NATIONAL QUALITY FORUM

Moderator: Measure Developer Maintenance
May 10, 2017
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Operator: This is conference # 4035678

Operator: Welcome to the conference. Please note, today's call is being recorded. Please stand by.

Suzanne Theberge: Hello everyone. Welcome to the call and thank you for joining us. This is the NQF Perinatal and Reproductive Health Committee's Off-Cycle Webinar and this is Suzanne Theberge the Senior Project Manager on the team.

So I just, next slide, want to go over the agenda for the call. And before I do that I will just state a couple of housekeeping items. First of which is, committee members please dial in to the phone line, also, that's on the agenda and the memo and in the chat box. We do need you to call in order to be able to speak, not just the webinar. And also just a – the same reminder we always give, please don't put us on hold but please do use your mute button during the call so that we can reduce background noise.

So, just briefly, the agenda for the call, we're going to do a very quick roll call just so we can get a sense of who's on the call with us today and then I'm going to talk briefly about NQF's off-cycle work and then turn it over to Erin O'Rourke, one of our Senior Directors, to talk about the disparities work that's been happening and then we'll open it up for discussion with the committee. And we'll close out, as we always do, with a public comment period and a couple of next steps.

So, next slide please, just our brief roll call, if you are on the phone please just say, here, when I call your name. Matthew Austin? Jennifer Bailit? Amy Bell? Tracy Flanagan?

Tracy Flanagan: Here.

Suzanne Theberge: OK. Gregory Goyert?

Gregory Goyert: Here.

Suzanne Theberge: Thank you. Kimberly Gregory?

Kimberly Gregory: Here.

Suzanne Theberge: Ashley Hirai? Mambarambath Jaleel? Diana Jolles? John Keats?

John Keats: Here.

Suzanne Theberge: Deborah Kilday? Nancy Lowe? Sarah McNeil? Jennifer Moore? Kristi Nelson? Juliet Nevins?

Juliet Nevins: Here.

Suzanne Theberge: Sheila Owens-Collins?

Sheila Owens-Collins: Here.

Suzanne Theberge: Cynthia Pellegrini?

Cynthia Pellegrini: Here.

Suzanne Theberge: Diana Ramos? Carol Sakala?

Carol Sakala: Yes, here.

Suzanne Theberge: Naomi Schapiro?

Naomi Schapiro: Here.

Suzanne Theberge: Karen Shea?

Karen Shea: Present.

Suzanne Theberge: Marisa Spalding? Sindhu Srinivas? Rajan Wadhawan? Carolyn Westhoff? And Janet Young? OK. One more quick reminder, please turn off the sound on your speakers as you may of just heard, that will cause some feedback. I know a bunch of folks whose names I called are on the webinar so please do dial in to the number on the agenda and in the memo if you haven't – if you haven't done so yet. So …

Jennifer Moore: Hi, this is Jennifer Moore, just wanted to let you know that I was waiting for the operator to let me in but I'm here now.

Suzanne Theberge: Great, thank you. Is …

(Crosstalk)

Matthew Austin: And this is – Matt Austin is on as well.

Suzanne Theberge: Thank you.

Nancy Lowe: And Nancy Lowe also.

Suzanne Theberge: Great. Anybody else?

Kristi Nelson: Kristi Nelson

Suzanne Theberge: Great …

(Crosstalk)

Amy Bell: Amy Bell – I'm sorry Amy Bell is on as well. Thank you

Suzanne Theberge: Hi. OK everybody, great. Just a reminder to turn the volume off on your computer. Thank you. So next slide, I just want to talk quickly about what off-cycle work at NQF is. During the times when we're not actually reviewing measures and we don't have an ongoing project NQF likes to bring our standing committees together for what we call off-cycle webinars to talk

about things outside the scope of a normal project. And we do this work via a two hour webinar on a quarterly basis.

So next slide, there's a variety of activities that we can do during this off-cycle work. Like today, sometimes we ask the committee to provide guidance or input to another committee looking at another topic, sometimes we ask – we just provide some updates about things that are happening at NQF and sometimes we ask you to do (CDP) related work which might include doing an ad hoc review of a measure or an off-cycle review of a new measure or it could include some follow up work such as dealing with the competing measure issue that came up in the last round of work.

So today, we are going to be asking you to talk more – to talk about infant mortality and low birth weight, to provide some guidance to our disparities committee and I'm now going to turn it over to our senior director Erin O'Rourke, to talk about the disparities committee's work. Erin?

Erin O'Rourke: Thank you so much, Suzanne, and thank you to the committee for your time today. On behalf of the disparities standing committee, really appreciate you taking the time to provide some input into our ongoing work in this area.

Next slide, so as Suzanne mentioned, my name is Erin O'Rourke. I'm one of the senior directors here at NQF specifically on working to support the disparities standing committee. Just as a little background we've convened a committee that's charged with developing a road map for how measurements and its associated policy levers can be used to reduce disparities in health and healthcare. We do have funding from the Department of Health and Human Services to provide guidance on how measurement can be used to address disparities in some selected conditions, you can see them on the slide.

Cardiovascular disease, cancer, diabetes and chronic kidney disease – infant mortality and low birth weight and mental illness – and these conditions were selected to serve as case studies for the committee's recommendation. They are also some of the leading causes of death and disability with known and notable disparities. Specifically the committee is tasked with examining the

disparities based on the social risk factors outlined in the 2016 National Academy's report accounting for social risk factors in Medicare payments.

Next slide. So on this slide you can see what those social risk factors are, specifically it's socio-economic position, race, ethnicity and cultural context – gender, social relationships and residential and community context.

The committee also decided to broaden their scope a bit and will also be examining disparities based on disabilities.

Next slide. So we're very excited because this work is very timely. We're seeing more and more discussion about the role of social risk factors in value based purchasing. For example, there was a recent article in the New England Journal of Medicine that analyzed the impact of social risk factors on Medicare data.

The researchers looked at dual eligible status as a proxy for low income residents in a low income area, race, Hispanic ethnicity and residents in a rural area. They found that beneficiaries with social risk had worse outcomes on many quality measures regardless of the provider they saw and dual enrollment status was the most powerful predictor of outcomes and, secondly, in every type of care setting examined providers that disproportionally served beneficiaries with social risk factors tended to have worse performance on quality measures.

So, as a result, safety net providers were more likely to face financial penalties in most of the value based purchasing in which penalties are currently assessed. One of the main recommendations coming out of this work was a need to measure equity itself and to tie equity measures to existing payment program and this really fits right within the scope of work for the disparities standing committee and is what they are really trying to achieve through the road map that they are developing.

Next slide. So this is a one year project that has a number of milestones. We began in September 2016, we're about at the halfway point. We've conducted a number of literature reviews to examine the disparities that exist in the

selected conditions as well as their potential causes and to find interventions that may be effective in reducing them.

Currently, the committee is undertaking an environmental (scan) for measures that could be used to assess the use of effective interventions to reduce disparities.

Next slide. So this just shows you the timeline, I don't want to dwell on this too far but to just let you know that we've issued a series of interim reports – Suzanne sent them out as – some of the pre-meeting so that you could examine the findings a bit more in-depth. We are preparing to issue our third interim report and after that we'll tie it all together with one more cumulative final report.

Next slide. So just to give you a little taste of what we found so far, I'm going to very briefly review the first reports to show what we found in the literature and then pass it to Suzanne who will go into some details on the findings around infant mortality and low birth weight. I do want to caveat this by saying that what we found wasn't ground breaking but it was important ground setting for the committee's work and was sort of a litmus test for the current state of the evidence.

So the goal of the first report was to review the evidence describing disparities and health outcomes. We focused on the selective conditions where we knew there were known disparities. The committee also begin developing a conceptual model that they'll use to drive their work. Their overall goal is, again, to develop a roadmap for how we can use performance measures and its associated policy levers to reduce disparities in health and health outcomes.

Next slide. So, just to briefly summarize our report, we found significant disparities across all of these selected conditions. We really found urgent need to a systematic approach to eliminate disparities. We found several ways that disparities have been reduced, particularly, in areas of patient safety.

In the first report, we also included some of the building blocks of these conceptual framework. They've modified a number of some of the seminal

framework in the world of disparities. Particularly building off of work by (Marshall Tin) and Lisa Cooper that they could use to be the basis of their roadmap going forward.

Next slide. So, the committee is developing a framework that will answer the following questions. What are the most critical disparities reducing interventions to measure, what types measures have the greatest potential to reduce disparities, which measures could be implemented now versus in the future, what data is available to support measurement and what are the current gaps in measurement and how can they be filled?

Next slide. So, I apologize this is a bit hard to read but this is an illustration of the most recent iteration of the committees conceptual framework. They identified three high level steps that are depicted in this framework.

First is, obviously, to identify disparities. The second step is to select equity measures that are tied to interventions that can reduce them. And then, the third to provide incentives tied to the use of measures with ultimately, hopefully, leading to the reduction or elimination of health and healthcare disparities.

The committee recognizes that measurement's only one tool in the toolbox and eliminating disparities will require a number of other tools and cooperation from stakeholders who have been outside of the healthcare system. That's really been on of the main areas we've been struggling with is knowing that so much of the causes of disparities in health and healthcare are perhaps outside of the scope of the healthcare system and not inside its direct control. But rather tied to factors based on a persons environment and their community that perhaps the healthcare system could help mediate but may not be able to directly control. So, within that context is how we're tying to do this work here.

Next slide. So, moving on to just quickly some of the results of the second interim report, this report aimed to document some of the effective interventions most frequently sited in the literature. Primarily focused on

previous literature reviews as well as multi target interventions. That is interventions that could adept disparities in multiple social risk factors.

We attempted to organize these interventions by the level at which they operate. So, what interventions could a community take, what could a provider or organization take, what policy interventions might be necessary to reduce disparities, et cetera. Recognizing that health disparities are really a problem we need to target at every level of the system.

Next slide. So, just to briefly go into some more details on what we found in the second report because, we did identify some significant gaps in the research. The first major finding is that the majority of interventions focus on improving outcomes and absolute terms rather than relative improvement to some sort of reference group.

For example, a study would examine an exercise program in a minority population and examine improvement from baseline rather than compare it to their more socially privileged counterparts. We also found the majority of interventions focused on disparities based on race and ethnicity.

We were able to find fewer interventions related to location, disability and social relationship. The interventions tended to be more upstream focusing on things like patient education, lifestyles changes and culturally tailored interventions.

Next slide. So, there were a number of common recommendations to address disparities. First, there should be a commitment to health equity. Specifically, at the organizational level, collaboration with stakeholders outside of the healthcare system to better address some of the social determinants of health.

There's a need to collect data that allows for the detection of disparities. There's need to integrate disparities reduction into all quality improvement frameworks. The research has shown that disparities need to be specifically targeted. That general quality improvement programs may not specifically improve the care for those at social risk. There's a need to partner with communities and to ensure buy in from patients.

And then, finally, ensuring that all interventions are culturally competent. And this idea of cultural competence should extend beyond race and ethnicity but really should apply to all social risk factors.

So, with that, I'm going to turn it back over to Suzanne to just share with you some of the highlights we found specifically related to disparities in infant mortality and low birth weight.

Suzanne Theberge: OK. Thanks, Erin. So, next slide. I think that many of you will be familiar with these statistics but we just wanted to ensure everyone was starting from the same page. And talk briefly about some of the statistics around low birth weight and infant mortality.

As you probably know, the U.S. has a very high infant mortality rate as compared to other wealthy and developed countries. An average rate of 6.1 per 1,000 live births. The leading causes are congenital malformations or chromosomal abnormalities, low birth weight or prematurity, SIDS, neonatal death due to maternal complications and unintentional injuries.

Next slide. We also know that there are very significant disparities in infant mortality rates with African American infants having a rate more than twice out of white and Hispanic infants. And American Indian or Alaska native infants also having a higher rate that with and Hispanic infants.

And we know that infant mortality is as Erin mentioned associated with socioeconomic status. And it's also associated with location of the family in terms of rural or urban and then access to prenatal care.

Next slide. We also know that the major driver in low birth weight is preterm birth for almost two thirds of infants who are born with low birth weight they are preterm. But, we also know that only two percent of infants are born before 32 weeks but they represent one third to one half of infant death. And we also know that they are associated with long term and short term complications.

Next slide. There are effective interventions out there and we know that some of them focus on promoting access to prenatal care, healthy behaviors, ensuring infant safety and as Erin mentioned just a minute ago culturally competent care.

Next slide. And the disparities committee, again, at going with what Erin said, they did recognize the need to address disparities at every level of the system. But the committee did recognize, of course, that many of these drivers are outside the direct control of the healthcare system. But, there is definitely still a role for healthcare to play.

Next slide. Effective policy interventions include increasing access to prenatal care and WIC and implementing policies that increase the transfer rates for women with high risk pregnancies to ensure that they are delivering in facilities that can handle their delivery and their possible high risk newborns.

Next slide. Community interventions include focusing on infant safety issues and then ensuring that public health programs are culturally appropriate and culturally competent. Effective types of interventions include home visits, group and one to one education and media campaigns addressing various safety issues.

Next slide. Healthcare provider interventions include – sorry, we've got – next slide. It's a healthcare provider intervention slide. That looks at expanded case management for high risk women, training for healthcare providers and public health initiatives.

We also found effective intervention for healthcare providers include screening for risk factors substance use, intimate partner violence, mental health issues and then ensuring that women are able to use preventive measure such as folic acid supplementation and of course increasing access to contraceptives and education.

So, before I turn it back over to Erin to talk about what the actual discussion questions are that we have for today I wanted to speak briefly about the portfolio of measures that we have endorsed at NQF in this topic area. You

will recognize all these measures since we just endorsed them last year but we thought a reminder would be helpful and I did also send along a list of these measures as well as the identified measure gaps in the e-mail I sent earlier this week. So, you have that, as well, attached to the invite.

So, next slide. The reproductive health portfolio – I think we're still behind a couple of slides. We should be on the portfolio slide. There we go. Great.

So, include some contraceptive care measures and then we've got – next slide. We've got several measures for labor and delivery for both normal risk and high risk pregnancies. Breast feeding measure.

Next slide. We do have some measures for newborns primarily focused on premature and low birth weight babies, although, we also have the unexpected complication and term newborns and the (Hep B) vaccination. And you'll probably recall that set of competing measures on infection prevention at length last year.

So those are the measures that are currently endorsed in this topic area. And then next slide just summarizes the measures that are included in the Medicaid Adult and Child Core set that focus on reproductive health and Perinatal health. Again not a huge number of measures, but there is some important topics in there.

And then final slide, next slide please, just looks at some other measures that MAP recommended be included in the core set but were not actually included.

And with that, I will turn it back over to Erin to discuss exactly what the Disparities Committee is asking the Perinatal Committee for, Erin

Erin O'Rourke: Thank you so much, Suzanne, next slide. So really the committee outlined a two-step approach to use a measurement for reducing disparities, the first is to use relevant structure, process and outcome measures to identify disparities. And the second is to use measures that assess the use of effective interventions to reduce disparities.

We know that few measures currently exist in this space. The committee's tasked with identifying areas for future measurement development as well. So really what we would like guidance from on the Perinatal Committee is where we can focus measurement efforts in infant mortality and low birth weight.

Next slide. So specifically we're looking for guidance in three areas, what process and outcome measures could be the most useful for identifying disparities. What interventions might be the most useful to reduce those disparities. How can appropriate perinatal care for a woman at social risk be measured?

This is a recurring theme in the literature and I know Suzanne mentioned that the committee began discussing this at your last meeting, but I need to move beyond past just counting the sheer number of visits, but actually coming up with some measures that could help assess the quality of what's happening at those appointments.

And then finally, does the committee have any ideas on policy recommendations that could help incentivize a reduction in disparities and infant mortality and low birth weight?

So we did put together a few questions to start conversation, so I think with that I can turn it to Kim and Carol to help moderate conversation.

Kimberly Gregory: Hi, this is Kim Gregory and welcome everyone, Carol and I had an opportunity to speak with the NQF members earlier this week and we thought we would think about it two ways – well we would address the two focus areas separately and the first was the low birth weight and infant mortality measure, which we'll talk about first. And I will moderate that portion and then talk about perinatal care and Carol will moderate that portion and then we'll conclude with their third topic question which is addressing incentivizes for the reduction of disparity.

So just to get us started, I want to share those questions again and then open it for discussion but 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 these be measured? And then what data might be needed to support measurement in this area? So let's start by thinking about the outcomes and processes. Does anything come to mind immediately?

Cyndy Pellegrini: Oh, Kim, this is Cyndy Pellegrini with March of Dimes, I'll jump in. One of the things that comes to mind is improving the way that we collect certain types of data and particularly making some of the data more granular for racial and ethnic groups. So right now, we've recently commented in a couple of other contexts to the HHS about the fact, for example the Asian Pacific Island or category is not particularly useful because there may be enormous disparities between people of different kinds of API descent.

The same goes for Native Americans and Alaska natives that you simply can't combine Alaska natives you know with Navaho in North – in New Mexico rather and expect that to be meaningful.

Kimberly Gregory: Yes to that same point, I think that adding the multi race variable was helpful for people personally, but from a data perspective, we're losing Asian Pacific Islanders and African-Americans because they're identifying as multi-ethnic and so we're not able to capture whether they're having adverse outcomes or not.

Sheila Owens-Collins: This is Sheila Owens-Collins and we're looking at – in Maryland, I'm in the state of Maryland, we're looking at our second preterm delivery and how we can – and how we can lower that risk. And we're looking specifically at 17P and is this giving – given appropriately. So as a process measure, I would recommend that we could look 17P administration to eligible women and the key outcome would be the second preterm delivery rate.

Kimberly Gregory: That's great because that's very specific.

Tracy Flanagan: This is Tracy Flanagan from Kaiser Permanente California. For a very long time, we've hardwired actually having in office substance counseling and really published several papers on outcome on (save) NICU days et cetera and so I think demonstrated intervention of first of all screening to substance use, but secondly having at least an assessment done could be quite useful.

And along the same lines in the psycho-social realm, perinatal depression screening and possibly some sort of demonstrated intervention, but at least screening at least once during pregnancy or the post-partum period could be another area to look at.

Juliet Nevins: This is Juliet Nevins, oh.

Kimberly Gregory: No, go ahead, go ahead.

Juliet Nevins: All right, it's Juliet Nevins with Aetna. And I'm with Aetna but I'm also – work at a city hospital on a labor floor, and one of the things that I'm thinking of is trying to measure the extent of the (attendants') obesity and hypertension that this population tends to sort of be burdened with in terms of percentage.

And then sort of similar to what someone else has mention, sort of measure the extent and the availability of real nutrition counseling. Not just you know the one sentence that you eat more fruits and vegetables and then you click the box stating that you've done your nutrition counseling.

So really sort of getting at the heart of the comorbidities have been led – lead to the kinds of iatrogenic preterm delivery, C-sections, all of that with poor outcomes by sort of really counting and assessing the disease burden and the interventions that is sort of support to target them.

So I would focus on diabetes and hypertension or excuse me, obesity because I would start there and then sort of the (attendants') services available to really address it, specifically nutrition counseling in the pre-conception and ante partum period.

Sheila Owens-Collins: OK. This is Sheila Owens-Collins again, and I would like to agree with that recommendation. Again, we were – in Maryland, we're looking at the second preterm and there is a measure, I'm looking desperately for it and hopefully I'll find it before we get to the end of this call.

But there is a HRQ measure for preterm birth prevention and a lot of that measure is looking at comorbid conditions and referring as prior speakers

said, referring those women to the appropriate agency, whether it's a diabetes counseling center or substance abuse or wherever, but it's something that is real that we can track, there's a claim for and we can say that it happened.

The other part is management of their comorbid conditions and so I think that's a piece that sort of falls by the wayside especially in the postpartum period. Women with hypertension or gestational diabetes are frequently lost to follow up.

So I think any measure – I mean an outcome – a process measure would be referral for management or co-management conditions as well as referrals for whatever the substance abuse or weight counseling or nutrition. And the outcome would be how well they're comorbid condition is controlled or, in the case of gestational diabetes, whether they (relate) to Type 2 diabetes or not.

Nancy Lowe: Hi, this is – hello?

Sheila Owens-Collins: Yes, hopefully, I'll find that measure before the end of the call.

Kimberly Gregory: Thank you.

Nancy Lowe: Hi, this is Nancy Lowe talking. And when I think about this issue, one of the things that I continue to be impressed with and hit over the head with is the issue of lack of access, particularly in rural and frontier America. And also – which covers a number of groups that are – have higher risk for preterm birth and so forth.

But also the issue – the continuing issue that we have is access to timely prenatal care. And I wish we could somehow measure from women themselves the issue of access. For example; when they give birth, if we could somehow ask them, "How able were you to get prenatal care with you sought it? And how long did you have to wait?" And I know systems have to provide that data, but I think the perception of the woman is a very important part of this whole picture that we often ignore.

So I struggle with is, but I think that we're – we tend to approach this as though all women have – are in places where they can get access to the specialist, they can get access to the diabetes educator, they can get access to a clinic that manages hypertension in pregnancy. And for many women that is simply not true.

Kimberly Gregory: I agree. Even the progesterone measure, you have access but by the time you get the authorization, you may not necessarily have initiated it in the proper therapeutic window.

Nancy Lowe: Correct, absolutely. And I think …

(Crosstalk)

Nancy Lowe: … that's ….

(Crosstalk)

Nancy Lowe: … the hardest …

(Crosstalk)

Sheila Owens-Collins: Go ahead.

Nancy Lowe: The access issue is not just geographic, it's also about money. Because you have these same problems in New York City; a highly populated and, in terms of money that's being put into the healthcare system, generous compared to other states. So in terms of …

Sheila Owens-Collins: Yes, toward the end of the prior auth requirements for 17P, we're looking at – on a state wide basis all of the (AMCOs) are considering doing away with the prior auth. Because it does delay time and people – women get lost and they lose that window of time when it's effective.

Kimberly Gregory: So that would be a policy …

(Crosstalk)

Sheila Owens-Collins: Right, that would be a policy. Yes. And other states have done it and it's worked really well.

Kimberly Gregory: So to that point …

(Crosstalk)

Kimberly Gregory: … I was at a meeting just recently where they went and make the argument that we call a 20 week loss a birth, but at 19 week loss a miscarriage. And so basically between 16 and maybe even 15 – 15 and 20 weeks, while we don't want to call them births for obviously reasons, we do want to track them. Because those woman should probably also be candidates for 17P. So there may need to be some reeducation at the medical system level to counsel pregnancies towards the preterm birth risk.

Gregory Goyert: This is Greg Goyert in Detroit and I would agree with Kim's point of more accurate identification for candidates for 17P. But I just wanted to interject one slightly different thought. I agree with the specificity of 17P and recurrent preterm birth as being a good example of a process and outcome. But I also wanted to emphasize more of a long game view.

And the committee mender that said this is all about money; of course this is all about money. This is all about poverty. And so from soup to nuts and in an era of Trump, Ryan and our current secretary of HHS, and looking down the barrel of an almost $9 billion cut in Medicaid over the next years potentially; the issue – I mean I'm not certain that we're not just rearranging the decks on the – rearranging the chairs on the Titanic.

But I think we need to have some sort of – at least give some thought to a long game strategy because for many if not most of our patients with adverse outcomes due to disparity, the die is cast by the time the rabbit dies, right? And we need to address – like obesity, like hypertension, long before they get pregnant. And I'm not sure how we as a committee approach that issue.

Female: I really …

Sheila Owens-Collins: OK, one thing – just for the before the pregnancy thing. One measure that I think we should think about at some point in time, maybe not now, is the unintended pregnancy rate. I mean, that's something that could be easily gotten. But in the general population, it's 50 percent …

Male: Guys.

Sheila Owens-Collins: … and women with substance abuse, it's 90 percent. And so that would be really important. To try to get women …

(Crosstalk)

Kimberly Gregory: … that goes back to the social determinant, but – I mean, it really goes back to education. That we …

Sheila Owens-Collins: Exactly, yes.

Kimberly Gregory: The studies are real clear, finishing high school matters and what they learn in school is important. And I think that addressing – we talk about the community education for safety, but really some of these things we need to be addressing at the community level too. Like 39 weeks, when we rolled that out, we went out to the community there were advertisements on TV about let your baby come to term.

So we need to put it on TV – if you've had a prior preterm birth or prior preterm delivery of whatever weeks we want to call it, you should see your practitioner earlier. And there's medicine that you might need to be on. I'm not convinced always that African American women want to take 17P, vaginal or (IN).

Sheila Owens-Collins: Yes, that's an education cultural issue.

Naomi Schapiro: This is Naomi Schapiro, I have another question just related to the nutrition and the food and poverty issues. Which is – and it's maybe a question also for the disparities committee. I think beyond counseling women about nutrition is the issue about access (to) fruits and vegetables and access to healthy food.

And we know there's a lot of disparities around food access, food deserts and stuff.

And I think a lot of hospitals and health centers are starting to actually try to measure food insecurity. They're asking people, "Do you have enough food to go through the month," and things like that. And I'm wondering if there are any measures that the disparities committee has looked at that are actually worth while on a bigger scale to measure food insecurity and how that contributes.

Erin O'Rourke: Sure, so this is …

(Crosstalk)

Sheila Owens-Collins: I would like to add housing insecurity to that also – to the food insecurity, housing insecurity.

Naomi Schapiro: Yes, absolutely. Because if you can't prepare it, you can't eat it.

Sheila Owens-Collins: Right. And then the third thing is Medicaid coverage – or insurance coverage or lack there of. There's a hot off the press article about Medicaid churn in the pregnant women population and …

Naomi Schapiro: Yes.

Sheila Owens-Collins: … how that impacts birth outcomes.

Naomi Schapiro: Yes.

Cyndy Pellegrini: This is Cyndy with March of …

Erin O'Rourke: This is Erin, we weren't able to find any existing measures, but you're tracking really with what we've heard from the disparities committee about needing to get measures assessing things like housing insecurity; food insecurity; access to insurance, particularly through Medicaid.

And what the system can do to perhaps help people make those connections. As well as, as we start to think more about the shift to population based

payment, what's the role of the community and what can the healthcare system do to promote access to things like food and stable housing?

Kimberly Gregory: So …

Karen Shea: Hi, this is Karen Shea. I'd like to add another concept to the list. And that is the affect of stress on pregnancy and our ability to measure the stress that a pregnant woman, or even a woman prior to pregnancy, has been exposed to; what she's bringing into that experience. I know we do have some measures for child exposure to violence. But I do believe this is an important concept that does affect the preterm birth rate. And if we have an ability to measure it, I think it would be really helpful in describing disparities.

Kimberly Gregory: We might be able to learn some of that from what the disability committee has put together on mental health, right, because there should be some overlap?

Erin O'Rourke: Good concern, absolutely. I think that's one of the key things we're learning that there's overlap between a lot of these conditions and the challenges of finding ways to address the root causes more upstream and target some of those rather than waiting until someone presents with a full fledged problem, if you will.

Kimberly Gregory: Because actually to – I believe it was Dr. Goyert's point about the big picture with pre-term birth, diabetes and hypertension. All of those women are now being – determined to be at increased risk of cardiovascular disease. You want to …

(Crosstalk)

Kimberly Gregory: … if you want to impact cardiovascular disease in the long term, look after these women post-partum for the duration to prevent them from developing cardiac disease. I mean, you've got a great screening test right there.

Sheila Owens-Collins: Yes, that's correct and they die early. And so, yes, so that points to the need for robust post-partum measure. We're also interested in in Maryland because the current ones that NCQA proposed. As you know, it wasn't

endorsed by NQF and so there's a void there. But, management and referral for women with this comorbid conditions should be an important part of that.

Kimberly Gregory: And there's something we haven't touched on, is the congenital anomaly issue. I thought that it was kind of interesting that the difference in both the rates of occurrence and then the case fatality rates. I'm not familiar with whether or not that's an access issue.

Like how many of those severe anomalies leading to death are potentially diagnosed late, where there could have been an opportunity to avoid them; and/or learning more about the patient centered perspective of maybe – how do I say this? Maybe they're actually born and just have palliative care; that that's actually appropriate and not necessarily a measure of poor outcome.

Sheila Owens-Collins: OK, yes, I'm a neonatologist and I see that a lot, and I've thought about it a lot. I think that it's a function of several things. Number one, the prenatal diagnosis, and that would be an access to care because women that have adequate prenatal diagnosis – I mean prenatal care, if they have their ultrasounds that they should have, these conditions could be picked up earlier and the family could be made aware of their options …

(Crosstalk)

Kimberly Gregory: I guess that my question is do we know that, or is that something we need to …

(Crosstalk)

Sheila Owens-Collins: I think that's something that we need to collect data on because we don't know that. And it would be good because it would point to access issue and subspecialty report.

The other thing is exactly what you said, the access and education on palliative and (comfort) care. I think that in the newborn world, that is not utilized as much as it should. And so, there …

Kimberly Gregory: So then, the disparity might be that some people are counseled with palliative care and some people are counseled towards heroics.

Sheila Owens-Collins: Right, exactly. That's exactly right. And that would be – that would start with the counseling physicians and their personal views as well as their – as well as their biases. It's a very complicated issue, but I think it's very important.

Kimberly Gregory: I'm going to stop for a minute on a process issue for the meeting. I think we've thrown out a lot of ideas. Some are process and outcome measures, some are interventions. We haven't really dealt with the data needed to support the measurements in these areas.

I'm wondering if we want to maybe just keep track of what we've proposed and then maybe do a virtual e-mail follow up later to talk about what the numerators and denominators might be for those measures and what the data sources would be.

Sheila Owen-Collins: Right.

Kimberly Gregory: In order to move the agenda, or do you want us to deal with the data sources now?

Suzanne Theberge: This is Suzanne, I think if you could just maybe talk briefly about the data sources now that would be great. We are taking detailed notes and we'll be sending out a summary after this call, which will include all of these topics that you've mentioned. But if you just wanted to spend a few minutes now talking about data sources that would be helpful for us.

John Keats: Yes, this is John Keats. Can I throw out one more process suggestion before we close that part out?

Kimberly Gregory: Oh, please.

John Keats: Yes, which is the (centering) pregnancy folks have some pretty good data that group OB visits have potential effect on low birth weight and premature delivery statistics. And it might be worth looking at the impact of group OB

visits on these disparities. But the data's mostly in a low resource setting of Medicaid populations and I think it would be good to include that as well.

Cynthia Pellegrini: Thank you for raising that, John. This is Cynthia at March of Dimes. I was trying to get a word in edgewise to say the exact same thing. I was surprised to see that missing from the list of interventions in the report there because it is one of the few that has actually demonstrated outcomes. I strongly echo your comment.

Sheila Owens-Collins: As well as care support. In some states, I think Mississippi, they show where women that have peer mentors did better in addition to the – or support from the group interventions. Does anybody recall that?

John Keats: I'm not familiar with that per se. Are you saying that would be instead of the group visits or …

(Crosstalk)

Sheila Owens-Collins: In addition to.

Kimberly Gregory: I'm familiar with that in the Latina population. The (primadora).

Sheila Owens-Collins: Right.

Naomi Schapiro: Yes, and this is Naomi. In terms of other kinds of shared medical appointments, there's definitely – people have shown that part of the impact of shared medical appointments is the peer support that happens in those appointments. And it seems to have some impact on control.

And that's not particularly around prenatal care, I know it more around diabetes or obesity care. But, I imagine that's also true for prenatal care. But, I'm not sure if it's being measured in terms of (centering) pregnancies.

I just have one more thing to say just in terms of what we're sorting of looking at in terms of process. And it was kind of a tag onto what was raised around educational level really impacting – economic level impacting preterm birth, which is to think about tracking access to contraception for teenagers,

especially as access may be changing in the coming years and seeing how that effects unintended pregnancy rates.

I mean, we certainly have a lot of good data around it, like from state to state, depending on access. But I think it's an important thing to keep tracking.

Ashley Hirai: This is Ashley Hirai. I just wanted to add on to that. (I recently approved) contraceptive quality measures but that's a really sensitive process measure that leads to reducing unintended pregnancy. We know there are disparities in use of highly effective contraceptive methods.

And it really can be global, not just specific to teens, in reducing those pregnancies. And improving, increasing planned and intended pregnancies is really a fundamental strategy to promote healthy pregnancies prior to conception. Also, any indicators about preconception care, that's also a strategy. Preventing those chronic conditions and managing them prior to pregnancy and anything involving care coordination and case management for those higher risk pregnancies and also medical home maybe. There's pregnancy medical home models, I know, in North Carolina.

Just some additional thoughts there. And also – so those are strategies to prevent prematurity, and then when caring and optimizing outcomes for those that are premature really – you take about progesterone, that's a huge measurement gap, also, the antenatal corticosteroids and the quality of risk appropriate care.

We're not sure – I think that report – the disparity report mentions some literature I think by Elizabeth Howell from New York City, where you can see that the outcome mortality is higher for those preterm infants in hospitals that predominantly serve minority populations. And that's for both black and white infants. It's kind of suggesting that there may be some quality disparities there.

(Crosstalk)

Sheila Owens-Collins: As well as looking at hospital that are failing to transfer the mothers or transferring, late, the babies that aren't equipped to handle those deliveries.

Kimberly Gregory: I think sometimes they need to understand what the resource limitations are in these hospitals and they may actually be doing a lot with less and that's part of where the disparity is, so maybe not just disparity at the patient level but at the facility.

Sheila Owens-Collins: Yes, I agree. As well as the policy – and policies regarding regionalization of care.

(Crosstalk)

Kimberly Gregory: So what data I mean for the – for the measures that you propose, could everyone take a moment and volunteer one by one what data source you would need for the measure you propose?

Sheila Owens-Collins: OK, so data source is different from data – data itself. So are you looking for data sources?

Kimberly Gregory: I guess I'm asking how you would get the measure? What would it take to get the measure?

Sheila Owens-Collins: OK. First would be claim, speaking from a Medicare point of view. Claims data …

(Off-Mic)

Kimberly Gregory: And this is for Progesterone?

Sheila Owens-Collins: Well for a lot of our – a lot of the measures.

Karen Shea: Well for particularly for the Progesterone measures, I understand it was, "let's look at women who are having their second pregnancy and make sure they were appropriately diagnosed and prescribed 17P". Getting the data from a claim that identifies the woman as having a second pregnancy and a prior

pregnancy with a pre term birth, I have not been able to develop that measure. It's just not out there.

Male: Right

Sheila Owens-Collins: OK so …

Kimberly Gregory: It would have to be a combination of birth certificate data linked to the claims.

Sheila Owens-Collins: Right, now there is because we're looking at this – you know, everyday all day, we're sleeping and dreaming about it. There is a code, if not we'll utilize. You know we're going to start the education process. But there is a code that did in fact a woman as having a prior pre term birth, there's ICD-10 code.

Karen Shea: But how would you require providers use it? How would you know that they have not (inaudible) on the claim?

Sheila Owens-Collins: So you know we would – they would have to give the information. We could also from the prenatal risk assessment form. I mean that would be the easiest way but, getting them to put it on the claim is also really important, because that's how your going to strategize these pregnancies.

Kimberly Gregory: So then that would be maybe a possibility for infant advising, like come up with whatever code we feel, if they're present, they should be documented and that they …

(Crosstalk)

Sheila Owens-Collins: Right, right…

Kimberly Gregory: … we need to increase reimbursement because it's …

(Crosstalk)

Sheila Owens-Collins: Right, exactly. But the prenatal risk assessment form is another source of data.

Kimberly Gregory: All right. Are there measures that people want to discuss or share about how they want to get the data?

Tracy Flanagan: Yes …

Juliet Nevins: This is Juliet.

(Crosstalk)

Tracy Flanagan: This is Tracy Flanagan, I suggested peri-natal depression screening and also substance abuse assessment and screening and (Hep) sampling. For depression, you'd use the denominator of any women who is pregnant and you could use the time frame of from, you know, some amount of time and gestation all the way till eight weeks post partum and that's already collected to the existing HEDIS measures and then the denominator would be evidence of screening either from a (V Code) or from direct evidence in the – in an electronic record with a (PHT9) or some other standardized depression tool.

As far as substance use, almost exactly the same, if we believe that the substance abuse screening is most valuable I the first trimester or even in the first two trimesters or whatever we could decide that. I believe you would you would probably want to use the first trimester, you would use the same sort of coding that you would use for entering the prenatal care, which is a lot right now, a standard HEDIS measure and the denominator would be evidence of screening. Either with a (V Code) or with a evidence in their electronic medical record for substance use assessment. And if you wanted to go one step further beyond the screening, that there was counseling, you also could use claims data – evidence of a visit with a qualified counselor with the appropriate coding.

Kimberly Gregory: Perfect, thank you. Anyone else?

Juliet Nevins: This is Juliet. And I think – what I was going to say sort of similar along those same lines and that I suggested sort of measuring obesity, the starting BMI and measuring the quality of nutrition counseling. And by that I mean, not just checking off in the electronic medical records that the patient received

nutrition counseling but that the patient was seen by a nutrition counselor. And being seen by a nutrition counselor, the number of visits and then whether or not the patient was able to adhere to, let's say the ACOG guidelines with respect to the appropriate amount of weight gain in a pregnancy, in a single (term) pregnancy with a given starting BMI.

Sheila Owens-Collins: That's interesting.

Tracy Flanagan: I'd like to make a comment about that, this is Tracy Flanagan. While I think obesity and pregnancy is very important, and actually we are doing a fair amount in that area, I'm not sure it's relevant. And maybe I'm going to be controversial in saying this, to prevent a pre term birth and low birth weight. I just don't think the evidence is strong enough. I'm not disagreeing with the importance of this; I'm just disagreeing with the connection of what we're talking about.

(Crosstalk)

Juliet Nevins: Well the reason I brought that particular issue up is because it is associated with gestational hypertension disease and with gestational diabetes. And it leads to inductions of labor often at preterm gestational ages. It also leads to long induction of labor, which we are still doing two days. It also leads to failed inductions that lend itself to cesarean sections. So not necessarily the obesity itself but certainly it's impact on other core morbidities or what happens inter partum in terms of how the patient and when the patient delivered.

Tracy Flanagan: I recognize what you say and I will tell you that having scanned the literature, there's almost no intervention that show a difference, because we're working really hard on this right now. And believe me I am in sync with you from being a doctor, but I'm just struggling with it for this particular area. Anyway, we don't have to belabor it; other people may have different opinions.

Sheila Owens-Collins: I'm sorry, I was trying to understand what you were proposing in terms of an intervention or measure?

Kimberly Gregory: I don't know the name of the person who was talking about obesity, but do you want to respond to that?

Juliet Nevins: Oh this is Juliet Nevins. So, my – the measure would be very simple, whether or not the patient received any kind of visit from a nutritional counselor and whether or not the patient was able to stay within the guide lines put forth, we'll use ACOG guide lines with respect to the prudent amount of weight gain for a starting BMI.

Sheila Owens-Collins: OK and you could look at outcome again. These women are having a C-section and they're definitely at a higher risk for developing gestational diabetes and diabetes. So, you know I think there are some things that you can infer and we could look at some associations.

Jennifer Bailey: This is Jennifer Bailit.

Juliet Nevins: Right, so I was trying to keep it very simple. That is the sort of extrapolation that I was – that was what I was trying to intimate. You know I don't know how in depth or in granular we could be but I think this is at least a good place to start, and then we could have some starting place, some data with which we could start in terms of its impact on those three variables, gestational, hypertension, gestational diabetes and the mode of delivery.

Jennifer Bailit: This is Jennifer Bailit. I'm coming a little bit late, so I'm at a bit of a disadvantage but, I mean, there are multiple trials – I remember the last one presented Alison Cahill at (NSM) this year showing that these widespread interventions don't work.

So why would we think – I mean in other words, to have a quality measure, one of the underlying guidelines is we have to have an intervention that's known to work or something that we know is meaningful and it seems to me that this is somewhere between research and quality measurement.

Sheila Owens-Collins: So, yes, I'm just having a hard time with, interventions don't work. That's really broad. There is a specific that you're referring to?

Jennifer Bailit: There have been a couple and this is not my area so if somebody knows more about this please feel free to speak up but people have looked at inter-pregnancy weight loss, they've looked at dietary counseling, they've looked at exercise and FitBit kinds of programs, nothing has changed people's weight gain enough to change outcome – is my understanding.

That may be …

(Crosstalk)

Sheila Owens-Collins: OK so …

Jennifer Bailit: … an overgeneralization, so please if anybody more about these kinds of studies, do speak up.

Sheila Owens-Collins: OK, so now I'm understanding that you're limiting the scope to weight loss specifically.

Jennifer Bailit: No, not necessarily weight loss, but any sort of how do you prevent diabetes, how do you…

Sheila Owens-Collins: Got you.

Jennifer Bailit: … prevent weight gain, how do you prevent big babies – I mean all that sort of range of things that go along with weight gain, we have not been effective at preventing.

Sheila Owens-Collins: OK. But there are just a slew of studies that are ongoing right now looking at that again and looking at it in different ways, using technology – so I think – I think the jury is still out. I agree that up until now there hasn't been any consistent that says, this is it. But there's just so much going on right now and …

Jennifer Bailit: I don't disagree with and I think there are some really good studies that are underway now that I'm anxious to see the result for but I don't think they're ready for primetime quality measurement until we know that we have something there.

Kimberly Gregory: Is there anyone that we have not heard from or we have not addressed how they would address their measure that they've proposed?

John Keats: Well I don't know how you would report the (centering) pregnancy, I'm not familiar enough to know if there's an ICD-9 – excuse me ICD-10 code for group OB visits?

Karen Shea: Well there actually is, there is a CPT code for group prenatal care.

John Keats: Well there you go then that would be how you get the numerator.

(Mambarambath Jaleel): Hi, this is (Jaleel). I don't know if I have any measure to point out to but I think two areas to look at will be one, from the neonatal standpoint once the baby – we spend a lot of money taking care of these babies in the NICU and we send them home to a social environment which is not optimal and they come back with readmissions or with mortality.

So if there is any measure to look at one, what kind of – how are we transitioning these babies home. The second one was to look at readmission rates and there was a measure which was brought up last time for consideration but that was not very robust. So if there are other measures to look at readmission or other ways to look at readmission, that'll be helpful too.

Sheila Owens-Collins: I totally agree with that and – that was disappointing that the other measure, the newborn readmission rate wasn't passed but I understood why. But I think we should not depend on that and try to sure it up so it can be something that we can pass.

(Mambarambath Jaleel): Yes.

Sheila Owens-Collins: Because …

(Crosstalk)

Kimberly Gregory: Go ahead, I'm listening.

Sheila Owens-Collins: … well because looking at data those babies do come back to the hospital frequently, they come back to the ERs frequently and – you know I went to a cardiology conference and one of the study that was done in Canada at the readmission rate of newborns looked at the degree of maternal worry, that was their measure, in terms of how comfortable the mom was and how worried she was and how it – how predictive that was of her coming back to the ER.

So I do think that we need to look at that and …

(Crosstalk)

(Mambarambath Jaleel): I think the difficulty with the last measure was that babies who get discharged from one hospital don't necessarily come back to the same hospital. Sometimes it is out of state, out of the insurance company and stuff like that so it was difficult …

Sheila Owens-Collins: Right, yes.

(Mambarambath Jaleel): … but if there is any way to measure this that'll be helpful.

Sheila Owens-Collins: Yes. Right. This (started) more of a hospital level of care and discharge planning and not a system. So I think the (managed) organizations can definitely look at that as well as the state Medicaid – but the health systems for sure can have a better view.

(Mambarambath Jaleel): Yes. I was at a recent conference where they talked about – Bill Silverman where he's one of the fathers of neonatology – his quote saying that he took care of a – saved an 800 gram baby, took care of the baby, sent the baby home only to no later that he died because a rat chewed his nose.

Sheila Owens-Collins: Because what? A rat chewed his nose, what?

(Mambarambath Jaleel): There were rats in the house and they – it chewed the baby's nose and multiple other sites and …

(Crosstalk)

Sheila Owens-Collins: Wow, who said that?

(Mambarambath Jaleel): … so we don't know what situation – social situation which we are sending these babies into …

Sheila Owens-Collins: Right.

(Mambarambath Jaleel): … and so if there is a measure where we can look at those kinds of things that will be helpful too.

Sheila Owens-Collins: As well as literacy level of the parents.

(Mambarambath Jaleel): Right.

Sheila Owens-Collins: What's the neonatologist – I'm a neonatologist also, who said that?

(Mambarambath Jaleel): Bill Silverman, he's one of the fathers of neonatology.

Sheila Owens-Collins: Yes, I know him. Yes. Thank you.

(Crosstalk)

Rajan Wadhawan: This is Rajan Wadhawan from (Orlando). Just wanted to add that one of the things that could be measured in that regard is discharge readiness.

Sheila Owens-Collins: Right.

Rajan Wadhawan: More than anything else – that includes an assessment of the social environment and the family's ability to take of the kid at home.

Sheila Owens-Collins: Right. Agree.

Kimberly Gregory: Is there a standardized measure for that?

(Mambarambath Jaleel): No.

Rajan Wadhawan: No, not that I'm aware of.

(Mambarambath Jaleel): So if …

Sheila Owens-Collins: We need to develop one, yes.

(Mambarambath Jaleel): Yes, that's why I said, we don't have measures but I think these are important things to look into and if we can come up with some measures like those that will be helpful.

Kimberly Gregory: And then lastly we had talked about congenital anomalies, so I guess gestational aid at the time the anomaly was diagnosed and type of counseling at delivery once the anomaly is recognized. So that brings us pretty much to …

Sheila Owens-Collins: OK. I'm sorry – there were a couple other things we talked about. We talked about disparity in counseling and offering palliative care and (comfort) care …

Kimberly Gregory: Yes, that's what I'm talking about.

Sheila Owens-Collins: …disparity in that. As well as a cultural disparity.

Karen Shea: And this is Karen, I brought up the concept of stress during pregnancy and I think the follow up comment was that this is something we could borrow from the behavioral health team but I want to go one step further and say that the measure of stress needs to be specific to stress during pregnancy because it's found at that – you know that measure is more specific in determining outcome.

So, there's a number of studies out there that measure stress, a number of different independent tools but I think what we would be gearing our measure towards is specific to pregnancy.

(Mambarambath Jaleel): Erin and Carol, how do we want to move forward with this agenda? We're throwing out a lot of ideas over here but is there a list of measures that you want us to go through and see whether these are useful and measurable. How do you want to do this?

Erin O'Rourke: Sure, so this is Erin, I can jump in and then maybe Suzanne or Kim, if you have other ideas – actually what you've been coming up with so far is

extremely helpful. I think we realize a lot of these are measure gaps but just getting your input on what these interventions are is crucial for us to come up with where the – where we need to focus development.

For your – the second point that you brought up about measures to look at, are there any specific measures endorsed right now that you would recommend perhaps could be – ones that might be able to be immediately moved into things like public reporting or value based purchasing programs to start to at least incentivize some improvements here?

I think Suzanne had in the slides a current portfolio, are there any there that you think could be particularly important to stratify, to find disparities or to address interventions that could help reduce them?

Sheila Owens-Collins: Are you talking about the ones that are already published or the ones we've been talking about?

Erin O'Rourke: The ones that are already published and endorsed.

Kimberly Gregory: The one – the behavioral risk assessment goes with what Dr. Flanagan discussed.

(Mambarambath Jaleel): Use of (inaudible) steroids might be one. Which might be used for disparities, which is already a measure which we have endorsed.

Kimberly Gregory: And …

Sheila Owens-Collins: They could be resource disparity also. As well as a policy.

Kimberly Gregory: And one – now, I don't think we – but I think in the core adult set was something about postpartum.

Juliet Nevins: This is Dr. Nevins. I don't know if there's any sort of stratification with respect to the cesarean sections before 39 – elective cesarean sections before 39 weeks. But if I – I just wanted to take a few seconds just to circle back to the induction. Is there – I'm not aware if there's any sort of outcome data on that or data on that with respect to stratification by race and ethnicity. Is anyone aware?

Sheila Owens-Collins: For which one?

Juliet Nevins: For the inductions. The inductions for …

Sheila Owens-Collins: Oh, less than 39 weeks?

Jennifer Bailit: Yes, there's some data out there. And I'm trying to think if it's one of the papers I did or one of the ones I read. But the bottom line, the people who have the worst inductions less than 39 weeks are upper middle class white.

(Crosstalk)

Jennifer Bailit: But it's the wrong way around. And Kim, you've done some work on this with sections – section rates so I think is similar.

Kimberly Gregory: Actually for elective. But for – if you take all comers, it seems as though there's a pretty significant disparity with African Americans having higher C Section rates. But if you look if you at elective section rates …

Jennifer Bailit: Yes. Right, correct. Section rates are different than the elective (fees), yes.

Kimberly Gregory: Right. Right. So that takes us right up to the – our sort of time limit for this topic. I'm going to throw out an opportunity for anyone who has not yet spoken and should to speak up before I turn it over to Carol. All right. Carol?

Carol Sakala: Great. Thanks, Kim. And good afternoon everyone. Appreciate your time today and the great dialog thus far. We wanted to take this opportunity of convening this valuable experience and expertise to discuss a second and related topic during this call. If you likely recall in our work last year, two previously endorsed HEDIS measures did not receive continued endorsement – these are frequency of ongoing prenatal care, and prenatal and postpartum care.

This (extern) in the context of a steadily rising bar for what are often called measures that matter. And I won't go into the reasons why but that does leave us with a challenge that we have no current endorsed measures for prenatal care at all. And just one postpartum measure – postpartum contraception –

contraception. So we wanted to seek your input today on priority measure concepts for these phases of care.

And we're going to broaden it just a little bit to disparity sensitive measures with the potential to improve caring outcomes for vulnerable populations and ideally they will have a relationship to the key indicators of low birth weight at least for the pregnant – prenatal care phase. And also infant mortality that we've discussing.

So time is short and I'm just going to open it up please to any concepts that we haven't already discussed for these phases of care. And feel free as well to mention the relevance levels of care, such clinicians, clinician groups, health plans and state level populations.

Sheila Owens-Collins: So I had question. I think we've – we internally and with NQF had a discussion about the postpartum care and actually we wanted to develop a measure. Are you – are you speaking specifically about an outcome measure or a process measure or either?

(Crosstalk)

Carol Sakala: Well I feel that what we're looking for is the highest impact measure. And there's a wish to move towards things like outcome measures when we can get there. But process measures that really would be impactful I think would also be quite relevant and welcome.

Sheila Owens-Collins: OK.

Carol Sakala: And some of them is – might be paired kind of things as we've discussed previously. Like depression screening and referral to get something more substantial going.

Sheila Owens-Collins: OK. So I think (inaudible) family planning, it would be very important. Especially inner pregnancy intervals. And I think referral for chronic condition management would be extremely important. As well as referrals specifically for women with gestational diabetes to a PCP. So a lot of that referral would be referrals to PCP or subspecialist.

And the issues becomes – as I've talked to people about this is that many women do not go to any other provider but their OB and they consider their OB their PCP even when they're not pregnant. So I think that's sort of a complication cultural thing that we have to look at and see how we can work around. Because not all OBs would be comfortable treating pregnant women or women that are no longer pregnant for their preventive health and chronic disease management issues.

Carol Sakala: Great. Thank you.

Sheila Owens-Collins: Your welcome.

Carol Sakala: Other concepts for measure concepts for these phases of care that have not yet been discussed?

Sheila Owens-Collins: I think you should really give us some time to really think about that and come back to it also. Because that is really important.

Carol Sakala: So I don't know about the resources and the committee process but I agree that it would be great to be able to comment on a summary of this call and further refine it before our work is done with this topic.

Sheila Owens-Collins: Right.

Suzanne Theberge: This is Suzanne. Yes, we can definitely share a summary with you with some time for comments before we send it to the disparities committee. And we can write that up and get it out to you next week.

Kimberly Gregory: Carol, are you aware of any (wrong) doing anything in terms of focusing more on the content of prenatal care?

Carol Sakala: So I am not. And what was – what really struck me with our work last years is that we had a hiatus of four years between our consensus development process work. And after that time we received exactly one endorsable maternity care measure which was the postpartum contraception measure. And so that's a real concern to me and discussions with a lot of colleagues

have suggested that we have some real problems with resources that are allocated for measure development in this area.

And there is a bill that will probably be refilled in both chambers later this year on quality care for moms and babies that does have resources for identifying gaps and developing measures. But other than that, and then possibly whatever HHS might do as a follow up, I'm not aware of other resources that are specifically available for this purpose.

Female: I have question …

(Crosstalk)

Sheila Owens-Collins: … as well as the bill number and the senator or the representative that is sponsoring it.

Carol Sakala: Sure. So the leads in the house have been Mr. (Engle) and it was cosponsored – there's an initial cosponsor, Representative (Stagress) as well in the last session. And in the – in the House, it was Debbie Stabenow and Senator Grassley. So they're just – they've had a lot of other things going. And so they're just working out the whole process for refilling and seeing who's on board, et cetera. But both of those were – bills were identical and they were very carefully aligned with the adult and child measurement – measure core sets as well. And they also include provisions for Quality Collaborative and adaptation of CAHPS maternity surveys for this population because the generic surveys don't map very well to the population.

Sheila Owens-Collins: Do you have a number? A bill number – or how do you …

Carol Sakala: No, it hasn't been refilled yet. But most likely will again be called Quality Care for Moms and Babies.

Cynthia Pellegrini: This is Cindy with March Dimes. It's a great bill, it's a really good piece of legislation and we supported it strongly and did a ton of work last year to recruit co-sponsors. And we're hoping we'll be more successful this year but there's one Senator who put a hold on it who's been really intransigent, unfortunately.

Sheila Owens-Collins: OK, Quality of Care for – Quality of Care for Moms and Babies.

Carol Sakala: Quality Care, without the of.

Sheila Owens-Collins: OK, Quality Care for Moms and Babies.

Carol Sakala: Yes, I can send you Sheila the file from last year if you're interested.

Sheila Owens-Collins: I would really appreciate that.

(Crosstalk)

Carol Sakala: Great.

Sheila Owens-Collins: Because that – would look deeply into that. Thank you so much.

Carol Sakala: Great.

Sheila Owens-Collins: Who's speaking?

Carol Sakala: Are you asking me who I am?

Sheila Owens-Collins: Yes.

Carol Sakala: Carol Sakala from the National Partnership for Women & Families.

(Crosstalk)

Sheila Owens-Collins: OK.

Carol Sakala: Sorry, Kim passed it over to me but I didn't exactly introduce myself so.

Sheila Owens-Collins: Yes, OK. That's fine, thanks so much.

Carol Sakala: Great, well …

(Crosstalk)

(Mambarambath Jaleel): Hi, Carol.

Carol Sakala: Oh, OK.

(Mambarambath Jaleel): Carol, I'm still not sure about what the next steps are. We've had a good discussion over here and we're going to create a summary of what we talked about. But maybe I'm too – I'm pessimistic about it. But I'm not seeing what we're doing – going to do after the summary is created.

Erin O'Rourke: Sure. This Erin, I can jump in and Suzanne please if I miss anything. So what we're going to is take what this group has said back to the Disparities Committee. And use it in our final report that we're putting together.

To basically identify what current measures we have might be the highest impact that – the Disparities Committee with input from other committees, would like to see move forward into varies quality improvement programs. As well as provide input to HHS on where measure development should go. That's just what they're most interested in. What new measures could they fund and develop to address these disparities?

(Mambarambath Jaleel): OK.

Erin O'Rourke: So some concrete ideas like you've all been putting out there today on the measures we need and the data that could help us get those measures.

(Mambarambath Jaleel): OK.

Carol Sakala: And just to add I think this – a lot of this needs a lot of further research to address some of the thing we've been discussing about whether the concepts are for research per se or whether the evidence base is there to propose that a measure be developed.

So, that's a big body of work connected with sorting out all these ideas.

(Mambarambath Jaleel): OK, thank you. Thanks a lot, Carol and Erin.

Carol Sakala: Yes. So we do have a third topic and I'm thinking there's a third slide available, is that right? For the limited time remaining? I think – is there – for topic three? That is on the handout. Thank you.

So I'm going to move us along to this topic. And there are two major questions here. First is, policies associating with measurement like reporting, payments that could help incentivize the reduction of disparities.

And I'm going to open it up but I've been very restrained on this call, wanting to hear from others. But I just want to support what Ashley said about Maternity Care Home and also about the – to say that I think (episode attainment) offers an amazing array of opportunities because of the various incentives that are put together.

And the opportunity for everyone to work together toward shared aim with clear measures. And also to innovate a lot because you can do things that you can't do based on current coding systems or whatever.

And one of the most important things I believe that we don't have the ability to do with our compressed prenatal visits is to do the kind of care coordination, the community referrals, et cetera, that are individualized to what these women and families may need and what can make a big difference in their care.

So having said that, I would like to open this up for other ideas about policies, all the levers that we could use with these measures to drive the improvement that we need.

(Off-Mic)

Cynthia Pellegrini: So this Cindy with March of Dimes, can I start?

Carol Sakala: Please.

Cynthia Pellegrini: Sorry, just briefly. Absolutely payment is one of the biggest ones, right? Things that get paid for get done and one of the examples of an area where that's an issue is Group Prenatal Care. That in quite a number of states, that can't be billed for – can't be billed (before) in the way that it is delivered and we need to update those systems.

The other thing I would say is restricting some of these systems to serve the patient's needs and the way that the patient needs to access the care rather than around our systems. And there is great example in Puerto Rico of access to 17P, where they completely reimagined how they were delivering that.

And they have public health nurses who go to the women once a week to give them their injections, wherever they are. That could be at work, at home in a location – another location convenient to them. And their access and compliance rates for 17P are incredibly high in Puerto Rico, it's amazing.

Carol Sakala: OK, thanks, Cindy.

Sheila Owens-Collins: Is that published anywhere?

Carol Sakala: We'll try and find that out.

Cynthia Pellegrini: I've gotten in some conversations with the people there but I think it has and I will try and forward that.

Sheila Owens-Collins: OK, that would be great.

Kristi Nelson: So this is Kristi. I just want to make a comment about not dis-incentivizing the use of like Telehealth or reducing visits from 14 to 8. There are several apps and stuff that they can do that actually engage the patients.

So I'd just be careful about not including that as a – if you're going to go with a pay model for care, if that's included.

Carol Sakala: So Kristi, I think that's a reference to the proposals that have come out of the Stanford team lately. Is that right? To reduce the visits?

Kristi Nelson: Well, there was – there's actually ACOG has said that they – you don't necessarily need to see the women and test their urine, you can do a home blood pressure monitoring and history. And diagnose hypertension and stuff that way also.

Carol Sakala: OK, so Telehealth, thank you.

Kristi Nelson: It just improves their accessibility also. So a lot of these – you know people can't get to their appointments – that they don't have transportation or a way to get there that might ...

(Crosstalk)

Sheila Owens-Collins: Yes, there are a lot of (inaudible) for babies that are educational. They're helpful.

Carol Sakala: And that circles back to Nancy's comment about the terrible challenges with access to care in rural areas.

Sheila Owens-Collins: Right.

(Mambarambath Jaleel): Is there a new way to incentivize home visits?

(Crosstalk)

Sheila Owens-Collins: Sure.

Carol Sakala: I think we should put it on our wish list.

Kristi Nelson: Yes, that would be interesting too. Because the conference that I just – I just went to the World Health Conference – and you know there – there was comments that home health care you know is actually not making as much money as you know. The reimbursements and stuff is low. So you know that might be a great incentive.

Carol Sakala: (Inaudible) thoughts about policies and system level innovation?

Sheila Owens-Collins: I think when we see it written – the summary that may trigger some other thoughts. Right now, I'm struggling to try to remember what everybody said.

Carol Sakala: So I'll just chime in with one of my concerns. I sit on the Map Coordinating Committee which has a Medicare frame. And it's very frustrating to me that there are all of these federal programs that can improve care for people with Medicare coverage. In those – that demographic and those conditions and

what we have, which I think is very important, is the Medicaid core sets for children and adults.

On the other hand, that doesn't really percolate down very well to the level of practice, it's state level, rolled up to the state level. And it's voluntary, so I feel that we have need for some kind of programs that impact Medicaid population conditions. And specifically the ones we're discussing today. For measurement, payment, reporting programs.

Naomi Schapiro: This is Naomi Schapiro. I agree and I just have to stop when we're talking about home visiting and there's a lot of data about home visiting programs for parents – new parents who are considered at risk to maybe either neglect or maltreat their kids based on their own history and/or otherwise high risk.

And I don't know if – and they're very robust programs in a few states but also many parts of the world and I'm wondering if any of them also track any pregnancy or kind of postpartum care issues?

And the moms who are being visited – I kind of, because I'm theatric, I'm much more familiar about what's some of the outcomes are about maltreatment or about, you know, care of kids or parenting issues and not so much about the mom that has individual healthcare and their subsequent pregnancies but I have a feeling it might be tracked elsewhere in the world.

It might be interesting to kind of look and see if we're looking at home visiting if that extends in the postpartum period for moms and not just for the baby care.

(Mambarambath Jaleel): I don't know about tracking but I used to live in England where most of the prenatal care was done by home visit. The nurse would visit home, do the blood test and all the other things. The only thing that they had to go to the hospital was when they had to do the prenatal ultrasound.

Female: Australia has a robust postpartum visit set up as well. So, that might be a good place to look.

Carol Sakala: Right. So we have just a few more minutes and there's one final question here which is how can we encourage increased measure development. We've already touched on some of the challenges but I'm hoping people have some ideas for new opportunities there and also just use of quality measures perinatal care in general.

Sheila Owens-Collins: So, I don't if this was said but we talked in another conversation about the time that it takes from measure concept to measure implantation or endorsements. And so, I don't know if that would be an area to look at. The time that it takes and the resources it takes for a measure to be – to go to a full cycle.

Carol Sakala: So, it sounds like you're – the recommendation is can that be foreshortened?

Sheila Owens-Collins: Yes.

Kimberly Gregory: This is Kim Gregory. We need money. I mean, it's just the amount of FTE it takes to collect the data, do the analysis, write the report, share it is – it just can't be done for free.

Sheila Owens-Collins: Also, if there was some sort of networking or resource guide that we could readily know who else is interested in a certain measure. And so, collaboration could be encouraged.

Carol Sakala: Maybe our NQF colleagues could talk about the incubator and any other efforts.

Sheila Owens-Collins: Right. Yes.

Suzanne Theberge: This is Suzanne. I can't speak too much on the details of the measure incubator but we do have a project at NQF that is helping folks develop measures and helping them work through that process and if people are interested in forum measure, definitely let us know and I can put you in touch with the team working on that.

And I'll also just mention quickly that we are doing a Kaizen next week in hopes of shortening our endorsement process. So, I know that the

endorsement process is not necessarily the longest and most burdensome part of getting a measure out there in the world but we are hoping to make that shorter and more agile and we'll be working on that next week.

Elisa Munthali: Hi, Suzanne. This is Elisa. I can help a little bit with the measure incubator. And for everyone on the call I'm Elisa Munthali, Vice President for Quality Measurement at NQF. And Suzanne is right we do our quality initiative department at NQF. We launched a measure incubator which we're bringing together the folks that are interested in developing innovative measures in which we have critical care gaps. Those include the folks that have the resources to do it, the ideas, the skill set to do it and we're not developing measures at NQF but we are making sure that there is an opportunity and a space for all of these folks that are interested in advancing performance measurement around quality, particularly around patient reported outcomes and a lot of the issues that you've talked about today.

And just to add on to the last comment Suzanne made about our Kaizen next week. We're very excited, we have heard over the years the criticism that was mentioned earlier about the time of measure development from concept to endorsement and how long it takes and the lack of opportunities to submit to NQF.

As Carol mentioned before, there was a lot of frustration, you waited for four years to review measures only to have one measure go through the process. And so what we're hoping through this Kaizen Lean Improvement Event is that we will offer more opportunities in a calendar year for measure developers to submit.

We don't know what that would like but definitely more than the three years that we're offering right now. And so what we will likely do is follow up with you via e-mail and probably a webinar to talk through some of those changes.

Female: Thank you, Elisa. We've come to the end of our time, I want to thank everyone for this whirlwind of a discussion and we look forward to seeing the challenge of writing this up and moving all these great ideas forward and I'm going to turn it back over to NQF staff now, thank you.

Suzanne Theberge: Great, yes, thank you so much everyone this has really been a great discussion. I'd like to open the lines now for public comment before we just close out with the next steps. Operator, can you open the lines please?

Operator: Yes, ma'am. At this time if you would like to make a comment, please press star then the number one.

There are no public comments at this time.

Suzanne Theberge: OK, thank you. Well again thank you so much for your time today. What we're going to be doing is writing up a summary of the call and I will share that with you next week, I'm going to – we took extensive notes and we also will have a transcript so we should be able to get everything in here.

But we'll hope to get some more input from you before we share this report with the Disparities Committee. The Disparities Committee's going to be meeting just about a month from now on June 14th and 15th and so we'll want to have this report to them before then.

And then we'll be including this input into their reports that are forthcoming and we'll be having a public comment period on the next report in July and I will keep you posted on that and on the other events and then as Erin mentioned the final report wrapping all of this up will be posted in September.

So I will keep you posted on how things are going and we'll share a draft next week and we'll welcome your comments before we provide the input onto the Disparities Committee. So, Erin, did you have anything else to add?

Erin O'Rourke: No, I think that covers it, but thank you so much to everyone for your time today and all of this fantastic input, we really appreciate it.

Suzanne Theberge: All right. Well with that, I will be in touch with you next week with a draft and we'll look forward to your comments and refinements and additional suggestions. I'm sure folks will think of things over the next week or two and we would welcome additional suggestions for measures and other areas to improve. So again, thank you so much and we'll be in touch. Have a great afternoon.

Sheila Owens-Collins: Can I ask just one quick question?

Suzanne Theberge: Sure.

Sheila Owens-Collins: Yes, so will there be an opportunity to have any overlap of the measures in the disparity domain with the perinatal health? The low birth weight and a lot of the measures that we're looking at are applicable to perinatal health.

Suzanne Theberge: Do you mean will they come to the perinatal health committee for review?

Sheila Owens-Collins: Yes, right, yes, right or I mean is there ever a case that you share measures?

Suzanne Theberge: Well I mean the Disparities Committee will have the information on the measures that you all endorsed last year and then of course if new measures came out of this discussion or out of this topic area, then of course they would come to this committee for endorsement. So I think …

Sheila Owens-Collins: OK, all right, that answers my question. OK, all right, thanks a lot.

Suzanne Theberge: All right. Are there any other questions before we wrap up? OK, well hearing none, again thanks so much for your time today and we will be in touch next week.

END