NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Maternal Morbidity and Mortality Committee Web Meeting #7

The National Quality Forum (NQF) convened a public web meeting for the Maternal Morbidity and Mortality Committee on January 26, 2021.

Welcome, Introductions, and Review of Web Meeting Objectives

Nicole Williams, NQF Director, welcomed participants to the web meeting, thanked them for joining in the work, and provided the Committee with an overview of the call agenda and meeting objectives. Meeting objectives were to come to consensus on prioritization of measurement topics for each framework, come to agreement on the final recommendations for maternal morbidity and mortality measurement approaches and to review the final visuals of the maternal morbidity and mortality measurement frameworks. NQF intended to also review maternal mortality measurement concepts with the Committee but there was insufficient time. Roll was taken for Committee members.

Maternal Morbidity and Mortality Workgroup Prioritization and Recommendations Results

Ms. Williams began by reviewing the elements NQF is required to include in a recommendations report. The report will reference the previously completed Environmental Scan, will contain independent frameworks for maternal morbidity and maternal mortality measurement, will contain recommendations for actionable short- and long-term approaches to improve this measurement, and will recommend an actionable measurement concept for maternal mortality.

Ms. Williams next introduced the first discussion topic: a review of the Committee workgroup conversations that were held in December 2020 to discuss measurement topics and approaches in detail for all sub-domains. A prioritization of measurement topics to present to the Committee was determined based on what was discussed more frequently across groups and NQF made an effort to not lose specific elements that groups initially deemed as important, but may have run out of time to discuss, or unintentionally neglected. One example is pain management, which was only discussed in one workgroup, but has important implications across many sub-domains. Ms. Williams also showed the Committee a few areas where measurement topics were combined based on workgroup discussion and perceived measurement similarity and asked for feedback. The Committee was not in favor of combining risk appropriate care with coordination of care, stating that risk appropriate care refers to systems and hospital-level care, while coordination of care should be measured at the patient and provider level. Other combined measurement topics were accepted by the Committee with minimal comments (e.g., timeliness to treatment and receipt of services).

Co-chair Dr. Elizabeth Howell led the discussion of measurement approaches for maternal morbidity. Pain management was discussed along with timely access to treatment and receipt of services, as members noted that adequate pain management is easily derailed by a lack of access to anesthesiologists, or by their limited availability within a hospital. The Committee also mentioned a geographic component to access – how far must people travel for care, and how much transportation is a barrier to timely access – as well as a financial component. Financial access barriers do not currently

appear within these measurement discussions but should be addressed. Financial access barriers can refer to more than just patients, as rural hospitals might lack the resources to provide timely access to anesthesiologists.

In response to the point on overuse of care during the perinatal period, the Committee felt there was a need to acknowledge the role that underuse plays as well, particularly with regards to disparities. It was suggested that the point be changed to reflect overuse, underuse, and misuse of care.

The Committee likewise advocated that measurement of unequal treatment was critical and should not be combined with any other topics. Some language change was proposed, including replacing the word 'minorities' with 'historically marginalized populations,' and to update the wording for the rationale from identifying the underlying issue to actually addressing the issue. The health community knows that racism, marginalization, and bias are the problem, so the emphasis should be on what is being done to fix this. The Committee also noted that approaches should capture what happens between hospitals and facilities versus within hospital and facility differences. In addition, short-term goals should include hospitals, not only physicians. The Committee would like to determine the best practices to create equitable outcomes and eliminate the effects of racism. NQF and the Committee have had repeated conversations trying to appropriately frame and describe issues of racism and unequal treatment in maternal morbidity and mortality care and measurement. NQF indicated that staff will reach back out to interested Committee members for assistance with finalizing the language in the unequal treatment section.

The Committee discussed short- and long-term measurement approaches in the screening protocols and guidelines section. One short-term approach identified was the ability to identify preexisting conditions. One Committee member noted that The Joint Commission is currently working with Yale CORE and CMS on a measure of severe obstetric complications that includes identifying preexisting and co-morbid conditions present at admission. The Committee also stressed the need to make sure screenings are paired with interventions in order to actually change outcomes. Screening for depression and having access to therapy and trained professionals do not always align. This is where measurement is needed to reveal the extent of the disparities and to force change. Screening can drive access to interventions, and both must be measured. There is also an NCQA electronic measure that was just adopted by HEDIS that fits this category (and whose use could be promoted) that looks at depression screening and access to treatments.

Co-chair Timoria McQueen Saba led discussion of the measurement topics and approaches for maternal mortality. One question posed by the Committee was if hospitals are able to identify people who are at risk in real time and not just retrospective – can clinical risk be identified in a timely manner? Real-time tracking of women who identify at a higher risk status is critical, as is ensuring follow-up and linkage to clinical care after discharge since not all mortality occurs in a hospital setting. The Committee suggested adding short- and long-term approaches for measuring outside a hospital setting as well.

The Committee also discussed the role of State Perinatal Quality Collaboratives in helping hospitals with uptake of AIM bundles for those who are enrolled. The Committee felt that mortality prevention can have protocols and guidelines, but it needs to have resources and should make people accountable for the actual adherence to these protocols and guidelines and should educate providers on how to use them. The Joint Commission is a powerful force for encouraging uptake and will begin evaluating hospitals level of adoption starting this year. However, since not all hospitals are accredited by the Joint Commission, nor desire to be, NQF's role in measurement is vital since it engages payors, which is something all hospitals care about. The Committee pointed out that the Joint Commission's work is focused mainly in hospital settings, leaving a need for work in outpatient settings in all stages (domains)

of care – preconception/well-woman, prenatal, and postpartum. The Committee felt that state collaboratives should be included in addition to The Joint Commission.

The Committee also commented on a couple of provider-related issues, the first being implicit bias. In trying to prevent severe morbidity by looking for demographics with higher rates, providers often focus on obese black women and end up missing situations of morbidity that develop into mortality or near miss incidents among other at-risk demographics. The Committee discussed that patients who experience mortality are often those that first experience severe maternal morbidity. The focus therefore should be on identifying clinical risk in a timely manner, which would need real-time tracking of women who are identified as higher risk, rather than only being retrospective, as it currently is. A second issue raised was financial incentives for providers – namely that the payment structure doesn't match with solving many of these issues through provider actions. Globally, obstetricians are not rewarded financially for doing the right thing, and in many ways the system disincentivizes good care. The largest incentive is given for delivery, which is time-wise the smallest portion of maternal care. Prevention is not financially valued; rather, responding to unfortunate outcomes with expensive procedures brings the most fiscal reward.

The Committee noted that one consistent element across AIM bundles is a multi-disciplinary review team that looks at how care could have been improved in all cases. This Committee noted the challenge with this approach is that it works better in larger hospitals, and not smaller hospitals with only a couple of providers reviewing each other's care. A proposed solution to this is to have larger hospitals helping smaller hospitals with quality reviews. There was conversation that this could be incentivized through quality measurement by requiring a quality leader or obstetric safety nurse to be part of all maternal care teams.

Ms. Williams wrapped up the conversation by reminding the Committee of the remaining discussion items that were not addressed due to time restraints. The maternal mortality measure concept was first discussed at the November web meeting but has not been revisited since, therefore NQF will be requesting specific feedback from the Committee via email to make sure the recommendations report contains the right level of detail for these concepts.

Maternal Morbidity and Mortality Measurement Frameworks

NQF showed the Committee the revised framework graphics for maternal morbidity and maternal mortality. Ms. Williams briefly explained how they came to be in this current form. The Committee had no additional feedback on the framework graphics at this time.

Public Comment

Ms. Williams opened the web meeting to allow for public comment. There was one comment from a member of the public who worked for a medical device company.

The commenter stated that she has noticed that past quality measures in maternal morbidity and mortality seem to emphasize the negative side of reimbursement. What this project appears to be doing is working on maternal morbidity and mortality measurement to develop new language and a paradigm shift for how CMS and other payors look at these types of measures, and how reimbursement based on them will look. A level of education needs to occur on the reimbursement side for both CMS and for payors. As the manufacturers of a medical device for induction of labor, the commenter and her organization will be interested to see how CMS and payors respond to the measures that are ultimately developed from this project.

Next Steps

Ms. Williams summarized the next steps for the Committee. The first draft of the Recommendations Report will be due to CMS on February 18. The Committee should expect to hear from NQF staff shortly with some items to review in advance of this deadline. The second draft of this report will be due March 18 and will be followed shortly by a 30-day public comment period from April 6 to May 5. The last committee web meeting will take place on May 26, 2021, to discuss public comments received on the Recommendations Report.