did vote.

Diana Jolles: We had two Diana, but I voted too.

Man: Thank you.

Carol Sakala: And we're now at 16.

Man: Perfect.

Carol Sakala: All right.

(Hannah): I'll talk to you soon and share. Okay, for usability you can see we have zero votes for high, 15 votes for moderate, one vote for low and zero votes for insufficient with a total of 16 votes. Therefore the measure passes on usability.

Carol Sakala: Great, thank you. And now we have our global recommendation about whether this measure is suitable for maintaining endorsement.

(Hannah): Great, so yes, I've opened that vote for overall suitability of endorsement your options are yes or no, we have seven so far. Waiting for four more. Okay, now just two more. And there we go. Okay, I'm going to lock these in, we have 16 and show the results. Okay, so for overall suitability of endorsement, we have 15 votes for yes, one vote for no for a total of 16. Therefore, the measure is recommended by the committee for endorsement.

Carol Sakala: Thank you. I see a discussion about whether we'll take a break, but we're a little behind now. Are we going to move on?

Man: So a great question, Carol. I'll see what the committee would like to do. I do want to remind folks, we do have a Fall 2019 discussion slated for today. However, we do not get to it. We'll have to move it to Monday. So does the committee like would like they'd like to take a break for about 10 minutes and then reconvene to finish out the measures and see where we are for Fall. Or do you want to keep going forward?

(Hannah): Keep going.

Carol Sakala: Okay, keep going.

Man: Okay.

Woman: Sorry Martha.

Man: So Martha, I appreciate it. If you do have to step away. Please just let us know and we would ask if you could try to keep in mind you know that we're, if you step away right when we vote to try to vote first. But thank you, thank you so much for trying to keep moving. Thanks Carol.

Carol Sakala: Great. Maybe we can take up some time on this well-known measure that's coming up now. So very inverse PCO2 and not complicated at this point in time by an e-measure version. This is a measure of this cesarean rate among first time moms who are giving birth at term with a single baby in a head first position. And I would offer the Joint Commission an opportunity to open the discussion with your thoughts.

Susan Yendro: Thank you. Hi, this is Susan Andrew again from the Joint Commission. So as Carol said, cesarean birth is a measure that we implemented back in 2010, there was a national rise in cesarean birth rate. We looked at studies that show that hospitals with cesarean birth rates of 15 to 20 had infant outcomes that were just as good and they actually had better maternal outcomes.

There is no data that shows that higher rates of cesarean birth improved outcomes. Studies additionally show that when labor is forced when the cervix is not ready, outcomes are poor. That labor and delivery guidelines can make a difference in the outcomes of labor.

And that many authors have shown that physician factors rather than patient characteristics and obstetric diagnoses are major drivers for the difference in the rates. And a recent study from California by Dr. Maine and all showed a collaborative effort of hospitals in the State of California were very successful in reducing the rate of NTSV, they did not show any increase in adverse maternal outcomes. And in fact, they showed a decrease in unexpected complications from the terminal one.

We see this measure of looking at neoteric term single babies in a vertex position where the high-risk moms have already removed from that down as a very important measure. We see that there is still a significant gap in the measure. There are racial disparities in the rates and improvement is possible as shown by the article that I just mentioned and it is included in our submission.

The measure has been retooled as an ECQM; the Joint Commission does offer this in the list of measures that hospitals can choose to voluntarily report to the Joint Commission to meet ECQM requirements. It is not currently interest endorsed.

We do continue to offer the chart abstracted measure for the same reason as we have for the other measures well hospitals are getting up to speed with being able to use ECQM, also wanted to mention that we were on track to begin public reporting and we've had to delay that a little bit due to COVID. But we are getting back on track and planning to report those for that measure in January of 2021.

And I also wanted to mention that we added the measure of PC06 unexpected complications in term of newborns in January of 2019. So we'll have data on that in a little bit again somewhat delayed due to COVID, but we're interested in seeing how that measure also plays as a balancing role for this measure. Thank you.

Carol Sakala: Thanks Susan. Could I just ask two questions? One is when you report this measure, will it be with a cut point or will it be actual scores, and also will you be submitting the ECQM measure for endorsements?

Susan Yendro: We are planning to report the measure for a cut point and higher the actual rates. If an organization is performing at or below the cut point, we will put the actual rate, we're world just a little concerned about where the low end of that starts to impact care. And so we've chosen to do it that way to start. And then regarding the ECQM, we hope to be able to do that in the future bring it tend to endorsement in the future.

Carol Sakala: Okay, thank you. And is the cut point 30?

Susan Yendro: Yes.

Carol Sakala: Okay, thanks. Great, so now we have a new team here for discussing any is to lead and the other reviewers are Diana Gallus. Deb Kobe and Sarah McNeil. So Amy, I'll turn it over to you for the question of evidence.

Amy Bell: All right, thank you very much. Good afternoon, everyone. So PCO2 and thank you to the Joint Commission for a great review and synopsis of the measure. This is a maintenance measure. It is facilities level and it is an outcome measure.

Previous evidence from 2016 submission did focus on the Level 2 recommendations from the 2000 ACOG Task Force on cesarean delivery rate and the evaluation of cesarean delivery that you have submitted updated evidence from two 2019 studies that do support the ACOG recommendations and from the committee reviews of this, there has been excellent evidence that has been reviewed. There are overall no concerns that were raised. The trial did change the previously held belief that in depth increase cesarean rates.

However, while this study affects the logic behind the measure, there's still empiric evidence that using this measure to lower the rate does not hurt babies

or mothers. I think what has changed is the perception of how it can be lowered and that was one of our committee members feedback there. That overall, the comments that we've had there's been no concern with that. I'm going to see if anyone else on the committee has any questions or comments?

Carol Sakala: That was great, Amy. The additional reviewers anything from any of you?

Deborah Kilday: Nothing from me. This is Deb.

Carol Sakala: Thank you.

Diana Jolles: Nothing from me, Diana.

Sheila Owens-Collins: This is Sheila. I just had a question. I'm trying now looking at this as a measure, but do you consider women that have where it may be difficult for the OB to determine the position?

Carol Sakala: I think that might be a question specification question for the developer to that ratio, okay.

Sheila Owens-Collins: Yes.

Carol Sakala: So there's a table that has the ICD-10 coding. And so whatever the determination, the record can be looked at in totality so that that final ICD coding for the position would be what would be used for this measure. Does that answer your question?

Sheila Owens-Collins: Yes and no, I guess I'm getting to what would be some exceptions for this measure, and there's been several maternal conditions and obesity is

the only one that comes to mind right now, that that could be potentially a deception.

Carol Sakala: So yes, I would have to be able to look specifically at how that's coded to be able to I think answer your question specifically.

Sheila Owens-Collins: Okay.

Kim Gregory: So this is Kim Gregory and I will follow-up on that and say that breaches coded. But certainly breach isn't. And some of the unstable lives aren't. And so, it is a problem that not all now physicians are listed as exclusion.

Carol Sakala: Right. And so one that you remind me the footling breech issue did come up specifically in that code while that to what we tried to avoid is to have codes that were ambiguous that could have things that should not be excluded in them.

But that one because that is one that we had gotten a lot of feedback on. We did add that code back in. So that's one of those things where we have utilized our coding experts and so forth so that we could be more precise in choosing the codes that fall on that list of exclusions.

(Hannah): Thank you. Any other comments on the question of evidence?

Carol Sakala: Okay, yes, I think we can go with that Hannah.

(Hannah): Thank you. Okay, so this is I've opened the voting on importance to measure and report there's an outcome measure, so your options are passed or do not passed. We have 11, okay, just waiting for one more. Okay, we have quorum, so I'm going to lock these in. And as you can see for importance to

measure report on this outcome measure, we have 16 votes for pass, zero votes for do not pass for total 16. So this measure passes on evidence.

Carol Sakala: Thank you. So, Amy, did we hear your thoughts on performance gap, please?

Amy Bell: Yes. So the developer provided data from calendar year 2018. And in that data, it did demonstrate that there is a considerable variability among hospitals. Over half of the hospitals in the United States report rates over the Healthy People 2020 goal of 23.9%.

And then from the feedback from our committee, there the data is very clear, overall consensus that we do have a large performance gap. It's still a significant in above stated target even now there's a wide range rates over the percentiles and pretty much consensus there with the performance gap still existing.

Carol Sakala: Thank you. Are there referees review?

Diana Jolles: This is Diana, I have no comments.

Carol Sakala: Thanks Diana. Anyone else on the committee wish to comment on the question of performance gap? Okay, thank you Hannah.

(Hannah): Thanks. It's now activated the importance to measure, important for performance gap. Your options are high, moderate, low or insufficient, we got six results. Okay, just need two more. Okay, now we have 16. So I'm going to lock them in and show the results.

Okay, so for importance to measure and report for performance gap, we have nine votes for high, seven votes for moderate, zero votes for low and zero

votes for insufficient for a total of 16 votes, therefore the measure passes on performance gap.

Carol Sakala: Okay, thanks Hannah. Amy back to you for reliability please.

Amy Bell: Okay, there was a new Empirical Reliability testing that was conducted using a couple of different statistical tests. And that was reviewed and by the U.S. Committee and given a rating with that from the comments that we had, we didn't have any concerns with reliability, except that there has been some controversy about whether this measure should be risk adjusted believing that transparency in the data shown in the application would help the argument to rest and others said believe it is highly reliable.

Carol Sakala: Thank you. Other reviewers?

Amy Bell: There are no additional comments.

Deborah Kilday: This is Deb, I have no additional comments.

Carol Sakala: Okay, any other committee members wish to comment on reliability or ask any questions? Okay, Hannah, please I think we can vote.

(Hannah): Great. Okay, so I've opened the votes for reliability for scientific accessibility measures. We have six votes. Okay, waiting for three more and just one more. Okay, great. I'm going to lock these in. And okay so for reliability for scientific acceptability, we have four votes for high, 12 votes for moderate, zero votes for low and zero votes for insufficient for a total of 16 votes. Therefore the measure passes on reliability.

Carol Sakala: Thank you. So back to you, Amy on the question of validity, please.

Amy Bell: Okay. New empirical validity testing was conducted. The developer did use construct validity to calculate correlations as a measure with other measures within our period of quality and other measures of hospital quality with a correlation with PCO1 or earlier like the delivery and PCO2 cesarean birth that were weakly negative that directional, correlation coefficient of 0.133 with PCO1 was recorded, a correlation of negative 0.28 between this measure and PCO5 was recorded as well.

It was weakly negative but directional as well. Developer reported a week negative correlation between the score for the measure and the overall hospital start quality rating and P value was less than 0.001. The measure is not currently risk adjusted, but the developer provided a conceptual rationale and empirical analysis to justify the approach specifically examining maternal age and body mass index.

And then it was also reviewed by NQF, our committee did look at this and did not have majority did not have any concerns. One said yes and clear the utility of comparing to breastfeeding and Hospital Compare five-star rating but overall no concerns with that.

Carol Sakala: Great, thank you. Any comments or questions from other reviewers?

(Hannah): No additional comments.

Carol Sakala: No comments. Okay, anyone on the committee? Okay, sounds like we can vote on validity please.

(Hannah): Thanks. I opened the voting for scientific acceptability, for validity your options are high, moderate, low or insufficient. We have 10 results. Okay,

we have quorum, so I'm going to lock these in. And as you can see for scientific acceptability for validity, we have four votes for high, 12 votes for moderate, zero votes for low and zero votes for insufficient for a total of 16 votes therefore the measure passes on validity.

Carol Sakala: Thank you. So, Amy feasibility please.

Amy Bell: So with feasibility data are generated and collected by healthcare personnel during the provision of care encoded by somebody else other than the person obtaining the original information and abstracted from a record by others obtaining original information.

Not all hospitals currently have the capacity to abstract the electronic version of the measure, so the Joint Commission continues to offer this chart abstracted version that allows for data capture from an unstructured data field. And the NQF staff did review this as well. Our committee reviewed and overall no concerns around feasibility.

For those facilities performing manual chart abstraction for the measure the feasibility is a challenge depending on volume with one piece of feedback there. They're not sampling that could be burdensome, but otherwise no, no concerns.

Carol Sakala: Thank you, Amy other reviewers?

Amy Bell: No concerns, no comments.

Deborah Kilday: No additional comments.

Carol Sakala: Thank you, other committee members, anything else to be noted on feasibility? All right, Hannah, please.

(Hannah): Okay, I've activated the vote for feasibility. Your options are high, moderate, low or insufficient. We've got eight votes, just waiting for one more. Okay, we still only have 18. So give everyone just another minute.

Carol Sakala: Isn't that a quorum?

(Hannah): We need 16 for quorum.

Carol Sakala: But you said 18.

(Hannah): We have 15, sorry. My apologies. Okay, we have 16 now, so I'm going to lock these in. And here for feasibility, you can see we have two votes for high, 14 votes for moderate, zero votes for low, zero votes for insufficient for a total of 16 votes, therefore the measure passes on feasibility.

Carol Sakala: So thank you, Hannah. Just to avoid confusion, I'll separate the discussion and votes again on use and usability. So, Amy, if you could start with use please.

Amy Bell: Okay, the developer reported the measure is used for accountability as part of the Joint Commission's Hospital Accreditation Program and also with the Joint Commission's perinatal care certification. The measure will be publicly reported beginning in July of this year as part of the quality tech from the Joint Commission. The developer did note for feedback that most statistical questions on the measure were regarding how this measure was to be publicly reported in 2020.

There was strong support for the public reporting of the measure for multiple stakeholders. Queries were submitted via the automated feedback system and they have decreased significantly for the measure during the past 30 years, the performance hasn't significantly changed across times ranging from 26.2% to 25.5 from the year 2015 to the year 2018 respectively. So we still have lots of work to do here. And then the feedback from our group around you are we doing user usability first?

Carol Sakala: I mentioned you.

Amy Bell: So the July 2020, the public reporting will start otherwise there are no concerns needed except mandatory reporting of the process and data is given on the ability to combine the measure with others to give an overall rating period inequality could be an option as well, but overall no real concerns raised the heartbreak.

Carol Sakala: Thanks Amy, other reviewers? Any comments?

Woman: No comments.

Woman: This is sorry for there, I just wanted to mention that it's also part of the child's core or Medicaid Maternity core, quality improvement measures. So it's also being used for that and it's a panel five measure as well about we're using it again.

Carol Sakala: Thanks. Good point. Any other members of the committee wish to comment or ask any questions about use?

Martha Carter: Carol, this is Martha. I missed the beginning of this discussion. So I apologize, if you had touched on this, but I think we need to consistently be

asking our data from this measure going to be reported by race and ethnicity, aggregate data across the nation but that's on an individual and regional level, I think it's really important that we make sure that happens all the time.

Carol Sakala: Go ahead.

Kimberly Gregory: This is Kim Gregory and I agree. And I also think although I've seen all these conversations and data and papers about not risk adjusting, I think we definitely need to think about the impact of age as age does increase risk and the proportion of women who are having babies in America is who are older is increasing.

Similarly, as we start looking at more community births meaning home birth, and birth center birth, the lower risk birth or going out of the hospital, so we're ending up with a higher acuity of women in hospitals.

So maybe the actual number that we're striving for may be changing and I don't see any research or evidence or anything addressing that, we go to set this number of 23.9. And we haven't revisited it. But I'm pro-gradual delivery, but I'm just going out through more context.

Carol Sakala: Good point and one comment is that healthy people 2030 I think actually did go up. I don't know the thinking behind that. But it went up a little bit, I believe. Would anyone from the Joint Commission care to comment on this constellation of related comments?

Susan Yendro: Hi, this is Susan. We appreciate the feedback and we can take under consideration some of those thoughts for the future.

Diana Jolles: Hi, sorry, this is Diana Ramos. I just wanted to kind of piggyback on Dr. Gregory's comment about the home birth. Oftentimes what we're seeing in

our hospital is that we get a lot of transfers, failed home births, failed birthing facility births and they end up being a C-section in our hospital because of what happened prior to the patient's admission and so the hospital gets dinged for it, even though it started outside of our hospital facility, so I don't know if there is a way to capture that information because that could bring down the reporting for hospitals overall.

Carol Sakala: Go ahead, Diana.

Diana Jolles: I was just going to mention that thanks for all these points, there is some work going on in other NQF workgroups around the issue of attribution, which is the concept that you're describing. And I think there are mechanisms to deal with this. However the specifications as written don't address this issue. But hopefully, as we move towards mandatory reporting and have more experience with it, people will work on these issues.

Martha Carter: This is Martha. I want to ask the committee to consider, I want to be careful here. I don't want to offend you. But I think that we don't want to talk about failed home births or failed percent of our C's are appropriate, hopefully appropriate transfers to the most appropriate level of care when a complication develops.

Diana Jolles: I agree 100%.

Carol Sakala: And this is Carol, just to comment that earlier this year, the National Academies released a very robust report on birth settings in America that inter policies issued is freely downloaded for a PDF as a PDF and any other comments on use?

Jill Arnold: This is Jill Arnold. Just real quick out of hospital versus planned and unplanned are well under 2% still I think so it's not a huge problem but it is probably something in smaller value hospitals to think about for sure.

Carol Sakala: Okay, are we ready for a vote and anything else to be sorted out. Okay, Hannah I think we are.

(Hannah): Wonderful. I've activated the votes for use, your options are pass or no pass, got six votes so far, waiting for one more. Okay, I am going to lock in these votes. And as you can see for use, we have 16 votes surpass zero votes from no pass for total 16 and the measure passes on use.

Carol Sakala: Okay, thanks everybody. So, two more votes for this measure, then the second to last vote is going to be on usability. Please, Amy.

Amy Bell: Okay, so comments from our reviewers do show that Harman rates are too low. And so we do need to be careful about that. Any potential harm seems to have an interest and to increase the benefit reporting disparities data does seem to be important. One of the comments stated all providers to provide labor support are always worried about potential for neonatal deaths.

Although the data presented at the beginning of the measure worksheet are compelling and reassuring, I'm interested to hear while the developers felt more progress wasn't made and how they think public reporting will change things. And then another comment was around the measure is especially important in reducing severe maternal morbidity and mortality because otherwise there are significant comments for me.

Carol Sakala: Thanks Amy. Other reviewers?

Amy Bell: None from me, thank you.

Carol Sakala: Great, other committee members? I think a few minutes back, we identified some of the reasons why the change rate maybe low wondered if anyone in the developer team wanted to comment further on the question.

Susan Yendro: Yes, this is Susan again, I think the only other thing I would comment on is that you knew the article from California Collaborative, where they really were able to through a collaborative make some real efforts, particularly honing in on or hospitals that had higher rates and something that you know we think we've seen more and more encouragement for that type of approach to improvement. And something that, we're considering as well within the Joint Commission little bit delayed with the COVID issues and so forth, but something that we're hoping to be able to support as well.

Carol Sakala: Does that mean through our programs, product feedback, the toolkit et cetera?

Susan Yendro: Yes, I don't know if Trisha if you want to comment on our CCE program, I don't know if we lost her but we have initiated a program for continuous customer engagement and something that we're looking at is opportunities, such as providing webinars with highlighting those who have had success in a particular improvement effort, particularly where it relates to measurement.

We've done this with several of our programs that we've rolled out dashboards for. And with the nursing care centers and Home Care Organizations presenting how they were able to make improvements on a specific quality measure. So that's the kind of thing that we're looking for joining in the future and this is certainly perinatal is certainly an area that we're looking to loop into that program as well.

Carol Sakala: Great, and thank you Susan. Okay, does anyone else have any comments on usability? Okay, I think we can vote in please. Hannah?

(Hannah): Great, I've now activated the vote for usability. Your options are high, moderate, low or insufficient. We've got 11 results; we are screening for one more. Okay, we've got our quorum, so I'm going to lock these in. And you can see here, we've got three votes for high, 14 votes for moderate, zero votes for low and zero votes for insufficient versus 17 votes. So that means that the measure passes on usability.

Carol Sakala: Okay, thank you. So our final vote, we can move right into that I believe it is our global recommendation about whether this measure is suitable for continued endorsement.

(Hannah): Great. Yes, I've opened the vote for overall suitability of endorsement your options are yes or no. Got nine results so far. Just waiting on a couple more and just one more. Wonderful, okay, I'm going to lock these in. And okay as you can see, we have overall suitability for endorsement. We have 16 votes for yes and zero votes for no. Therefore the measure is recommended for endorsement by the committee.

Carol Sakala: Okay, thank you, Hannah. And now I'm going to pass this back to Kim as the next measure and final measure of the day. Well, there are some measures to consider in another way, sorry.

Kimberly Gregory: So we were all in a room together, I'd tell you all to stand out and stretch and then sit back down. So we've all stood up and stretched and shake our hands and beak. And now we're going to do unexpected complications in terms of newborn. The measure steward is the California Maternal Quality Care Collaborative.

It is a maintenance measure and it's a reported at the hospital level, unexpected newborn complications in my full-term newborns with no pre-existing conditions. And it has actually offered balancing measures primarily for the cesarean break measure that we just discussed. So I'm going to open the floor to the measure development, are there.

Man: Good afternoon, could you all hear me?

Kimberly Gregory: Yes sir.

Man: Okay, it’s great. I have been quiet all day. But I think the last discussions that we've been having shows you the value of having a package or a suite of measures that can support each other this, whenever you make change in medicine, people worry about the consequences of making the change.

And therefore, there's a strong need for balancing measures when you do that. We've been very successful in California with this measure called the MTSV C-Section. It's been publicly reported for three years for all of our hospitals, all of our births.

And I think one of the successes we've been able to drop the MTSV C-section rate in California from 26.5 which is the exact same as the U.S. to currently 22.3 by the end of 2019 is the ability to show about C-measure and to allay the concerns or fears that people have, the most important childbirth outcome for families is not necessarily your C-section rate but bringing home a healthy baby.

While there are other metrics that it can examine a small population of very ill infants, there's been a lack of metrics that assess the health outcomes of term babies who represent 90% of all the births in the U.S.

Our underlying premise was to narrow the population by excluding pre-existing conditions to allow the measure to focus on babies that were healthy on arrival to labor and delivery, since the concept of unexpected. This allows a measure to focus very closely on the differences in obstetric and neonatal care provided in the hospital.

The main exclusions for this measure are prematurity, low birth weight, intrauterine growth retardation anomalies, other fetal conditions and maternal drug use. These are actually the same conditions that account for much of the differences through the social determinants and race. I'm happy to discuss this issue further later in the measure discussion.

To allow this measure to be widely utilized for all hospitals and apply to all births it is ICD code based in a novel approach to create safeguards for both over coding and under coding, we combined additional data elements to service double checks, most importantly this is length of stay. For example, a baby with a code of sepsis but the length of stay of only two days really did not meet the established criteria for sepsis and would be excluded.

The goal of this measure is to really guide obstetric care and provide a balance to measures that were purely maternal. And our vision to, there are two attributes and there could certainly be others, but the two attributes of an ideal birthing facility be a reasonably low primary caesarian rate, such as PCO2 which is the third, combined with a reasonably low unexpected newborn complications.

The three major changes to this measure from this initial endorsement include: first, transition from ICD 9 to ICD 10, which added hundreds of additional codes mostly from anomalies.

Second, a series of tweaks that code categories based on feedback in real world uses your diagnosis or procedure codes. We've had the ability to get feedback from over 200 hospitals that use this measure very carefully and give us feedback on a monthly – on an annual basis.

For example, we learned that a lot of – a number of university centers use the code for CPAP. For (unintelligible) resuscitation in the delivery room to enable billing for a pediatrician to attend. This is not the intent of the code, but this is how it's being used in real life. Therefore, we changed the use of CPAP and procedure codes.

So it's had to be used for over 24 hours before it's of an importance. The third change that we made was to move from a linked birth certificate to ICD file, data system to an ICD 10 file alone, and that would allow us to use this broadly in states and environments where that linkage was not currently in use. So this is our ICD 10 log file. So I'm looking and we are looking forward to discussions and questions. Thank you.

Sheila Owens-Collins: Hi, this is Sheila Owens-Collins, can you hear me?

Kimberly Gregory: Yes, ma'am.

Sheila Owens-Collins: Okay. Okay. Again, I don't have it in front of me. But and so I may be skipping around in terms of which specific portion of the endorsements that you're looking for. But overall, in general, I thought that

there still wasn't enough of a deep dive into the social determinants of health, especially in this case, access to care.

The only – it could be that, you know, when we could not get to the doctor and have a bad outcome, when if she could have gone to pediatrician, she would have had a better outcome. That was one comment that I had. The other comments that I had was in I don't think we've gone to that was, looking at you know the length of stay and the cost metrics as a proxy for quality.

And I think that's a slippery slope as we're trying to get more transparency and cost. I think if we started using that, you know, we're going to get data that's not transferable or possible.

Kimberly Gregory: Dr. Collins, thank you for sharing that. And I'm going to ask everyone to keep that in mind, as we hear from our lead discussion of Dr. Bailit.

Jennifer Bailit: Thank you, Dr. Gregory. So as Dr. Maine just introduced, this measure has two numerators, if you will, it's almost two measures within one. One is severe complication, the other is moderate complication. The denominator is term, normally grown babies so there is a weight component to the denominator as well.

And the denominator takes out preexisting conditions such as multiple gestation, (unintelligible) growth, malformations, genetic disorders and other drug use other sort of things like that. It is typically paired with other measures so that you have both a measure of the mother and the baby.

And in looking at the comments from the committee on importance to measure and report, comments were fairly supportive, significant and demonstrable evidence to support this measure.

And the committee noted or the reviewer has noted that additional evidence was submitted with this application, given some of the changes in ICD 10, et cetera. Kim, Dr. Gregory do you want me to stop there or do you want to continue on to performance gaps?

Kimberly Gregory: No, we're going to stop there and I'm going to ask if Dr. Jaleel or Dr. Srinivas want to add to the comments by Dr. Owens Collins.

Mambarambath Jaleel: Yes. This is the measure, the balancing measure and the value of the work of the Joint Commission in creating this measure and bringing it to APF. I think one of – I do review the charts for this – for my own hospital and one of the concerns that has been brought up and that I see is with the moderate complications and the length of stay modifiers that are attached to that.

I think one of the concerns is that, there are no maternal indications involved with the length of the stay modifiers say for example, there is a baby who has jaundice and stays for more than five days, not because the baby is unwell, but jaundice has improved, but the baby had jaundice and that's documented in the chart. But the mother has preeclampsia and is being treated for that as severe hypertension after the delivery, and so the baby stays back in the NICU (unintelligible) nursery.

Similarly, if the baby has some prolapsed cord or breech delivery or had a one dusky episode of the choking that feed, and the baby stays for more than two days, sent to the (unintelligible) delivery, but if the mom is not ready to go

home, it's still that is considered as a PCO 6. So that is a concern that I would like to bring up.

Kimberly Gregory: Those are great points. Does anyone else of the discussions have a point they want to raise?

Rajan Wadhawan: I just have – hey this is Raj Wadhawan. I just have one of the thoughts and comment that I want to share. This is – this is designed originally to be as I understand, to be a balancing measure for PCO 2. If that is the case, would it not have been more valid to have this only be applicable to that particular group of infants, which is NTSV, vaginal births who are the target for the overall NTSV that from a C-Section point of view. This is a lot broader category. And does it really serve well as a counter balancing measure for that purpose?

Kimberly Gregory: Is the measure developer want to respond to that?

Man: Sure, I'd be happy to. We did divide the measure into moderate and severe who were those – to address the specific issues raised. First, we particularly like severe and feel that that's severe, unexpected and different complications, which is more than half, actually and use that primarily as the balancing measure. The moderate one has more fuzziness to it, depending on local practices. And we think that's important to look at your – to identify cases to look at your practice locally.

So both are – both have value but severe is where cost of money is in terms of major neonatal complications. If you do have a baby that does have jaundice, and that's the only reason that it's been in the nursery, that would be excluded actually by the coding algorithms.

If the baby has stayed in the hospital only because of the mother stayed in for a long time, most insurance companies don't like that actually intended to want the baby to be discharged to the mother's room or elsewhere as opposed to still being in the hospital for extra days, with – without indication for the baby to stay.

In terms of broadness of category, this is intended to be a broader in nature necessary – not necessarily NTSV measure in California, we actually can calculate it on an NTSV population as well in our quality collaborative serves all of our hospitals, but it is meant to be an indicator for how you're doing with term babies in general. Term babies that don't have preexisting conditions.

And on those – those should do well, and particularly following the severe unexpected newborn complications over time in that we'll serve from – multiple different obstetric categories potentially.

Kimberly Gregory: Thank you. I just want to add that the issue of sepsis or newborn sepsis is another fuzzy space that requires coding education. And I think the other issue is if you don't have that middle ground step down unit. And so it's either with the mom or in the NICU that can be a problem. So just sort of sharing that. I'm going to open it up to the committee..

Mambarambath Jaleel: Can I?

Kimberly Gregory: Yes, please anybody want…

Mambarambath Jaleel: And I will make the comment a bit, yes this is Dr. Jaleel here. I just want to add on to the comment, which was mentioned about maternal issues and I think it puts some of the hospitals at a disadvantage, where if it is

an inner city hospital and the population if there is a mom who is a single mother, and if she is unwell, she is not able to take this baby home.

And so there is no other way to discharge this baby or centers where there is a high-risk OB unit, it puts those centers at a disadvantage as well, because those moderate the complications that these length of stay modifiers put them at a disadvantage. I think it would be helpful if there are maternal implications as well, which are put in that has modifiers in that.

Elliott Main: Kim would you like to respond now…

Kimberly Gregory: Together at the end.

(Gregory): You can respond on that.

Elliott Main: Oh, we look very carefully at levels of care and how they're treated by these, by both moderate and severe and actually our tertiary centers, both level three and level four nurseries in California actually do better for severe UNC than level two and level one.

The maternal conditions have not proven to be a big factor. I could talk about that as we talk about risk assessment is that where you get sick babies are largely in the preterm or very preterm when you have severe preeclampsia or things of that kind.

Kimberly Gregory: But there's a lot of women who get post-term preeclampsia nowadays on indexing and once they're baby.

Mambarambath Jaleel: Yes, preeclampsia was just one example and these are high responders with various other conditions, congenital birth, heart diseases and nephropathies and multiple other things. If it has high risk in this.

Kimberly Gregory: I'm going to open it up to the committee. Are there any other questions that we would like to address with our developers? Okay. Well, Elliot, is there anything else you'd like to add?

Elliot Main: Oh, I'm happy… you know there was a discussion earlier – the preliminary assessment earlier was asking about risk adjustment, because this is risk stratified to begin with. So we did run the risk adjusted model for this but it includes maternal age, pre-pregnancy, BMI, race and ethnicity, educational levels, insurance type, the adequacy of prenatal care, parity, birth weight and comorbidity – maternal comorbidities including preeclampsia, chronic hypertension, diabetes, and gestational diabetes.

Individually, a number of these they have significant changes, but in the risk adjusted model, the correlation coefficient between unadjusted and adjusted models was 0.98 for total and 0.97 for severe.

So it really didn't change the outcomes much even we did a fully risk adjusted model, which is not possible when you're only looking – you can't do a risk adjusted model with all these factors if you're only looking at baby ICD 10 codes. So if you were to want to do that, you would – it would completely change the usability of the measure.

And so we instead wanting to do the risk adjustment, the risk stratification and will be able to show risk adjustment didn't change the outcomes. The other way of looking at this is, if you take the top quartile of unadjusted hospitals in

our state that predicted 95% of the hospitals that were in the fully adjusted model to be in the top quartile.

And the three that were in the second or in the third quartile were very close to the top quartile range. So again, the data we presented in the application did show that level three hospitals and level four hospitals for severe had rates that were equal or lower than level two or level one suggesting again that the patient mix does not really lead to a disadvantage for those facilities.

Kimberly Gregory: Right. But when you're doing those models, you're doing them at the population level and when you're doing them at your hospital, you're in as really small and that one or two babies makes a big (unintelligible).

Tricia Elliot: But the end is 90% of the births in the facility. So that's the joy of this measure.

Kimberly Gregory: It's numerator.

Tricia Elliot: Suppose the others not.

Kimberly Gregory: The numerator is small. But I hear you, you're basically saying adjustment isn't – the juice isn't worth the squeeze.

Man: This is helpful. Thank you, thank you for the explanation.

Kimberly Gregory: If there are no further comments, and I don't see any in the chat box, I think we can vote for important to measure based on the evidence. So Hannah, are you ready?

Hannah Ingber: Yes, I'm ready. Okay, hearing all of their comments, I'll activate the votes for importance to measure and report for evidence with an outcome measure so your options are pass or do not pass? We've got nine votes so far. Okay, we're waiting on two more votes.

Kimberly Gregory: Oh, and just a reminder that, denominator worth is 15 now, because one of our (unintelligible) Hannah.

Man: Sorry, Kim it's if you're not speaking please put yourself on mute getting some background noise Kim, I didn't really hear what you said.

Kimberly Gregory: I just said, remember the denominator for the standing forum on all of these votes is 15, not 16.

Man: Is that because of Matt Austin?

Kimberly Gregory: Yes.

Man: Are you saying? Yes, so just to clarify that. So you are correct Kim, in the sense that Matt would be (recussed), but only for the scientific acceptability. So only for validity and reliability, voting so that in that case, the denominator would be 15 for those two components, however, Matt, if he's still on is able to vote on evidence, performance gap and all the other criterion except for reliability and validity.

Kimberly Gregory: Thank you for that clarification.

Man: Thank you for remembering that. I appreciate that.

Kimberly Gregory: (unintelligible)

Hannah Ingber: Okay, I think we have all our – all of our votes in so I'm going to lock them in and share the results. Okay, so for importance to measure and report for evidence, we have 15 votes for pass, 2 votes for do not pass for a total of 17 votes. And that means that the measure passes on evidence. Thanks, everyone.

Woman: Okay, I guess I'll continue then with gaps in care quality for opportunity for improvements. The developer did display performance gaps. First of all, they state rates over time from 2013 to 2019 has dropped quite a bit. And they also provided this data by race showing over 1% spread in the outcome rate or the measure rate over races and so there is – there are measurable differences in this over time as well as over different populations. And so that I believe addresses performance gap as well as various that I will stop there.

Kimberly Gregory: To the other discussion have anything to add? Okay hearing that so we vote on the gap. Hannah?

Hannah Ingber: Sure, happy to open that. Okay, voting is now open for 1b for performance gap as gap size develops. Okay, waiting on a couple more. Okay, just waiting for one more. Okay.

We have our votes, so I'm going to lock these in. And share. Okay so for 1b for performance gap, we have 5 votes for high, 11 votes for moderate, 1 vote for low and 0 votes for insufficient for a total of 17 votes. Therefore the measure passes on performance gap.

Kimberly Gregory: So next is the acceptability of measure properties. And this was reviewed by the scientific methods panel. The signal of noise to sort of good signal was 0.9 which is very good and when they looked at it over deciles, it was greater

than 0.9 in 7 out of the 10 deciles and greater than 7 in the remaining. So that is good.

I'm just looking to see what the comments were here. The – some of the questions came up in terms of reliability were coding intensity and ability to get accurately have the exclusions from hospital, the hospital and there was another comment here it's concerning the initial submission should measurable – measure reliability scores by hospital vary from 0.99 to 0.53. And I don't know if the developer wants to comment on the large spread between hospitals is that a coding issue or what?

Man: So the 0.52 was in a small number of hospitals that were very low volume in the we have the cut at 250 first volume per year and the only ones that were in the point 0.56 range were in the under 500 birth volume I think that can be addressed in two – one of two ways either don't look at – don't use this measure for under 500 birth hospitals. We had our cut off at 250 or students are willing to hear average low – very low birth volume facilities.

But still think in any case, it's useful to identify hospitals for case – identify patients per case review a very small hospital. So the utility may be different rather than as a measure more as an indicator for case review. There's a very small hospital with 250 births will only have a handful of cases that meet these criteria in a given year.

Kimberly Gregory: And I would argue then we're not publicly reporting the smaller hospitals, but giving them the data to be able to act internal quality improvement process.

Man: Yes, exactly.

Kimberly Gregory: Okay, so I'm going to stop there do any of the other discussed ones want to add anything?

Matthew Pickering: So this is Matt sorry to interrupt real quick. I just wanted to remind the group that this did go to SMP. So the Scientific Methods Panel, I know that Matt Austin, if he's still on, he was the individual that was on the Scientific Methods Panel, he had also reviewed this. So if there's any questions related to the scoring of Scientific Methods Panel, he may be able to help and provide some responses there.

But just for reliability, the Scientific Methods Panel did rate this as a high. And a reminder, when we go to vote, you will be asked the question whether or not you want to uphold the Scientific Methods Panel rating of high. And so if there's more than 60% of our committee that chooses not to uphold that vote, then the committee would provide their own vote, it will be the same thing for validity. So I just wanted to make that clear and remind the group, so I apologize. I'll hand it back over to the discussions.

Hannah Ingber: So just to add to that, the preliminary ratings for the validity from the Scientific Panel was moderate the science – the rating was high for reliability.

Kimberly Gregory: Any comments or questions from the committee? Okay, hearing none, we will be voting on whether we are – we would like to accept the scientific method committee vote on reliability and validity. So Hannah, can you put that up for us?

Hannah Ingber: Yes…

Kimberly Gregory: I think it's one vote at a time. But let me see what happens.

Man: Right?

Hannah Ingber: That's correct. Yes, I've activated the votes for accepting the methods panel rating a high for reliability. Your options are yes or no. We're waiting for a couple more that so give people have a minute. Okay, just one more.

Kimberly Gregory: So confirming this is the one that Matt is not voting.

Hannah Ingber: That's correct. Okay, we have all our responses. I'm going to lock them in and share. You can see here the committee has voted 14 votes for yes to accept the Scientific Methods Panel rating high and 2 votes for no, for a total of 16 votes. And that means that the committee has voted to accept the rating applied from the SMP.

Kimberly Gregory: Okay, moving on to feasibility. This is a largely electronic combination. So it's not largely it is from electronic sources.

Man: Sorry, sorry. We still have to do the validity.

Kimberly Gregory: Oh, my apologies.

Man: Yes, no, it's okay. So, yes, if the committee has any discussion around validity, and you had mentioned to Jennifer that it was moderate from the SMP. But if there's any further discussion around validity from the committee.

Kimberly Gregory: So the vote will be to accept the SMP recommendation of moderate.

Man: Correct.

Kimberly Gregory: Hannah, can you put it up for us?

Hannah Ingber: Oh, yes. Okay. Hearing no comments yes. I've now activated three vote view accept the Scientific Methods Panel rating of moderate for validity. The options are again or yes and no. Okay, looking for three more votes. Okay, just one more. Okay, great. I will lock these in. Thanks, everyone.

And you can see here for accepting the Scientific Methods Panel rating of moderate for validity. The committee has voted – has put in 15 votes for yes, 1 vote for no, for a total of 16 votes, which means that the committee has voted to accept the SMP's rating of moderate for validity.

Kimberly Gregory: Right. and now Jennifer, you can take it over to feasibility.

Jennifer Bailit: I was over exuberant still, feel the wording from the measure sheet. So the main issue of feasibility remembering that this is an essentially all electronic data source is over and under coding, over and under coding are a known variation between hospitals, although there are some systematic things known in the literature.

And the preliminary reading for feasibility from this group was moderate. And most seemed to think that this was a feasible study, although that the coding issues might be responsible for some of the variation. So the other – any of the other discussions, anything to add?

Kimberly Gregory: Any other committee members have anything to add? Then I feel a vote for feasibility coming, Hannah?

Hannah Ingber: Great, let me just activate that, one sec. Okay, I've now activated the votes for feasibility. Your options are high, moderate, low or insufficient. We've

got 6 votes so far. Waiting for 3 more. Okay, we have all our votes in I'm going to walk those in. And okay so for feasibility we have 1 vote for high, 15 votes for moderate, 1 vote for low and 0 votes for insufficient, for a total of 17 votes. This means that the committee has voted to pass the measure on feasibility.

Kimberly Gregory: So for 3 and 4 is use and usability. The developer reports that well it's not publicly reported, is currently in use in the accountability programs, both through the California Quality Collaborative and then Blue Cross Blue Shield. They also report that Joint Commission has been collecting data although not reporting it with plans reported at some point in the future.

Comments from the reviewers talk that it's relatively a limited use so far, but that – this place where it has been used it has been helpful. And again, highlighting that this is a balancing measure often uses caesarian delivery is an important one to make sure that we are not over exuberant in our all of our measures. I'll stop there. Do other discussants have anything to add?

Man: No, this is (unintelligible)

Woman: I have a question, Elliot, do you think – to what extent do you think that the measure got better, because people learn to code better versus people change their practices?

Tricia Elliot: I think it's a combination of three things. People coded better, we tweaked the measure in response to how codes are actually used in the real world which is different than coding guidance often, we learn that you know for example, around the CPAP and several other codes and we learn that for pressure clavicle was sounded pretty bad to begin with, but the reality most of those

babies do just fine and illustrated in the hospital for a longer period of time. We don't count it.

So those kinds of tweaks is, we found there were clear care practices that were improved as a result this one was around diagnosis and treatment of sepsis in a number of hospitals. The other was an interesting one in the small hospitals. Level 1 hospitals where the predominant severe UNC is transfer of care taking the baby transferring it to a higher level of care which is dislocating that from the patient and the family. And that that varies greatly among level one hospitals.

Some level one hospitals take unexpected term babies and only transfer half a percent to level three, level four facilities, whereas other level one hospitals transferred 5 or 6% of their other perfectly normal babies to higher levels of care. In those settings, the issue was the comfort that the family doc or the pediatrician had they're dealing with grunting, flaring and mild respiratory stress.

And there – and that was an education in facility training opportunity to transfer 6% of term babies that were otherwise uncomplicated on admission was clearly an improvement opportunities. So the improvement opportunities at all levels of care that we saw some were improved coding, of course, that's always the case with any of these measures. But there were some actual care improvement opportunities too.

Woman: That's helpful, thank you.

Martha Carter: This is Martha I had a question. Dr. Maine is our individual hospitals reporting these data or seemed when I read the narrative that you're doing the analysis, you know or third parties doing the analysis and I wondered this is

probably more of a feasibility, but it's also usability question. There so many exclusions, how difficult is it? Is it going to be or is it for hospitals to actually set this up for themselves? And do I have the process right at this point?

Man: So it's simply a taking the ICD 10 file for the newborn and passing it through in an algorithm. So all the data that you need for this measure is in the discharge diagnosis health of the baby, both…

Martha Carter: Individual hospitals, sorry go ahead yes.

Man: Yes, so for example, from the Joint Commission, there's always a vendor or someone else who acts with the intermediary for all the Joint Commission measures who establish the algorithm so you know that's – there's about 6 or 8 different vendors that have done all the quality measures in all the different areas. So it's not like an individual hospital has to sit down and calculate if they ask the vendor to or a third-party to do that.

Martha Carter: Okay, I see thank you.

Kimberly Gregory: Okay. I think it's time that we vote on this. And everyone is ready. So we'll be voting on first use, which is they pass, fail. Hannah?

Hannah Ingber: Yes. Oh, thanks, Kim. Yes, I've been voting for use your options are pass or no pass. We've got nine so far. Okay, we've got 5 more. Still waiting on. Okay, great. We've got all the results in so I'll lock those in. And you can see here for usability and use – for use specifically, we've got 16 votes for pass, 1 vote for a no pass, for a total of 17 votes, which means, the measure passes on use.

Kimberly Gregory: So that brings us to usability. And the staff recommended high on usability. Are there any comments from the committee before we move to voting?

Woman: None from me.

Kimberly Gregory: Okay, shall we vote in?

Hannah Ingber: Yes, if there are no other comments from the committee, I'll activate the vote for usability. Your options are high, moderate, low or insufficient. We've got 7 votes so far. Just waiting on a couple more. Great, Okay. I'm going to lock these in and share the results. Okay, for usability we have six votes for high, 10 votes for moderate, one vote for low and 0 votes for insufficient, for a total of 17 votes. Therefore the measure passes on usability.

Kimberly Gregory: And I believe the last criteria is related to competing measures of which there are none.

Woman: So I think we are doing pretty good. Our next agenda item is the –

Man: What? If we could – sorry, we have to do the overall vote.

Woman: Okay, my question has been (unintelligible)

Kimberly Gregory: So now we're going to do the overall vote before I go and take this measure.

Hannah Ingber: Thanks. Yes, the voting is open and we have 11 results so far. Waiting on just one more. Great, thanks everyone. Okay.

Kimberly Gregory: Wow. Okay, so I think we are actually we made up a little bit of time. And –

Man: So can we have – sorry, sorry, we have to read the votes for the record. Sorry.

Hannah Ingber: Sorry –

Kimberly Gregory: I'm trying to make up ties, anyway go ahead.

Man: I know, I know.

Hannah Ingber: Across, real fast.

Man: Thank you.

Hannah Ingber: Okay, so for overall suitability of endorsement, we have 16 votes for yes, 1 vote for no, for a total of 17 results. Therefore, the measure passes or rather than Committee recommends the measure for endorsement.

Kimberly Gregory: Okay, so I –

Man: I'd like to, if I could – if I could just thank the committee and we will take all of your concerns to heart as we continue to tweak this going forward, thank you.

Kimberly Gregory: Thank you very much Dr. Maine. All right. I'm turning the agenda over to Ms. Ingber, who is going to talk about public comments. Ingber on public comments.

Hannah Ingber: Yes, thank you. Thank you, Kim. So the lines are open. We'd like to open or we welcome comments from the public and NQS members at this time about the spring 2020 measure evaluations. If anyone has any comments, please feel free to speak up or chat us through the chat feature. Okay, hearing none. I'll go through just a couple of next steps for this cycle before handing it off to Matt.

So we were – sorry, so the spring 2020 cycle we've gone through all the measures and we'll be drafting up the report on those measures for comment between August 3rd and September 1st. The Committee Post Comment Web Meeting will be in September, September 18th where we'll go over comments on that report for all the measures we just reviewed.

Then the (CSAC) will take review of the measures over for their meeting on November 17th, November 18th. And they will vote to take the committee's recommendation or not. And then we'll have an appeals period at the end.

So just a reminder, we just like to remind everyone that for fall 2020, the intent to submit deadline is August 3rd. So all of the information for testings to be in by that deadline.

The full submission deadline is November 9th, where the rest of your information needs to be submitted. We anticipate 5 maintenance measures and their topic areas include chlamydia screening, neonatal screenings, and bloodstream infection rates, and episiotomy. So, if there are no questions about spring 2020, I'll hand it off to Matt to go over fall 2019.

Matthew Pickering: Great. Thank you, Hannah. So first of all, I wanted to also thank the developers, the discussants, the lead discussants, for all of your help, all of the

work that you've done to get us through the spring 2020 portion of the meeting today.

I also want to personally thank again, the Standing Committee for your endurance to get us to this point, we have a few moments remaining to get through the fall 2019 discussion. And before I go any further, I just want to check, do we have the developer on the line for the fall 2019, discussion – is the developer on the line?

Woman: Yes, we are on the line.

Matthew Pickering: Oh, excellent, great. Okay, thank you. And just want to move forward here, so we will be doing another attendance roll call, we have to sort of treat these two meetings differently. So we'll just do a brief attendance, we'll go through the names and just to make sure we keep that on record that those here for fall 2019 keep the track of those individuals.

We'll then just review and discuss the public comments. We'll also then have another public comment period, as well as next steps for the fall 2019 portion and then we will adjourn.

And just to and of sort of focus the conversation, again, the purpose of the fall 2019 discussion is really to present any new information that the committee really should be thinking about or deliberating on and adjudicating. If the committee does feel based on what we have provided, as well as the post comment member to the group that feel that the comments that were shared was taking into account.

But it really was nothing new to deliberate on, the committee can mention this and then move forward and with their decisions to keep their decision and rate

– rating of the measure as is, and no need to revisit any of the issues that the committee already deliberated on back in fall 2019.

So we had shared a post comment memo with this committee, which summarizes the comments as well as the developer response was added to that memo. And we welcome you to provide any other information based on those responses.

If there isn't any other any information, we will just move forward in this fall 2000 – this measure will move forward to fall – to the CSAC for final decision making. So I'm just going to go through attendance again, we're just sort of keeping track of who is on this call – who's on the portion of this call. So I'm just going to go through the list here. And if you can just say present or here, that is perfectly fine. Kimberly Gregory.

Kimberly Gregory: Here.

Carol Sakala: Yes.

Matthew Pickering: Jill, Jill Arnold.

Arnold: Here.

Matthew Pickering: Hi Jill.

Matthew Pickering: Matt Austin.

Austin: Present.

Matthew Pickering: Thank you. And Jennifer, Jennifer Bailit.

Jennifer Bailit: Here.

Matthew Pickering: Amy.

Amy: I'm here.

Matthew Pickering: Thank you, Martha.

Martha Carter: Here.

Matthew Pickering: And Tasha, Tasha Cooper. Ashley Hirai.

Ashley: Here.

Matthew Pickering: Thank you. Lisa Holtzclaw.

Lisa Holtzclaw: Here.

Matthew Pickering: Thank you. Dr. Jaleel.

Mambarambath Jaleel: I'm here.

Matthew Pickering: Thank you. And Diana Jules. Sorry, Diana. Was that, were you saying you were here?

Diana Jules: I am here.

Matthew Pickering: Thank you. Debra?

Debra: Here.

Matthew Pickering: Thank you and Sarah McNeil.

Sarah McNeil: Here.

Matthew Pickering: Jennifer Moore, Sarah Nathan, Christie Nelson, Sheila-Owens Collins.

Sheila Owens-Collins: Here.

Matthew Pickering: Thank you.

Sheila Owens-Collins: But I will have to get out about 10 minutes so, but I am here. Thank you.

Matthew Pickering: Great. Thank you. Thank you. Diana Ramos.

Diana Ramos: Here.

Matthew Pickering: Cindy Srinivas. Marine Strauss?

Marine Strauss: Hi, I'm here.

Matthew Pickering: Thank you. Angeline T, Raj Wadhawan.

Rajan Wadhawan: Yes. I'm here.

Matthew Pickering: Okay, great. Was there anyone on this list that I did not call? Okay, great. So on slide nine, I'm just going to touch on the comments here. So, again, this

is one measure that came through for fall 2019, which was 3543, Patient Centered Contraceptive Counseling Measure or PCCC.

Measure in the University of California in San Francisco and this is a four item Patient Reported Outcome Performance Measure or PROPM, designed to assess the patient centeredness of contraceptive counseling at the individual clinician or provider and facility levels of analysis. NQS received 21 comments of which, 17 were in support.

And so, the comments are summarized below here, in which no measure for inquiring about a patient's history of family planning or respect for pregnancy, intendedness, no inclusion of information on a situation where a patient would like to become pregnant. So these are the comments that were of concern or of non-support that kind of came through in the 21 comments.

Survey point for a language implies a provider has all knowledge and expertise needed for the patient to make the best decision and limited descriptions of diversity of – diversity within study samples and submission is non-explicit about the inclusion of marginalized communities in the development of this measure.

Again, the developer also provided a series of responses to the comments, and really the comments focused in on these three themes across what I've just mentioned in which is the consideration of disparities during measure development, measures to support pregnancy intentions and utility of survey questions.

And so for that consideration of disparities during measure development, one comment were really expressed concerns that the measure did not adequately

validate disparities and that certain communities of patients and providers were not part of the development of this measure.

Specifically, the comments are found that problematic at the measure or that the researchers do not – have not named their own identities and possibly – and positionality with respect to the measure concept, further without reassurance that communities of color were part of shaping the PCCC instruments. The comments would suggest that the measure falls short of what have been produced if people and practitioners of color have been part of the investigative team.

The developers response and developer is on the line to answer any other questions that the committee would like really mentioned that the purpose of this measure is to highlight the patient's whole knowledge about themselves, their lives and their preferences and their experiences and that providers must listen to these things, respect them, and center them in the conversation.

The developer then proceeds in their response to talk about how they drew from the existing literature on person centered care and work to ensure that the questions did not make any assumptions about what patients need or want.

They then provide a series of explanation and rationale about the construction and framing of the questions that were used. And then while they appreciate that individuals may interpret this – the question differently, the validity testing we – that they conducted with patients as part of the measure development process indicated that the question was understandable and considered highly important.

The developer also recognized that due to a large number of different samples and data collection strategies in their application to NQS they did not include

participant characteristics for all phases of the formative and validity reliability testing.

They did describe in the application that the validity reliability testing sample for their provider level testing included 29% black and 25% Latino or Hispanic participants. And they also referenced in the application, the demographics of participants included in the initial qualitative work with 24% black, non-Hispanic Latina, 24% white non-Hispanic Latina and 50 – 52%. Hispanic Latina and they understand the desire for additional information about the demographics of other phases of research process, and they plan to include in this information and publish manuscripts in the future.

Lastly, with respect to this team, they did work to include a range of perspectives in the measure development framework, including through collaboration with a patient advisory group and they recognize that having researchers of color to lead this work could not have resulted in or – excuse me, and they recognized that having resources of color lead this work could have resulted in a different result.

They are committed to continuing to strive to collaborate, step up and step back with the goal of lending their voices and efforts to broader efforts to advance person centered equitable care through racial justice more broadly. I'll stop there. So that really is around the theme of considerations of disparities during measure development, and I'll turn it to the committee and our co-chairs to see if there's any dialogue, that any questions they'd like to ask the developer potentially.

Sheila Owens-Collins: This is Sheila Owens-Collins. There’s been a lot of discussion about intention to get pregnant. And so I wasn't really sure in your methodology, if you – if that was a routine question, which you know, there's

– there is care – primary care positions that say they should, but a routine question that you ask about their intention of getting pregnant and depending on the answer are they using birth control?

Christine Dehlendorf: So, this is Christine Dehlendorf from UCSF, The Person-Centered Reproductive Health Program. Thanks for that question. So, the question, the denominator for this particular measure is people who receive contraceptive counseling.

So it is people who for whatever – in whatever way that the clinic has identified a person as wanting contraceptive care has received with that care. So in some circumstances, in some of the sites, there was a formal pregnancy intention screening process, and in others, it was - it would have been different, perhaps less standardized.

So this measure does not itself rely on having pregnancy intention be assessed, it more relies on people having received contraceptive care and wanting contraceptive care itself. And as we described in the application or in the response to the comments, our measures very much designed to take into account as Dr. Pickering described that people have a broad range of feelings and preferences related to contraception, including related to method effectiveness, which will relate to how they feel about the potential for pregnancy in their lives.

So we design the measure to not make assumptions about how people feel about method effectiveness and the importance of avoiding pregnancy, and to be flexible around that. We do acknowledge as described in the comments that there is desire for many in some quarters and some movement towards a separate measure that would look specifically at whether or not people are being assessed for their pregnancy desires when they're seen by a healthcare

provider or health care system, but that would be distinct from this measure, which includes only those who have received contraceptive counseling.

Sheila Owens-Collins: Okay, thank you. That clarifies it for me.

Christine Dehlendorf: Okay, thank you.

Matthew Pickering: Any other comments from the committee? So I will just mention for, because it gets to that aspect over that last comment Sheila, that measure to support pregnancy intentions, there were several commenters expressed that the need for a measure that captures information regarding women's intentions, pregnancy intentions.

And the developer responded that they agreed. Many patients, including some patients received contraceptive counseling would want to receive information about achieving health pregnancies as well. And the resources suggest that are highly valuable.

And so I think developer sort of summarized that and touched on that in your last response. And they agree that future work could focus on additional performance measures that would provide standardized approaches to evaluate in a provision of care focused on health pregnancies as another component of experience of reproductive health care.

Sheila Owens-Collins: Okay, Thanks. I would look forward to that, because I think that does influence outcomes, maternal outcomes as well as new available outcomes. You know, I think it's, you know, one is intending to get pregnant and she could be counseled on how to take care of herself that the outcomes are better. And you know, it needs to start early, it will be quotient as to get (unintelligible) because as you know the unintentional pregnancy rate is 30%.

Matthew Pickering: Any other comments related to pregnancy intentions or the consideration of disparities in the measure development from the committee? So I'll just touch on this last theme and maybe I'll also turn to the developer as well to further their response to this.

But two commenters expressed concerns regarding the questions used within the measure specifically, one commenter really stated that the questions were really not helpful. And then the questions do not include any information related to whether the provider inquired about the history of family planning or any previous unintended pregnancy.

So the commenter further mentioned that the questions do not ask patients about their sources of information or contraception. Additionally, another commenter had concerns that the framing of certain questions implies that the provider holds the information needed for the patients to make decisions and this contrary to the patient centric dynamic. Would the developer like to provide their response to this?

Woman: Yes, thank you so much. So I think that this is coming from – those two comments were coming from two different perspectives. One was a provider perspective on discussing how the provider themselves feels that quality contraceptive counseling, what the content of quality contraceptive counseling is, including, the considerations that are taken into account when providing this counseling. And that person desired more specificity, inquiring, in fact about the specific content of counseling.

And I think that there is reasonable debate among individuals about exactly what questions can and should be asked as part of contraceptive counseling, specifically questions about prior method use, history, reproductive – history

of reproductive experiences, and so on. That said, our particular measure was designed to get away from specifically looking at the content of counseling but to look at the patient experience of counseling and to get their sense of whether or not the provider met their needs as they themselves to find them.

So I think that this is important both because I think that that is what we ultimately care about is patient experience of counseling and because it acknowledges that patients will have different reactions and feelings about different content and different ways that questions are posed to them and counseling is provided.

And it is the role of a patient centered healthcare system to respond to individual desires and preferences for how counseling is provided, and there's not a one size fits all approach.

So I think that we definitely heard from other providers and intentionally elicited from other providers during the course of our measure development to ensure that in general, providers felt that this measure did represent a valid from a face validity perspective, valid measure of patient experience that they felt could be actionable. And through our modified Delphi process, we did find that to be the case.

To take the second comment, which is coming more from the patient perspective about whether or not these questions, in fact, reflect the desired goal of getting, measuring patients' experiences and whether or not their needs are met as they themselves define them.

The specific question that was – that an issue was the question about giving me enough information to make a decision about my birth control. And the commenter was concerned that this could be interpreted from the perspective

of the provider having all of the information and giving all of the information to the patient.

And well, we certainly understand how in general, in the health care system that is often how things are framed and we concur with the comments are that this is a move – this is a framework that we should absolutely be moving away from. We think that one of the things that make this not a concern, in this particular context is that this question is being posed to the patient. It's not being posed to an observer; it's not being posed to the provider. It's being asked to the patient whether or not the patient felt they received enough information.

So it doesn't presuppose that the patient wanted all of the information from the provider, but rather that asked them whether or not they got the information that they wanted from the provider. And we did do as described in our evaluation and our submission to NQS, we did do a process of cognitive interviewing around our questions to select the measure items.

And we asked people to do a think out loud approach with their patients to do a think out loud approach around on what they heard and what they thought when they were answering the specific items. And we did hear from participants when we did the – that particular question about enough information.

We did hear a range of responses that indicated that participants were asking questions – were answering the question from their own perspective around what was enough information and not from an externally defined standard. And then as last thing I'll say that from in terms of the measure overall, we also did face validity for the four questions overall, and did hear from

participants that they felt that it represented well in their perceptions of quality in general, in terms of patient centered contraceptive counseling.

Man: So, was there – did you were you able to standardize what is considered enough information, because now you're getting into the health literacy domain. I'll let you answer that question first.

Woman: Yes, so enough, again – enough information is defined from the patient's perspective. So a patient will at the end of the visit, the patient is asked to assess whether they feel, they received enough information to make the best decision about their birth control method and from a perspective of a structurally competent healthcare system that meets patient's health literacy needs, with the health literacy residing in the relationship between the patient and the system and not in the patient themselves.

We would argue that all patients should get enough information, regardless of their – whatever their measured health literacy might be. And then it's the responsibility of the system to meet their information needs.

Man: Yes, you know, the problem is, there's an old saying, you don't know what you don't know. And so, you know I think that's a good measure, but I'm not sure if we get granular enough. Because, you know, it's okay if they think that they get enough information. But if it's not enough information and not enough to have to improve the outcome, whether it'd be the pregnancy outcome or the newborn outcome, then it's not that helpful.

Woman: So I think yes, your comments touched on a couple of points. One is the question of what type of a measure this is? Is it a process measure or an outcome measure? And as per NQF guidance, patient reported outcome measures of patient experience are outcome measures that are ends in and of

themselves, and not only valued with respect to the clinical outcomes that they produce.

That said, I definitely agree with you that providing an adequate information and more generally, meeting patient's needs for patient centered contraceptive counseling is something that can absolutely improve reproductive health outcomes more broadly.

And I understand your point that a single – one single performance measure cannot assess all of those things, and honestly, the only way to really assess information transmission would be to either observe all contraceptive counseling visits or to do a quiz of patients after their contraceptive counseling. Does that, which is I think beyond the scope of performance measurement, but it is actually worked at my team in on a research basis is continuing to engage it.

Man: Okay, all right. Thank you. I think we do have more work to be done, but I think that's a great start.

Woman: I agree. Thank you. Yes, there's more work to be done. Thank you very much.

Matthew Pickering: Any other questions or comments from the committee or the developer on this?

Carol Sakala: Dr. Dehlendorf, this is Carol Sakala from the National Partnership and I've heard quite a few presentations over the years, and I understand that all the work that went into this measure. And I just want to thank you, I feel that contraceptive care is such a huge part of women's health and that we now

have, it's not complete, but it's a lovely, small, very robust set of measures for this domain. So thank you for you and your team for the work on this.

Christine Dehlendorf: Thank you so much. I really appreciate that comment.

Matthew Pickering: Are there any other views or considerations, any disagreements from the committee that we should that discussants deliberate on? Okay, hearing none, that also means hearing no other considerations for – no other reconsiderations around this measure. We will go ahead and move forward.

Want to thank the developer for dialing in for this afternoon to address the comments that have been received and we will move this to CSAC. So with that, I will turn it over to Hannah to do the final member public comment and next steps around fall 2019.

Hannah Ingber: Thanks, Matt. So again, we are opening the lines to members of the public and NQF members, if you'd like to make a comment, please do so now, either verbally or through the chat box. Okay, hearing none, I will move to the next step. So as Matt just mentioned, this measure will now go to CSAC review. And that will be – the CSAC will be meeting on November 17th and 18th. And we'll be voting on the measures then.

And then that will go through an appeals period for between November 23 and December 23. And this slide has, you know, our project contact information, the project webpage information, we just always like to show this to make sure that everyone has access to all the resources they need to contact us and to learn about the project. Are there any final questions? Okay, I will hand it back to Matt then. Thanks, everyone.

Matthew Pickering: Well, thank you, all. It's now 5:10 on the East Coast, we actually ended 20 minutes early, look at that. But thank you to the standing committee, again, recognizing everyone has competing priorities right now and for a full day on a webinar or virtual meeting is a lot to ask and we really, really appreciate that, especially holding quorum for the rest of the day so we very much appreciate that. We will be following up with a, again, a survey for the initial measure so that we can get quorum on the votes for the initial measure.

But I believe we all know where we – where the other measures stand at this point. I also want to thank our co-chairs Carol and Kim, great job. Thank you so much for keeping the dialogue moving and keeping us moving and focused today.

Thank you very much to lead discussants and discussants. And also thank you for the developers as well for all your time and patience throughout the day, both for spring 2020 measure developers and fall 2019 post comments. Just thank you again, and if you have any other questions, please don't hesitate to reach out to us and those partners from the project box or those communications that Hannah had mentioned previously. Kim, Carol, would you like to say any closing remarks?

Kimberly Gregory: No it's been a very productive day. Yes, I guess, a very productive day. And I thank everyone for their patience and fortitude and I look forward to the opportunity when we can be in the same room together again.

Carol Sakala: Thanks, everyone. Looking forward to the next round, because we have another set of measures that will be coming up in a few months.

Matthew Pickering: All right. Thank you. Thank you all very much. Have a great weekend and we will talk to you soon.

Carol Sakala: Thank you all to the NQF staff.

Hannah Ingber: Thank you all so much for considering our measure.

Kimberly Gregory: Thank you, bye.

END