NATIONAL QUALITY FORUM

Meeting Summary

Perinatal and Reproductive Health Standing Committee May 2017 Off-Cycle Quarterly Webinar

The National Quality Forum (NQF) convened a public webinar for the Perinatal and Reproductive Health Standing Committee on Wednesday, May 10, 2017. An archived recording of the webinar is available for playback.

Welcome, Introductions, and Overview of Topic

Suzanne Theberge, Senior Project Manager with NQF, began by welcoming participants to the webinar and providing an overview of NQF's off-cycle work. Erin O'Rourke, Senior Director with NQF, then presented an introduction to the work of the Disparities Committee, including the project charter, activities, and a brief review of the two reports published thus far. Ms. Theberge then presented a brief summary of the statistics regarding disparities in infant mortality and low birthweight, and research on which policy, community, and healthcare provider interventions have been effective. She also summarized the state of NQF's portfolio of endorsed measures on reproductive and perinatal healthcare. Ms. O'Rourke then explained the three topic areas and the associated discussion questions that the Disparities Committee is seeking input on from the Perinatal and Reproductive Health Committee. NQF staff then opened the call for discussion by the Committee, facilitated by the Committee Co-Chairs, Dr. Kimberly Gregory and Dr. Carol Sakala. NQF shared the discussion questions with the Committee in advance of the call.

Discussion Questions

- What process and outcome measures could be the most useful for identifying disparities in infant mortality and low birth weight? What interventions could be the most useful to reduce those disparities?
    - What are the key outcomes and processes that should be stratified to identify disparities in infant mortality and low birth weight?
    - What are the key interventions to reduce disparities and how could their use be measured?
    - What data might be needed to support measurement in this area?
- How can appropriate perinatal care for women at social risk be measured?
    - How could the quality of prenatal care for vulnerable populations be measured?
    - How could the quality of post-partum care for low birth weight infants be measured?
    - Are there specific areas of care that measurement should focus on for vulnerable populations?
- What policy recommendations could incentivize a reduction in disparities in infant mortality and low birth weight?
    - Are there policies associated with measurement (reporting, payment, etc.) that could help incentivize the reduction of disparities?

- How can we encourage increased measure development and use of quality measures for perinatal care?

Committee Discussion

The Perinatal and Reproductive Health Committee held a wide-ranging discussion that covered many of the discussion questions simultaneously. Committee co-chairs Dr. Gregory and Dr. Sakala facilitated the discussion portion of the call. Dr. Gregory led the first section, focusing on measures that could potentially be most useful for identifying disparities in infant mortality and low birthweight, and which interventions have shown to be effective. During this first part of the discussion, the Committee also delved into exactly how to measure the quality of prenatal and post-partum care, particularly for vulnerable populations.

Effective Interventions and Measure Gaps

- The Committee noted that, in the Disparities Committee's report on interventions did not discuss access to 17P (a progesterone injection that can reduce the likelihood of preterm birth in women who have previously delivered early; it is given weekly starting in the second trimester)as an effective intervention for reducing disparities in pre-term birth and low birth weight. Committee members indicated the success of pilot programs focusing on 17P, such as a home health worker meeting a patient to administer the drug. The Committee suggested a number of potential outcome and process measures related to this intervention:
  - Access to 17P (including geographic issues, patient education, and financial access);
  - Timely access to 17P (it was noted that requirements in some states for pre-authorization lead to delays that prevent it from being received when needed to be effective);
  - Accurate identification of patients in need of the protocol, which could include patient education and outreach, and ensuring that women who had previous preterm deliveries or miscarriages between 15-20 weeks of pregnancy are included as women at risk of preterm birth; and
  - Committee members discussed an effective community health education program that included television commercials regarding the need for waiting until 39 weeks to deliver, and suggested a similar campaign could be used to reach women who may need 17P, encouraging women with prior early deliveries to see a doctor.
- Access was a reoccurring theme, with the Committee stating that at times it is assumed that all women have access to specialists, educators, and clinics, which is simply not true, especially for rural and frontier women. The Committee discussed the increasing access to telehealth, which could be a key intervention for this particular population. Committee members noted difficulties in finding care that is accessible for women in urban areas as well. Members of the Committee referenced successful programs that use visiting nurses to provide care to women in their homes, at work, or other convenient locations. Two examples discussed including a program in Puerto Rico that has public health nurses meet women needing 17P injections at locations and times that are convenient to them; and routine maternity care in England, which is almost exclusively provided by a nurse via home visits, other than for special tests such as ultrasounds.

- Access to family planning and contraception is another key tool in reducing disparities in infant mortality and low birthweight. In particular, Committee members agreed access to contraception for teenagers is crucial, especially since higher education levels are linked with lower infant mortality. Both preconception and interconception care, along with family planning, have demonstrated improvement of outcomes.
- The Committee commented that psychosocial factors could contribute to disparities in low birthweight and infant mortality. Committee members noted that screening for prenatal and postpartum depression at least once during pregnancy and within the first 8 weeks after delivery is key. It was stated that lifetime burden of stress and trauma, as well as stress during pregnancy, are correlated with poor outcomes.
- A major topic of discussion, and one that overlaps with the other topics under discussion by the Disparities Committee, was the need for measures and interventions to assess and treat comorbid conditions, including diabetes and hypertension. Patients with diabetes are more likely to deliver early or have complications in pregnancy, and complicated pregnancies. These conditions are most likely to cause low birthweight and preterm birth, and have a strong link to later development of cardiovascular disease, diabetes, and kidney conditions. In addition, mental health can affect pregnancy rates and outcomes, and prenatal and postpartum depression and anxiety are common and serious side effects of pregnancy.
- Committee members also commented on the need for women to deliver in facilities that are equipped to handle low birthweight or premature babies as well as the need for policies that ensure patients in need are transferred to appropriate levels of care. The Committee discussed the role of the quality of care and disparities in the resources available to facilities, with Committee members stating that there are higher rates of mortality in hospitals serving minority populations. The Committee questioned whether this was a resource issue (do these facilities have the right resources?) or a quality of care issue (is the care being provided subpar?).
- The Committee recognized the importance of appropriate care transitions. Committee members noted the need to ensure that families with babies sent home after being in the neonatal intensive care unit (NICU) are especially in need of education and support. Babies leaving the NICU sometimes need special care and the parents need training and assistance with the process of transitioning home. Committee members also agreed that home visits for these families to assess safety and readiness of the home environment are important to ensure the baby can be cared for adequately. Members of the Committee shared examples from their own clinical practices of babies who suffered serious, preventable adverse events or died from conditions arising from unsafe housing. Preterm birth and low birthweight are associated with the same socioeconomic factors that are often linked to unsafe housing. Measures that would be particularly useful for this population include readmission and mortality rates focusing on babies leaving the NICU, discharge readiness, and ability to care for the baby at home. There is currently a Canadian measure that tracks the degree of maternal worry, which is predictive of the likelihood the baby will return to the Emergency Room. Committee members thought this could be a useful measure to implement in the US.
- Committee members discussed their professional experiences with effective interventions in their practices and in the literature, including substance abuse counseling that is “hardwired” into the office, allowing women to access it immediately. While they agreed substance abuse

interventions are important to measure, they flagged screening and assessment for potential substance abuse as the bare minimum of needed practice in this area. The Committee mentioned other interventions proven effective, such as group prenatal care and peer support (including both one-to-one and group models).

- Since congenital malformations or chromosomal abnormalities are the largest cause of infant mortality, causing 20% of neonatal and infant deaths, the Committee also discussed disparities in this area. It is not known how many of these cases could have been prevented with interventions such as folic acid supplementation, or treated with earlier access to screening tools such as ultrasounds, but the Committee agreed there are gaps in both areas. In addition, once cases are diagnosed, there is not enough access to counseling and education for parents. In some cases, this includes receiving no counseling at all, but when counseling is received, it may not be unbiased or high quality. Committee members noted that counselors may urge parents towards either comfort and palliative care or intensive medical interventions without fully educating parents about all available options.
- Committee members indicated that systemic factors, including education, housing, and food, are major factors in infant mortality and low birthweight babies. The Committee strongly recommended the development of and a focus on systemic measures that take a broader view of health. Measures to be developed should focus on access to healthy food and food insecurity, access to safe housing and housing insecurity, and continuous insurance coverage, particularly for Medicaid patients. While Committee members agreed there are several factors healthcare providers can influence to reduce disparities in infant mortality and low birthweight on a systemic level, changes must occur prior to women becoming pregnant. As systemic factors are present earlier in life and cause long-term health impacts, it can be too late to prevent problems by the time a woman becomes pregnant. Since social determinants are the biggest risk factor for low birthweight and preterm birth, the Committee strongly emphasized the need for women to be able to complete high school, and have access to healthy food, good quality healthcare, and contraception, at an early age or at least by their teenage years. The Committee mentioned that the cuts to Medicaid funding will have long-term negative impacts and are likely to increase rates of infant mortality.

Data issues

Dr. Sakala facilitated the second section of the call, which focused on data issues for measurement in this area, and policy drivers for improvement. A lack of data or challenges in data collection can hinder measurement. NQF sought suggestions from the Committee on the challenges and opportunities for advancement.

- Committee members suggested the need for better data collection and more granular data. For instance, currently all Asian and Pacific Islanders are reported together and all Native Americans and Alaska Natives are reported together when reporting on measures, which may hide disparities in different subgroups and does not produce meaningful data. While Committee members noted the importance of “multiracial” as a reporting category, they are concerned that it could mask disparities.
- Committee members stated that there is an ICD-10 code for women with prior pre-term birth and if a measure on 17P use is developed education should be provided to ensure more providers are using the code.

- Committee members were hopeful about the opportunities for quality improvement offered by information available through coding, indicating that data for many of the measures proposed could be collected via ICD-10 codes in electronic medical records (EMRs) or medical records.

Policy drivers for improvement

After discussing measures and data needs, the Committee turned to potential policy drivers for improvement. Given the systemic causes behind infant mortality and low birthweight, NQF asked the Committee for input on policies that could be used, in addition to measurement, to improve outcomes. In particular, the Committee was asked what policies might incentivize reductions in disparities, and drive innovations in measurement and in care.

- The Committee noted that episode-based payment provides opportunities for improving care and outcomes, particularly around the idea of maternal care medical homes and care coordination. Currently it is difficult to bill properly for group prenatal care, a proven-effective intervention, which reduces the number of clinical practices who are able to or willing to provide group prenatal care.
- The Committee suggested the development of policies that encourage and incentivize access to care in patient-centered ways, including nurses providing care via home visits and telehealth options to increase access to care for women in rural areas and women at highest risk. Home visiting programs providing a range of medical care have strong outcomes. The Committee discussed a successful program in England, where virtually all prenatal care is provided in the home by a visiting nurse and women only go to the hospital for special tests, such as ultrasounds. Australia has a robust post-partum home visit program, which provides care for both mothers and babies after birth. Puerto Rico has had great success with increasing rates of 17P use by having public health nurses give shots to women at locations and times convenient to the patient. Telehealth, (including home-based blood pressure tests, smart phone apps that allow health tracking and make it easy for patients to communicate questions or test results with providers, and provider visits/consultations by phone/internet), were noted as especially important for rural women who do not have healthcare providers nearby.
- The Committee commented that increased access to Medicaid, as well as policies that ensure continuous coverage, should be a major area of focus for improving care.
- Committee members closed the discussion by noting the dire need for funding for measures in this topic area. In the recent (2015-2016) cycle of Perinatal measure endorsement, only one new measure of perinatal care was submitted to NQF and received NQF endorsement, despite the four-year gap between Perinatal endorsement projects. (The one newly endorsed measure is #2902*: Contraceptive Care – Postpartum*, an intermediate outcome measure that assesses the percentage of women provided a "most" or "moderately" effective method of contraceptive or a long-acting reversible method of contraception (LARC) after childbirth.) Given the number of measure gaps identified by the Perinatal and Reproductive Health Committee in 2011, Committee members expressed the need for more research on perinatal and neonatal health. Funding is needed for researchers to collect, analyze, and share data to illustrate the need for additional measurement in the topic area. Given the Committee's concerns, NQF staff mentioned the Measure Incubator, a NQF initiative to address important aspects of care for which quality measures are underdeveloped or non-existent. The Incubator is an innovative

effort that facilitates efficient measure development and testing through collaboration and partnership and could provide an avenue for faster development of measures in this area.

Specific Measures

During the discussion, the Committee had a number of specific suggestions to address the gaps in measurement.

- Screening for prenatal and postpartum depression at least once during pregnancy and within 8 weeks of delivery
- Substance abuse assessment, counseling, and treatment
- Screening for maternal stress
- Behavioral risk assessment, particularly for substance use
- Quality and comprehensiveness of nutrition counseling during pregnancy and access to nutrition counseling before, during, and after pregnancy
- Measure of extent of obesity and hypertension
- Healthy weight gain in pregnancy with a given starting body mass index (BMI)
- Referral and management for chronic conditions, especially ensuring patients with diabetes have a primary care provider: Referral of management and co-management of conditions and how well comorbid conditions are controlled
- Appropriate transfer of high-risk women and babies (transfer to appropriate facilities)
- Access to 17P to prevent preterm birth, particularly in a timely fashion and for women who have already had a preterm delivery or miscarriage during weeks 15-20 of pregnancy
- Actual and perceived ability to access prenatal care, including the maternal perspective on how easy it was for women to access prenatal care, how long the wait was to get a needed appointment, how easy it was to attend appointments, etc.
- Availability of screening to diagnose congenital anomalies and chromosomal abnormalities
- Access to counseling on options and access to palliative and comfort care for babies born with severe abnormalities
- Use of antenatal steroids: the Committee recommended endorsed measure *#0476: PC-03 Antenatal Steroids* be stratified for disparities
- Induction of labor: While elective early inductions are highest among upper middle class white women, when looking at all inductions, including non-elective, outcomes are worse for African American women who have higher corresponding C-section rates
- Discharge readiness: A measure assessing a family's readiness to care for their baby after discharge from the NICU
- Readmissions rate for babies discharged from the NICU
- Mortality rate for babies discharged from the NICU
- Measures of food and housing insecurity
- Access to contraception (particularly for teenagers) and family planning for first pregnancy and pregnancy intervals
- Access to preconception and interconception care and continuous enrollment in insurance
- Resource limitations in hospitals with poorer outcomes

Opportunity for Public Comment

Ms. Theberge then opened the call for public comment and no comments were provided.

Closing

In closing, Ms. Theberge and Ms. O'Rourke thanked webinar attendees for their participation. Ms. Theberge summarized the next steps, including the creation of the meeting summary. Ms. Theberge will share a summary of the discussion with the Committee for review and input prior to sending to the Disparities Committee. Ms. Theberge also mentioned the Disparities Committee's upcoming June 14-15 in-person meeting, and invited the Perinatal and Reproductive Health Committee to comment on the Disparities Committee's report, which will reflect this discussion, during the commenting period in July 2017. NQF staff also mentioned the upcoming Kaizen event on improving NQF's consensus development process CDP and encouraged interested Committee members to contact NQF staff for more information.