NATIONAL QUALITY FORUM
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Meeting Summary

Maternal Morbidity and Mortality Committee Web Meeting #8

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

Welcome, Introductions, and Review of Web Meeting Objectives

Chuck Amos, NQF Director, began by welcoming participants to the web meeting. Mr. Amos provided opening remarks and reviewed the following meeting objectives: discuss and consider public comments received and come to Committee consensus on an actionable maternal mortality measure concept to recommend in the final report. Hannah Ingber, NQF Senior Analyst, conducted a roll call for Committee members and federal liaisons.

Review of Public Comments

Mr. Amos began by reviewing the public comments and NQF's proposed responses. A total of 19 individual comments were submitted by nine unique individuals/organizations. NQF staff themed the comments for Committee discussion. These themes include aligning financial incentives with clinician behaviors, monitoring for unintended consequences from measurement, incorporating patient/staff feedback in quality improvement and measurement, incorporating common complaints (e.g., hyperemesis) as potential contributors to medical comorbidity and/or psychosocial stressors, clarifying language (e.g., alphabetized lists, clear definitions) including risk adjustment for the measure concept(s), and widespread support and gratitude for the Committee's work.

Prior to the meeting, NQF staff proposed responses to each comment and shared these with the Committee and the public for review prior to the web meeting. Mr. Amos raised some specific comments for Committee discussion during the web meeting and Committee members offered a few changes:

- NQF will include more specific language in the report about the importance of staff feedback and the unintended consequences of financial incentives on clinical behavior (row 3). The Committee agreed that this comment also warrants edits to the report to acknowledge the impact of individual provider behaviors, financial accountability, professionalism, and potential bias.
- NQF sought to confirm a new definition of provider with the Committee (row 15). Previously in the report, providers were referred to but not strictly defined. The Committee agreed to move forward with a definition of provider as, "physicians including anesthesiologists, advance practice registered nurses such as nurse practitioners, certified registered nurse anesthetists and certified nurse midwives, doulas, certified midwives, social workers, and mental and behavioral health providers such as psychologists."
- Some comments generally request that additional evidence be presented to support the Committee's recommendations (rows 17, 18, 19, 21, and 22). The Committee agreed that in the coming weeks they will supply NQF staff with peer-reviewed literature or grey literature that supports the recommendations, including which recommendation it supports.

- These same comments (rows 17, 18, 19, 21, and 22) also generally raised questions about the alignment between this Committee's recommendations and other national guidance that is moving forward (mostly through the Alliance for Innovation on Maternal Health (AIM) bundles) and whether recommending adoption of existing guidelines is redundant. The Committee recommended against removing items in the report that may be considered duplicative. This report is an opportunity for the Committee to reinforce the importance of adopting and implementing these guidelines, and the redundancy of some recommendations stresses their importance across subdomains and offers an opportunity to highlight previously unexamined impacts on maternal morbidity and mortality. The Committee also requested some general notes be added at the beginning of the recommendations section in order to emphasize the applicability across all recommendations, including the fact that all recommendations should be viewed through the lens of anti-racism.
- The above comments (rows 17, 18, 19, 21, and 22) also noted that short- and long-term designations may appear arbitrary for some readers. While the Committee did acknowledge this possibility, Committee members thought carefully about feasibility when creating these designations. The Committee emphasized that these recommendations are guidelines and that the designations of short- or long-term may shift over time. One Committee member volunteered to craft language on this for Committee review.
- A Committee member highlighted one specific comment (row 20) and suggested acknowledging the importance of ensuring channels exists for patients and clinicians to identify and escalate concerns related to safety, facility operations, etc. No Committee members dissented.

Finally, the Committee expressed appreciation for the work of the commenters, both individuals and organizations that put forward their opinions, questions, and thoughts on the report.

Discussion of Proposed Maternal Mortality Measurement Concepts

The Committee came to consensus on their final recommendations for the maternal mortality measure concepts. Three measure concepts were previously raised to the Committee and a survey was sent to the Committee prior to this meeting to gauge Committee members' views on these proposed concepts. The three concepts considered by the Committee are:

1. Measure concept #1: *Cases of pregnancy-related deaths/Cases of severe maternal morbidity (SMM)*
2. Measure concept #2: *Ratio of pregnancy-related mortality AND pregnancy-associated death by overdose, suicide, violent deaths per 100,000 live births*
3. Measure concept #3: *Pregnancy-related deaths per 100,000 live births*

Measure Concept #2

NQF summarized and distributed the results of the survey to the Committee and to the public. Concept #2 had the most buy in from the Committee via the survey, so it received the greatest share of the discussion.

Co-chair Ms. Lekisha Daniel-Robinson opened the discussion of concept #2: *Ratio of pregnancy-related mortality AND pregnancy-associated death by overdose, suicide, violent deaths per 100,000 live births*. Prior to the web meeting, the Committee expressed concerns with data collection, standardization of data, and viability of risk adjustment. During the web meeting, the Committee agreed that having an aggregate numerator containing overdose, suicide, and violent deaths presents an opportunity to count these deaths in a reliable way. Meanwhile, the ability exists to disaggregate the data in ways that enable states to better understand needed policy changes based on what their data shows (for example, states

with increased violent deaths or suicides might advocate for improving gun laws). The Committee suggested that the denominator eventually be expanded beyond live births to include all deliveries; however, at this point, the Committee did not recommend that change due to feasibility concerns. They did agree that comparisons between states would be appropriate using this measure and that it would add incentive to prevent mortalities. Committee members added that child death review committees could provide an important learning opportunity for improving this measure concept, especially regarding violent deaths, as maternal morbidity review committees could learn from the processes and capabilities of child death review committees.

NQF opened the conversation regarding risk adjustment for this measure concept and encouraged the Committee to participate in a thorough discussion about what risk adjustment would look like for the measure. NQF strongly urged the Committee to make recommendations on risk adjustment because it is likely that measure developers will examine risk adjustment in the future even if this Committee recommends against it. The Committee strongly stated that risk adjustment would not be appropriate for the measure. Since this is a population health level measure it should not be risk adjusted. Measures at these levels of analysis are not risk adjusted to improve comparison over time because taking care of the population is the primary concern (rather than attribution). Additionally, there are only about 700 cases of maternal mortality a year, so it is difficult to risk adjust this measure concept as some states may not have a death for more than a year or longer. As an alternative to risk adjustment, the Committee recommended that stratification of the measure could occur, and that stratification could be based on medical and obstetric comorbidities (unrelated to the outcome of interest), insurance status (Medicaid expansion state vs. non-expansion states), parity, hospital/care system (high vs. low acuity settings; urbanicity vs. rurality) qualities, socioeconomic (SES) risk indicators/social vulnerability, and race. The Committee recommended that additional research be performed to identify which predictors of mortality are most accurate for improving outcomes and stratifying, and then to narrow this list accordingly.

Measure Concept #1

Co-chair Dr. Elizabeth Howell led the discussion of measure concept #1: *Cases of pregnancy-related deaths / Cases of severe maternal morbidity.* Prior to the web meeting, the Committee expressed concerns with flaws in the ratio concept, choice of denominator, lack of standardization of data elements, and lack of data sources of adequate quality. The main issue identified is a problem of incentives: When making improvements in the care of patients, the measured rate would increase. The Committee recommended to instead separate this into a few different measures based on common SMMs. Many of these occur in a hospital-based setting so this measure would be appropriate for hospital-level measurement. For example, a measure of preeclampsia death over all cases of preeclampsia, or a measure of hemorrhage over all cases of hemorrhage. However, other Committee members raised concerns about coding and noted that this measure could create unintended incentives to code down or up depending on the measure's construction. It would be best to introduce incentives to code properly at the same time as this measure is introduced, in order to ensure the measurement is valuable and accurate.

Risk adjustment in hospital-level measures warrants different concerns from risk adjusting a public health/population measure. For example, age has an adverse impact on maternal mortality outcomes and is more relevant to the patients of some providers than others. One Committee member gave the example that because her practice relies on referrals, many of her patients are within an older age group that is more at risk for an adverse outcome. Being compared to another provider who takes care of many younger patients is not necessarily reasonable in that instance. The Committee agreed that if hospitals or providers are being compared through this measure, then adjustment is more appropriate

than it is in measure concept #2. Regarding risk adjustment, Committee members did not raise any objections to the suggested categories of medical and obstetric comorbidities (unrelated to the outcome of interest), insurance status, parity, hospital/care system characteristics, SES risk indicators/social vulnerability indicators, or race/racism, and agreed that age should be added to the list as it is relevant to these outcomes.

Measure Concept #3

Co-chair Ms. Timoria McQueen Saba led the discussion of concept #3: *Pregnancy-related deaths per 100,000 live births.* Prior to the web meeting, the Committee expressed that the measure is not innovative enough to recommend as it is currently in use. The Committee discussed whether this measure identifies more than maternal deaths after live births. The Committee agreed that deaths after stillbirth and ectopic pregnancy are identified in the numerator, but would not be identified in the denominator. For the future, the Committee suggested developers investigate expanding the denominator beyond live births to include often unmeasured populations.

Public Comment

Ms. Ingber opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Udara Perera, NQF Senior Manager, summarized the next steps for the Committee. NQF staff will incorporate all feedback into the report in the next few weeks. The Committee will then have one more opportunity to review the report prior to delivery to CMS. NQF will deliver the report to CMS on June 30, 2021 for their review. The final report will be posted to the NQF NQF Maternal Morbidity and Mortality project page on August 13, 2021.