NATIONAL QUALITY FORUM

Moderator: Kim Patterson
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12:00 pm ET

Suzanne Theberge: Hi, this is NQF. Welcome to the call. We'll be getting started shortly. Welcome to the call, this is NQF. We'll be getting started soon. Hi, everyone. We'll be getting started shortly. If you could put your line on mute in the meantime? We'll get started shortly around noon. Good afternoon, thanks for joining. We'll be getting started shortly. Welcome. We'll be getting started shortly. Thank you for joining us today.

Man: Great.

Suzanne Theberge: Hi, everyone. Thanks for joining us today. We'll be getting started shortly. In the meantime just wanted to mention we do see quite a few folks on the audio line but not too many on the webinar so if you are at a computer and can connect to the webinar we'll be displaying some slides and along with the verbal content.

Nicole Williams: As a reminder the webinar link is in the agenda if you're looking for it.

Suzanne Theberge: Thanks for joining, everyone. We'll be getting started shortly. We have some lines still connecting so we're going to wait another minute or two

before we get started. Thanks for joining, everybody. We're just letting - making sure everyone is connected before we get started.

Okay, it looks like all the lines we saw connecting have connected so we can go ahead and get started. Thanks, everyone, so much for joining us today on our first webinar for the Maternal Committee. Before we begin the call just wanted to offer some general NQF housekeeping for our webinars. We do ask that your put yourself on mute if you're not speaking to reduce feedback on the line.

We will be showing slides on a webinar. And if you're on the webinar and the phone we ask that you turn off your computer speakers to reduce any feedback but do know that you need to be connected via phone in order to speak, we don't have the capability to get verbal input through the speakers.

So we will begin shortly. If you have any questions or any technical difficulties please do send us a chat via the chat box on the webinar or you can send an email to the material@qualityforum email address and we'll track that during this webinar. So with that I will turn it over to Nicole Williams, our director, to begin the call. Nicole.

Nicole Williams: Good afternoon, everyone. This is Nicole Williams from NQF. Welcome to the Maternal Morbidity and Mortality first web meeting. This is our orientation web meeting. We are excited to have a fairly large group of committee members joining us today over the course of this project.

We're hearing some feedback, if someone - if everyone could place their lines on mute? So we're excited to embark on this project over the next 22-24 months working with this great group of experts. And we're going to get

started with going through the NQF mission, vision and values. We'll then introduce the project team and provide an agenda for our all today.

So the NQF mission is to be the trusted voice in driving measurable health improvements. Our vision is that every person experience high value care and optimal health outcomes. And our values include collaboration, leadership, passion, excellence and integrity.

Our project team for this project includes myself, Nicole Williams. I've been with NQF for a little over six months and excited to be leading and directing this project with a great team. I am joined by a few other colleagues who I will allow to briefly introduce themselves.

Suzanne Theberge: This is Suzanne Theberge. I'm the Senior Project Manager on the team. Really excited to be here today. Thanks, everybody.

Nicole Williams: Tammy.

Tamara Funk: Hi. This is Tammy Funk. I'm the Project Manager on the team. I'm so excited to kick off this project with you all.

Hannah Ingber: Hi, my name is Hanna Ingra. I'm a Project Analyst on this project. And I'm - welcome everyone and I'm excited to be working with you all. Audra.

Audra Meadows: Can you all hear me?

Hannah Ingber: Yes.

Audra Meadows: Oh great. Hi. Also excited to be working with you all. We have a great group of people and honored to have you all in the same call together.

Nicole Williams: Great. Our agenda for today is to first provide some time for introductions. I think as most of you know we have a large committee, we have 30 committee members and about five federal liaisons. So we'll devote a little time to getting those introductions underway. We then wanted to give the overview of NQF as a whole and what the roles of the standing committee, the federal liaisons and the co-chairs are. We'll then talk through some project-specific activities, timelines.

We will introduce the environmental scan as that being our first deliverable, and talk a bit about some of the work that's been done to date to start that. And then follow up with more specific committee information such as how to access materials, we will open it up for any further committee discussion. With all of our NQF web meetings, they are open to the public and so we do leave time for public comment at the end of each web meeting. And we'll talk about next steps.

((Crosstalk))

Woman: Hello, are you guys still there?

Nicole Williams: Yes, we're here. Thank you. I would like to start off with allowing our co-chairs to briefly introduce themselves, welcome themselves to the group and as a co-chair of this project, and then we'll go through introductions for the rest of the team. Starting with Lekisha Daniel-Robinson.

Lekisha Daniel-Robinson: Sure. Hello, everyone. I'm Lekisha Daniel-Robinson. I'm currently the Maternal and Child Health Lead within IBM Watson Health and the Federal Consulting - Federal Consulting Group. I know many of you actually from my time at the Centers for Medicare and Medicaid Services, however,

where I collaborated with my colleagues to launch the Child and Adult Core Set measures as well as launch or - or launch the Maternal and Infant Health Initiative that focused on improved postpartum care and contraceptive access. I'm happy to join you all for this very important topic. Thank you.

Nicole Williams: Thank you so much. Dr. Elizabeth Howell. Okay. We have a third co-chair, Timoria McQueen Saba.

Timoria McQueen Saba: It's Saba, but that's okay, I'm used to the correction. How are you doing? Good afternoon, everybody. I'm Timoria McQueen Saba. I think a lot of you know me for better or for worse. I'm usually known as a troublemaker and whistleblower in these types of situations but I'm here to keep the pace and voice centered. Some of you may know that I am a survivor of a postpartum hemorrhage back in 2010, I had a totally different career before that.

And three years after I had that postpartum hemorrhage I learned of the disparities in outcomes. So I wasn't actually aware when I had a postpartum hemorrhage that I was a statistic. So after that I changed course in my career and became a full time maternal health advocate and I'm active in patient advocacy as well as legislation and policy work. And I sit on a variety of boards, but important to me is making sure that patient voices are heard. Thank you.

Elizabeth Howell: Hi. This is Elizabeth Howell and I'm now on.

Nicole Williams: Great. Thank you, Dr. Howell. Did you want to briefly introduce yourself?

Elizabeth Howell: Yes, and I apologize, I was on the webinar and somehow I didn't realize I had to call in too, so I'm now connected. And I'm so happy to be here and be with this, you know, really wonderful group of people. I think I know many of you.

I am an OBGYN, health services researchers, I'm a Professor at Mt. Sinai and have, for the last 15 years, been doing research investigating the ways in which quality of care contribute to racial and ethnic disparities in severe maternal morbidity and I have been - had the privilege of working with many of you on this already - this committee on some other committees that have been specifically targeting disparities in severe maternal morbidity and mortality. So I look forward to this work with the rest of you.

(Diana Ramos): Hi. And (Diana Ramos) is also on. I just joined.

(Emily Briggs): And (Emily Briggs).

Nicole Williams: Okay. Thank you so much.

((Crosstalk))

Nicole Williams: Great. We're going to go through a formal roll call so you don't need to announce yourself at this time. We will now go through our disclosure of interest process. You received a disclosure of interest form from us before you were named for the committee. And in that form you were asked a number of question about your professional activities. Today we'll ask you to orally disclose any information you provided that you believe is relevant to the subject matter before the committee.

We are only interested in your disclosure of information that is directly relevant to the work that the committee will do. We are especially interested

in grants, research or consulting but only if it relates to the subject matter before the committee. Just a few reminders, number one, you sit on this group as an individual; you do not represent the interests of your employer or anyone who may have nominated you for this committee.

Number two, the other thing I want to mention is that we are not only interested in you disclosure of activities where you were paid but also unpaid. Number three, just because you disclose does not mean you have a conflict of interest. We do oral disclosures in the interest of openness and transparency. Please tell us your name, who you're with, and if you have anything to disclose. If you are on the call we will call your name so that you can disclose.

Starting with our co-chairs, because they provided a brief introduction already, I will ask them to each take a moment to disclose any conflicts of interest if there are any. So starting with Lekisha Daniel-Robinson.

Lekisha Daniel-Robinson: No specific conflict of interest, however, I am working currently on a contract with the Centers for Medicare and Medicaid Services looking at severe maternal morbidity and mortality from a data perspective.

Nicole Williams: Great. Dr. Elizabeth Howell.

Dr. Elizabeth Howell: Yes, again, no conflicts I think but just want to disclose that I have NIH funding to look at - of contribution of quality of care to racial and ethnic disparities in severe maternal morbidity and RO1 and then also have a CDC contract to investigate racism as a contributing factor to maternal deaths and thinking about for the (Maria Form).

Nicole Williams: Timoria McQueen Saba.

Timoria McQueen Saba: No, I have no conflict of interest.

Nicole Williams: As I call the next committee members, if you could briefly introduce yourself and also state if you have anything to disclose. (Angela Anderson). (Kathleen Barrett).

(Katherine Barrett): Hi, it's (Katherine Barrett) or you can just call me (Katie). I'm the executive director of an organization called March for Moms which is the consumer-led advocacy organization and I am a postpartum hemorrhage survivor five years out. I have no disclosures. Forgot that part.

Susan Yendro: It's Susan Yendro, and I apologize, I didn't unmute appropriately.

Nicole Williams: Okay, go ahead.

(Angela Anderson): I'm (Angela Anderson), I'm a certified nurse midwife. I've been participating in perinatal mortality review at the state level since 2006. And I've also participated in some (unintelligible) and CDC endeavors in the past. Our state did receive CDC funding for the race maternal mortality grant but I am a volunteer member of that committee.

Nicole Williams: Thank you. Debra Bingham.

Debra Bingham: Hello, good afternoon everyone. My name is Debra Bingham. I am the executive director of the Institute for Perinatal Quality and Improvement. I'm also an associate Professor for healthcare quality and safety at the University of Maryland. I don't think - I do some consulting primarily for the state of New Jersey and then also do some work with the Institute for Healthcare Improvement as well as my own organization, so I don't think there's a direct conflict but I do want to make sure that I outline those items as well because I

use a quality improvement approach which means that we do use data to drive decision making.

Nicole Williams: Thank you. Emily Briggs.

Emily Briggs: Good morning everybody. I am Dr. Emily Briggs. I'm a family physician, full scope, in New Braunfels, Texas. I have served for the last decade at the state level as we have developed our Texas designation process for maternity as well as neonatal rules and so now we are also in the AIM project and I've been involved with that. And I serve on the American Academy of Family Physicians Maternal Mortality and Morbidity Taskforce and in all of that am involved of course with these metrics as they - when they are finalized. So I am excited about this process and otherwise I don't think I have any disclosures. Thank you.

Nicole Williams: Beth Ann Clayton.

Beth Ann Clayton: Hello. This is Beth Ann Clayton. I am with - I'm the associate Professor at the University of Cincinnati. I am nurse anesthetist who practices primarily obstetric anesthesia. I work with the American Association of Nurse Anesthetist Foundation looking at closed claims research and particularly I spent - I've spent my time evaluating preventative morbidity and mortality related to obstetric anesthesia care. And we created and developed evidence-based guidelines for nurse anesthetists providing obstetric anesthesia care in the United States. I do not have any disclosures to reveal.

Nicole Williams: Thank you. Charlene Collier.

Charlene Collier: Hi, this is Charlene Collier. I am an associate Professor of obstetrics and gynecology generalist at the University of Mississippi Medical Center. I also

serve as the Director of the Mississippi Perinatal Quality Collaborative and the Mississippi Maternal Mortality Review Committee. I don't have any specific disclosures. I am - I've been on the Executive Committee for the National Network of Perinatal Quality Collaborative and on the ACOG Committee on obstetric practice. Happy to be here. I also survived a hemorrhage five years ago as well so my little one just turned five so don't often think of that but happy to share it.

Nicole Williams: Thank you. Joia Crear-Perry. Okay. Michael Curry.

Michael Curry: Good afternoon. Mike Curry, I'm the Chief Health Equity Officer here at United Health Group. I have no disclosure to report.

Nicole Williams: Thank you. Eugene Declercq.

Eugene Declercq: Hi. I'm Gene Declercq. I'm at the BU School of Public Health. I'm also on the Massachusetts Maternal Mortality Review Committee. I'm not sure if these are disclosures but I have a subcontract to - on an NIH grant looking at the quality of measurement of maternal mortality and vital statistics. And I have a contract with Commonwealth Fund to produce some reports on maternal mortality and severe morbidity.

Nicole Williams: Thank you. Mary-Ann Etiebet.

Mary-Ann Etiebet: Good afternoon everyone. This is Mary-Ann Etiebet. I'm the lead of Merck for Mothers, which is Merck's global health initiative to help end preventable maternal death. In terms of disclosures, Merck for Mothers does fund a number of organizations including community-based organizations, programmatic activities, research activities, on the issue of maternal mortality and morbidity across the world including in the United States. Thank you.

Nicole Williams: Mary-Ann, can you specifically state if you have any conflicts to disclose?

Mary-Ann Etiebet: No specific conflicts to disclose.

Nicole Williams: Thank you. Dawn Godbolt.

Dawn Godbolt: Hello. Good afternoon everyone. I'm Dawn Godbolt with the National Partnership for Women and Family located in Washington DC. I co-lead our maternal health portfolio that includes a little bit of research and a lot of advocacy work with different congressional offices. I do not have any conflicts to disclose.

Nicole Williams: Thank you. Kimberly Gregory.

Kimberly Gregory: Good morning or afternoon depending on where you are. I'm Vice Chair and Professor of Women's Healthcare Quality and Performance Improvement at Cedar Sinai Medical Center and School of Public Health at UCLA. I've been - I have no conflicts but the following disclosures, I've been a member of the California Maternal Quality Care Collaborative pretty much since its inception and have served on - this is now their third cycle of maternal mortality reviews.

I have a grant funding from the state of California looking at variation and disparities in severe maternal morbidity. I'm on the advisory committee for a CMS project funded through MS (Madiga) looking at improving maternal and infant health. And I have a (Percori) project looking at patient satisfaction with the childbirth experience.

Nicole Williams: Thank you. Kay Johnson.

Kay Johnson: Hi. I'm a consultant who's been working in various roles on the health of women and children over the past 35 years. In my current role as a consultant I have, you know, in the past 20 years had a variety of projects related to the health of women in perinatal health through the CDC, through HRSA, through states and through a variety of professional organizations with Kimberly. I'm also part of that CMS expert panel on maternal and infant health convened by CMS. I don't think that's a conflict.

In the past I've served as the National Policy Director for the March of Dimes. I was the Chair of the HHS Secretary's Advisory Committee on infant mortality in the Obama administration. And I had roles as research Assistant Professor both at the Geisel School of Medicine at Dartmouth and at George Washington University. Again, I don't think I have any conflicts.

Nicole Williams: Thank you. Debra Kilday.

Debra Kilday: Good afternoon everyone. I am currently - I currently manage the women, infants and children's program for Premier Healthcare which is an alliance of about 4000 hospitals and over 175,000 other provider organizations focused on healthcare improvement and various solutions.

I serve on a variety of committees including the NQF Perinatal Women's Health Standing Committee, IHI Health Advisory Network and various other state and local volunteer groups. Other than that I don't believe I have anything to disclose than Premier has released a tremendous amount of data on maternal mortality that has been publicly released, and we support our hospitals with quality improvement and with the Bundle of Joy campaign from Premier, it is focused on maternal infant quality improvement efforts.

Nicole Williams: Thank you. Elliott Main.

Elliott Main: Good afternoon. I'm Elliott Main. I'm a Professor of Obstetrics and Gynecology at Stanford University but my main job is to be the Director of the California Maternal Quality Care Collaborative and I also Chair the California Maternal Mortality Review Committee, known as (PAMR), since its inception in 2006. I'm also the National Quality Lead for the AIM project which is trying to support perinatal quality collaborative and their maternal efforts in 30 states, and serve on a number of national committees.

The - as a disclosure, which I don't think is a conflict, I'm in the process of getting a contract for serving with the Yale in the Joint Commission for formalizing a measure of severe maternal morbidity for CMS.

Nicole Williams: Thank you. Claire Margerison. Kate Menard. Katrina Nardini.

Katrina Nardini: Hi, this is Katrina.

((Crosstalk))

Kate Menard: Sorry, I was muted there for a moment.

Nicole Williams: Yes, go for it.

Kate Menard: …didn't realize you didn't hear me, so apologize. This is Kate Menard. I'm an active clinician practicing maternal fetal medicine at the University of North Carolina, an educator in that role. And I have a number of - I don't think I have any conflicts per se but I do have a number of disclosures, funding related to this work.

One is that I'm the Medical Lead for North Carolina's Pregnancy (at the) Home program which is a population-based program for quality improvement in the outpatient arena for the Medicaid population. I'm the - I also have funding through HRSA grant which is the Maternal Health Initiative recent HRSA grants. North Carolina was the recipient of one of those to evaluate maternal morbidity and mortality particularly with the lens of disparities. And I'm serving on that.

And at the School of Public Health we are - I'm engaged with a consultant on the technical assistance initiative to work with all of those nine states that were funded. In my context of the work I do with the Pregnancy (at the) Home working with both Medicaid and Blue Cross in North Carolina to conceptualize some value-based care models for payment and along the way have been quite involved with the AIM initiative, the Office of Maternal Care through ACOG and serve on the North Carolina Mortality Review Committee.

Nicole Williams: Thank you. Katrina Nardini.

Katrina Nardini: Hi. This is Katrina Nardini. I'm a midwife in New Mexico and I serve as the Associate Chief of Midwifery Division at the University of New Mexico. I also am contracted with the state's - New Mexico Department of Health and I'm part of the core leadership team for our Maternal Mortality Review Committee; I also serve as lead abstractor for the committee and work on the state's AIM initiative and represent the American College of Nurse Midwives, ACNM on AIM as well as was nominated by them for this position.

Disclosure-wise, as someone else mentioned funding from (MMRS) CDC's recent grant of which New Mexico was a recipient. I am contracted with the

New Mexico Department of Health so I do receive some grant money towards hours for my contract as my disclosure. Thanks.

Nicole Williams: Thank you. LaQuandra Nesbitt.

LaQuandra Nesbitt: Hi. My name is LaQuandra Nesbitt, I'm a family physician by training. Currently I serve as the Health Officer for the District of Columbia. I have - the only disclosures I can think to disclose is that as a governmental public health agency I serve as the PI of record for a number of grants related to maternal and perinatal health from federal agencies.

Nicole Williams: Nicole Pernell.

Nicole Pernell: Yes, this is Nicole Pernell. I am in North Texas in the rural part of - just north of Dallas. And I am a patient advocate in this role. I am a health survivor that ended up in the still birth of my son in 2005. Also I serve as the program manager for the Momma's Voices Coalition and that is started with a grant from Merck for Mothers. That's the only disclosure.

Nicole Williams: Thank you. Dana Ramos.

Dana Ramos: Hi, good morning. I'm Dana Ramos. I am an OBGYN by training. I'm the Public Health Medical Officer for the California Department of Public Health and the Division of Maternal Child and Adolescent Health, and also adjunct clinical professor at the Tech USC School of Medicine at the Department of OBGYN. I - in terms of conflicts of interest, there are none, but disclosures, I am with the California of Department of Public Health and we oversee the maternal mortality reviews as well as being a recipient of the ERASE grant from the CDC.

Also I am the National Co-chair for the Health Equity Workgroup for the March of Dimes and I am a California Medical Association technical advisory group for health equity in California.

Nicole Williams: Thank you. Elizabeth Rochin.

Elizabeth Rochin: Good afternoon or good morning everyone. This is Elizabeth Rochin, Liz. I'm the President of the National Perinatal Information Center located in Providence, Rhode Island. I don't have any conflicts of interest. I do have just a few disclosures. I am helping to coordinate the work of establishing Rhode Island as an AIM state, as well as co-coordinating the (effort) of the development of a perinatal, neonatal quality collaborative here in Rhode Island. And it's a pleasure to meet all of you.

Nicole Williams: Thank you. Rachel Ruel.

Rachel Ruel: My name is Rachel Ruel, and I'm the Co Director for Sister to Sister Community Doulas of Essex County located in Newark, New Jersey. And we serve Newark, East Orange and Irvington, New Jersey. And what else? We are funded by the New Jersey Department of Health and the Nicholson Foundation. I also sit on the C-Section Workgroup in New Jersey and I'm also a BELA leader through HealthConnects One BELA Leadership Academy.

And I've been doing this work for about 15 years and currently in this project we use the Uzazi Village perinatal doula curriculum to train the doulas and then provide mentor support for the doulas. And so thank you for - thank you for being here with all of you.

Nicole Williams: Thank you. Amber Weiseth.

((Crosstalk))

Amber Weiseth: Hello there. I'm the Associate Director for the Delivery Decisions Initiative at Ariadne Labs. And I have nothing to disclose.

Nicole Williams: Tiffany Willis.

Tiffany Willis: Hi there. This is Tiffany Willis. I'm a licensed clinical psychologist working at Children's Mercy Hospital in Kansas City, Missouri. Here I work in our fetal health center in the NICU and in our NICU follow up clinic with babies and families. I don't have any conflicts of interest to disclose but my research is around perinatal mental health in black and brown moms. Thank you.

Nicole Williams: Susan Yendro.

Susan Yendro: Yes hi. This is Susan Yendro and I'm a Project Director with the Joint Commission, I work in the Department of Quality Measurement. And we develop and maintain quality measures. I have no conflicts of interest but I would like to disclose that I am part of the project team working on maternal morbidity measure for inpatient hospitals as a clinical - electronic clinical quality measure and I am working on that project with the - with our team here at the Joint Commission along with Elliott Main and Yale Corp to develop the measure for potential use in CMS programs as well.

Nicole Williams: Thank you. Thank you, everyone, for your cooperation. I'd like to remind you that if you believe you might have a conflict of interest at any time during the meeting please speak up. You may do so in real time at the meeting, you can approach your chair who will go to NQF staff or you can go directly to NQF staff. If you believe that a fellow committee member may have a conflict of interest or is behaving in a biased manner, you may point this out during the

meeting, approach the chair or go directly to NQF staff. We don't want you sit in silence if you believe there are any irregularities due to conflicts of interest or biases, please speak up.

Are there any additional questions or anything else that you'd like to discuss based upon the disclosures that were made today?

Amanda Williams: Hi, it's Dr. (Williams) from Kaiser Permanente. I don't know why I'm not on the list. I don't know if something - something happened. But I'm Dr. Amanda Williams from Kaiser Permanente Medical Group in Northern California. I'm clinical faculty at University of California San Francisco. And in my day job at Kaiser Permanente I oversee the pregnancy continuum from prenatal to maternity in the hospital and postpartum care for all of our members in Northern California. And I have nothing to disclose.

Nicole Williams: Dr. Williams, please accept our apologies for accidentally omitting your name off the roster on the - on our webinar presentation so thank you so much for chiming in and sharing that.

Elizabeth Howell: Yes, this is Liz Howell. I just had a question - this isn't a conflict issue but I wondered if now was - could we understand from Dr. Maine and also the person who just spoke from the Joint Commission about the measure that's being developed and how this work that we're going to be working at NQF will sort of augment and, you know, be complementary to that? Could we have a little conversation or better understanding of that?

Nicole Williams: That's a great question, Dr. Howell. We'd like to reserve that if we could to - for a little bit later on in the call just to get through some of our overview and project specific information.

Elizabeth Howell: No problem at all.

Nicole Williams: Okay, I would like now to allow our federal liaisons to briefly introduce themselves if they're on the call starting with (Germa).

(Germa Ramu): Yes, I am (Germa Ramu) with the Health Resource and Service Administration, HRSA. So I have participated in several NQF projects related to (unintelligible) population and I am happy to be in this group. Thank you.

Nicole Williams: Thank you. Wanda Barfield.

Wanda Barfield: Good afternoon. This is Dr. Wanda Barfield. I direct the Division of Reproductive Health at CDC. And I'm also a clinical (neonatologist) and direct a lot of the activities that were mentioned to include work on maternal mortality, the (REA) work and the PQC as well as work on several maternal morbidity.

Nicole Williams: Thank you. Renee Stotts. Erin Patton.

Erin Patton: Good afternoon, this is Erin Patton. I currently work for the Centers for Medicare and Medicaid Services. I am participating on this committee based on some previous work I've done related to maternal health in particular with CMS as well as some previous other organizations and then some work I've done on maternal mortality as well. I'm happy to be here. Thank you.

Nicole Williams: Thank you. And Marcia Smith.

Marcia Smith: Hi, I'm Marcia Smith. I'm a medical officer in the Center for Medicare and Medicaid Services and Center for Clinical Standards and Quality. I have

worked on our quality improvement and public referring programs and have experience in working on maternal and child health issues. Thank you.

Nicole Williams: Thank you. I'd like to also welcome our CMS funding partners to provide any welcoming comments.

(Laura Jenoble): Hi, yes this is (Laura Jenoble). I'm an RN and JD and I'm the CMS contracting officers' representative for this work. Thank you all so much for your time, expertise and support for the CMS NQF task order. And we'd also like to acknowledge our HHS federal partners particularly the CDC and HRSA for their support in this effort. So thank you all again for your time and your expertise.

Nicole Williams: Thank you. I will now turn it over to my colleague, Suzanne Theberge, who will give the overview of NQF, the roles of the committee co-chairs and NQF staff throughout the course of this process.

Suzanne Theberge: Great. Thanks, Nicole. Okay, so a lot of you have worked with NQF before and are familiar with us and we also have a lot of new folks here on the phone today who are not familiar with our work so we want to take a few minutes and just talk about NQF and how it all works here.

We were established in 1999 so we just celebrated 20 years, and we're a nonprofit nonpartisan organization and we bring together people from across the healthcare spectrum, all the stakeholders to discuss and come to consensus on healthcare performance measurement and improving healthcare quality.

We have a number of different areas that we work in. One of our big areas and one that I know several committee members are familiar with is our measure endorsement work. We have a number of standing committees across various

topic areas including perinatal health. And these committees review submitted performance measures against the standard NQF evaluation criteria and make recommendations for endorsement.

Our measure applications partnership advises HHS on selecting measures for federal programs, for public reporting and accountability. The National Quality partners work brings stakeholders together around all kinds of critical health and healthcare topics, new and emerging issues in healthcare.

We do a lot of work in measurement science, we bring people together to talk about measurement as a science and how do you make it better and what are new areas to work on. And we have a range of work in that area. And then finally we do some work in our measure incubator where we work with folks who are developing measures and help them get those developed and tested and ready for submission to be endorsed to be used out in the world.

This is one of our framework projects where we're thinking about measurements, and it's an exciting new area for us, we're really excited to begin work on this maternal health project.

So now I'm going to switch gears and talk a little bit about what the general rules of this committee will be before we talk about the content. So as you saw, we have three co-chairs on the committee. NQF staff - or NQF committees always are - include two to three co-chairs, people who are asked to advise NQF staff on achieving the goals of the project, provide a little bit of strategic direction, help frame the discussions and then the - as well they act as general committee members.

Our committee members are asked to really guide the work of the project and really weigh in. We ask you to help us think through the problems that we've

been tasked with addressing, we ask you to help us frame out the content for the reports that we write. You give us the information and we write it up. And we ask you to review public comments and respond to those and think about how they have impacted your recommendations or not. So it's really - you're kind of driving the project in terms of the outcomes that will come out of this.

As I said, we have some co-chairs, they assist us with facilitating the committee meetings and keeping us on track and some strategic planning as well.

For all of our committee members we do ask that you attend all the scheduled meetings. You know, we know that stuff comes up that you may have somebody gets sick or, you know, something comes up at the last minute and you can't attend and we do ask that you notify us if you can't attend. NQF has a quorum requirement that 66% of a committee must be attending the meeting for us to make formal recommendations; if we don't have - if we have under a certain number of committee members we do have to cancel calls so definitely let us know in advance if you think you can't make it and that would be helpful for our planning purposes.

And so for NQF staff, we're here to support the project. We ask you to - we'll work with you to put out our deliverables. We organize all of the meetings and the conference calls, we facilitate communication between everyone engaged in the project whether that's our committee members or public who are interested in commenting or CMS. And we help make sure everyone has the materials they need. We document all the project activities, we write up the reports summarizing your discussions and then we publish final reports.

So I will pause here and see if there are any questions before I turn it over to Tammy to talk about the project.

Lekisha Daniel-Robinson: Will you also summarize notes of the meeting?

Suzanne Theberge: I'm sorry? I'm sorry, I couldn't quite…

Lekisha Daniel-Robinson: Oh sorry, hi. Will you also be providing summary notes of the meeting?

Suzanne Theberge: Yes, we do meeting summaries after the meetings and we will share those with you and those do get posted publicly as well. Any other questions? All right, I will turn it over to Tammy to talk about the project overview.

Tamara Funk: Thanks, Suzanne. So the project that we're all here to talk about, the purpose of this project is to assess the current state of maternal morbidity and mortality measurements and to provide recommendations for specific short and long-term innovative actionable approaches to improve maternal morbidity and mortality measurements, and then to use measurements to improve maternal health outcomes.

So taking this from our work plan, the things that we have promised to do to achieve it are to recruit and convene a multistakeholder committee which is all of you on this call, so thank you for joining us, as well as a consultant who will guide us in this work.

We will be examining maternal morbidity separately from maternal mortality, though maternal morbidity will be our primary focus. And we'll be conducting a comprehensive environmental scan to review, analyze and synthesize information about both maternal morbidity measurements and maternal mortality measurements.

To give you an overview of the main objectives of our project, the first one that I just mentioned is this environmental scan. The early draft of this we'll actually review quite soon coming up in March and April, but that final scan will be due in August of 2020.

And then in year 2 of this project we will be focusing on creating two separate frameworks, one for morbidity measurement and one for mortality measurements, and identifying existing measures as well as measure concepts and these will contribute to our recommendations report. So we will provide two sets of recommendations for morbidity and for mortality and this final report will be due about a year and a half from now in July 2021.

On this next slide we've laid out for you the - an overview of the main topic of each of our planned webinars. You should all have received invitations for all of these webinars but of course please reach out if you're missing anything and we're happy to provide those again. Today, obviously is the introduction and orientation for the committee, and then web meeting 2 will really focus on the environmental scan that we've already begun work on.

Web meeting 3 will occur while our environmental scan is undergoing public comments so we will shift focus for that meeting and begin looking preliminarily at draft outlines for the measurement framework. And then web meeting 4 we'll circle back and discuss any public comments received on that environmental scan. Web meetings 5-9 will then focus more on development of the framework and the recommendations report.

Similar to this meeting you will get much more specific and detailed information as each meeting approaches including agendas and any other relevant meeting materials.

So to recap today's meeting and next month, today we're here to orient you, the committee, to the scope and objectives of the project and to present our initial outline of the environmental scan in order to get your early feedback on the direction that we're going. And we'd like to seek recommendations on any additional information that can supplement our early work and guide us over the next several weeks.

Web meeting 2 is a month from now, February 24. And in that one we will present back to you the progress we've made on the environmental scans and then obtain much more detailed feedback on the scans and any additional input that you the committees can provide for us before we send that scan for public comment.

And then just a general overview of our project timeline, so as I mentioned before, the first draft of this scan will be due in March, a little less than two months from now, the second draft will be due a month after that. You will then have a 30-day public comment period on this draft scan through - from May 4 through June 2, and then that final document will be due in August.

And then we'll begin working on that - the framework and recommendations report and those drafts of the recommendations report will be due in 2021 about a year from now in February and March. You will also have a 30-day comment period on the recommendations report. And then that final report will be due in July of 2021.

And now I'm going to pass this over to Nicole to guide more in depth about the project.

Nicole Williams: And before I do that I just wanted to pause really briefly to see if there were any questions about any of the information that we've shared thus far?

Lekisha Daniel-Robinson: Can you just give a quick overview again of all the web meetings?

Nicole Williams: Sure. We'll just pull the slide up for you. You should be able to see it. And this is really just a general topic guide but we will really hone in on each subject and the subject being discussed for each meeting as we get closer to those meetings. Were there any other questions? Okay.

So moving on to our environmental scan, as Tammy just mentioned, our deliverables for this project, the environmental scan is the first deliverable and likely the largest part of our overall project. There are some clear tasks and objectives that we need to accomplish for the completion of the scan. So on your slide you can see we are reviewing and analyzing peer review literature to understand and assess the prevalence and incidents of both morbidity and mortality.

We are to outline the standard processes for maternal care delivery and to identify any gaps in care where patients could be placed at greater risk. Conduct an outcomes assessment that reflects the current outcomes landscape with respect to mortality, readiness, complications, also including some cross cutting topics such as rural communities' access to care, disparities, social determinants of health.

Highlight innovations and measure methodologies, so we'll be conducting a scan of regional, state and federal level maternity health measurement-based initiatives. And finally, identifying measure concepts and fully develop measures as well as any limitations or gaps as it relates to maternal morbidity and mortality measurements.

As with all of our framework projects, similar to this one, NQF has a process for collating work and getting things completed. The NQF staff will do the bulk of the writing and present information to the committee for reaction or response. There will be points and topics when a discussion is needed by the committee. And during our web meetings we'll present some of those more pressing issues and questions for the committee to consider and then further discuss as a group. There may be certainly some small writing again editing or reacting to what the staff has pulled together based on the committee's feedback.

Our timeline - do we have a timeline? Okay. So I wanted to jump into a little bit of a discussion with the committee presenting some information that we have pulled together at the onset of this project and starting to think about a timeline and, excuse me, an outline for our environmental scan. Some of this is - has been included in our background and kind of rationale. But there are certain key areas that we feel again as a committee we're expecting the committee to help us fill out for example standard processes for maternal care delivery, certainly our outcomes assessment, our measure methodologies. We will be leaning on the committee to fill us in and help us identify resources for that section as well as identifying gaps and measurement.

So those are some of the key pieces that we wanted to - we certainly will be looking to the group to help us fill in. But our goal today was to really present this outline to the committee as a starting point and invite the group to just take a look at it and certainly share if there was any initial reaction to it or particularly if there's anything within this initial outline that you feel is missing or lacking.

So I will - I will open it up really briefly for a discussion amongst the group to provide any initial comments.

Lekisha Daniel-Robinson: So what is the intent of the section for standard processes for care delivery?

Nicole Williams: So our intention for that section was to help define what the standard process for maternal care delivery is and from there to identify if there are particularly points at which patients are more vulnerable to certain morbidities or mortalities. Audra or our co-chairs, if you all have anything to add to that, please feel free to do so.

Audra Meadows: I heard - this is Audra Meadows. I heard your question, I'm just curious about - can you say it again and see what the intention of the standard process? Can you say that again, you mean for clinical delivery?

Lekisha Daniel-Robinson: So to whom are you directing the question? The person who asked the initial question?

Audra Meadows: Yes.

Nicole Williams: Yes.

Lekisha Daniel-Robinson: So I was asking what was the intent of the section so and someone from NQF just responded.

Audra Meadows: Oh sorry, I thought it was the other way around, okay. Thank you for clarifying that. Yes, it's the only environmental scan the standard process for maternal care delivery so just definitely thinking through a lot of the work in terms of thinking about the process and thinking of process measures of how a lot of the starting points and ending points of the measurement and how we're doing the work in the hospital systems would be looked at and so just

basically defining those so that when we describe a process we're speaking the same language.

Kay Johnson: This is Kay Johnson. I have a question about the role of policy in the scan, you know, the process, the gaps analysis. And I know it's not your job to review pending legislation, but I do think often pending legislation proposes measurement methodologies. And so I just think being aware of those as part of the scan could be useful for us in our deliberation.

Nicole Williams: Thank you, Kay. This is Nicole. I think that's a great point and something that we'll definitely take into account while we - once we get to that point in the project.

Kay Johnson: Thanks.

Timoria McQueen Saba: Hello? Can you guys hear me?

Lekisha Daniel-Robinson: Yes.

Nicole Williams: Yes.

Timoria McQueen Saba: This is Timoria. I'm just curious why racism and bias isn't explicitly listed on the discussion topics?

Nicole Williams: Timoria, that's a great question. I think that we have been careful in how this - the wording for certain things related to this project was - is communicated and crafted. And we all understand and recognize that that is a huge part of this overall discussion, and expect that at points during our discussion, should that be a prominent piece to mention and the influence of that we encourage

the committee certainly to have that be a part of their discussion and include that where they see fit.

Timoria McQueen Saba: See here's sort of like the whole problem, right, like in general is that when we don't sort of put things in the forefront sometimes it's an assumption that we're all thinking about it but maybe it won't come up because we don't visually see it. And that's how all of this work in general in maternal health, anything that isn't specifically listed and - for people to see can kind of, you know, get brushed under the table.

And as we all know, racism and implicit bias is, you know, the highest risk factor for these disparities in outcomes. I mean, we've seen enough stories now to know that, right? So for someone like myself, and I would hope for a lot of other people on this call, while yes, we all know it, I think that it's important enough to make sure that it's visually there so that, you know, we make sure that it is something that we're consciously thinking of at all times.

Amanda Williams: Hi, it's Dr. Williams from Northern California Kaiser. I'd like to support that comment. In California we have new legislation that all providers in the maternal health space are trained in implicit bias, and that's certainly something we should be scanning for if that sort of legislation is coming up around the country. And perhaps when we're looking at, you know, this - these various data polls around prevalence and incidence, we want to make sure that we are capturing race and ethnicity data.

And then when we're looking at innovations and measure methodologies, maybe that would be a location to call out specifically exploration of issues of race and ethnicity. I agree, it's sort of like doing a project where someone says "everybody" and everybody then becomes nobody so I do think it's worth a specific callout.

Elliott Main: This is Elliott Main from CNQCC. And I agree as well. We started now in California to just stratify every single measure in maternal health by race and ethnicity and that's eye opening to many of our hospitals and providers and systems, where they've identified issues that they didn't know they had and now their head was in the sand perhaps but it's a critical piece to understand this issue.

And the other point I'd make while I have the floor is the National Center for Health Statistics is going to have a webinar on Thursday where they're releasing for the first time since 2007 national maternal mortality rates including by race as formal national rates. And so stay tuned for that because there's going to be a lot of press around that.

And secondly - thirdly, I'm a little unsure about what mortality outcomes are we - measures are we really looking at, because they are really determined by CDC and WHO. I'm not certain we're going to come up with new mortality measures - maternal mortality measures here.

Audra Meadows: This is Audra Meadows. Dr. Main, I agree with that. Definitely we're using those definitions from CDC and WHO for morbidity and mortality. And I just wanted to lean in on also and say thanks to Timoria. In looking at this slide it definitely needs to be explicitly stated about the issue related to race and racism but I just also want to assure everyone from the conversations that we've all been having up to this point making certain that race ethnicity and even considering geography when it comes to disparities is something that is important in this piece.

And this is the important part of having this conversation and having the meeting with all of the experts together because in the depth of putting the

information all together we want to make sure that even in putting it in a slide as to what the information that we're gathering and putting all together is there that we don't miss certain words, so thanks, Timoria, for pointing that out because it is a big piece of gaps in measurement as well as innovations, as well as environmental scan findings. And so it is a part of all of that and we'll find ways for it to be explicitly stated as well.

Elizabeth Howell: So this is Liz Howell, and I so agree with everything that's been said. You know, I'm also thinking - I know that you guys were thinking about this but just - not seeing here thinking about social determinants and thinking more broadly. So it sort of feels like the scan is pretty, in a lot of ways narrow. And maybe your thinking is that it's going to come out as we discuss more, but it just feels like there are a couple other gaps in it. So I don't know - I just wanted to sort of bring that up.

And then the other question I had, which is about what we mean by maternal morbidity and what that means and what you guys were trying to get at here because it's a very broad topic, and I guess this ties in a little bit to the measure that's already being developed by - and maybe we could learn more about that, but is that just in hospital severe maternal morbidity defined by (ACS)? And just so we can understand the overlap, that's the other question I have.

Debra Bingham: This is Debra Bingham. I'll kind of dovetail onto that as well. I support all of the other previous comments, but I also was wondering about the fact that, you know, approximately 80% of women are, you know, relatively healthy, low risk. So are there ways to measure respectful care of other topics around caring and that we'll get to some of the, you know, some of the ways - things that women really care a lot about other than just in addition to, I should say, being injured or dying?

Not that those aren't really important obviously but I think there's that other level of caring and support and lack - and not having posttraumatic trauma so they may have survived, they may not have long term injuries but there may be long term sequelae or a traumatic emotional experience related to (unintelligible).

Rachel Ruel: Hello, this is Rachel Ruel. So everything that is said is - I'm on board with it. Also when I think of birth trauma I don't know if like - was the woman or the person satisfied with her birth, because we find a lot of women or people in the project that are birthing don't have any access to like the Lamaze Six care practices. And so we find that when people are walking away from a birth that's just as traumatic as other things that they could have experienced and then they're living and parenting feeling like this.

Eugene Declercq: This is Gene Declercq. I just had a question about - because I haven't been involved in one of these particular processes before and that is the openness to completely new approaches. I mean, Elliott's right, it's pretty structured what we do for maternal mortality but it seems to me in the case of maternal morbidity there's more opportunity.

And I'm wondering the extent to which we'll go beyond the sort of standard CDC 25 ICD code measure that only captures maternal morbidity at the hospital - at the birth hospitalization and the extent to which you look to measures that might not be there now but need to be developed in creating these standards.

((Crosstalk))

Audra Meadows: …Audra Meadows. I completely and wholeheartedly agree with that comment and want to continue to hear more because we've had those conversations about the limitations of those 21 and thinking about even just mental health disorders and what someone mentioned already about patient satisfaction factors, access to enhanced prenatal care factors. And so I want to keep this conversation going as well.

Timoria McQueen Saba: So this is Timoria…

((Crosstalk))

Timoria McQueen Saba: …I just wanted to - oh, hello?

Lekisha Daniel-Robinson: So go ahead, Timoria.

Timoria McQueen Saba: Oh, I just wanted to add in particular to the last of these comments because they really pertain to my exact situation of what I went through. So for me I'm a black woman with good education, good socioeconomic status. I had what could be considered the absolute best possible income - or outcome, I'm sorry. I went into the - I had no preexisting condition, healthy five baby full term and had a postpartum hemorrhage. And what I find lacking in so many conversations is my exact scenario, the life of the survivor.

I was diagnosed with PTSD after this happened to me. There does tend to be, and for obvious reason, focus on mortality. But I think this is a real opportunity to do more on the morbidity side and really think about what good care looks like. I had great healthcare, I had a good doctor who knew exactly what to do and that's the reason why I'm alive. So the last few comments really resonated with me so I just wanted to put that out there.

Wanda Barfield: Hi, this is Wanda Barfield. I appreciate all the comments that have been made before. And I think in terms of addressing some of the issues particularly that Timoria alluded to it's going to include a measurement of things other than clinical so actual process measures of how people are cared for rather than just what the specific outcomes are.

Nicole Williams: Okay. Thank you. We greatly appreciate the discussion and openness of the committee. I would like to also share with the group a few discussion topics, again, not to go through a deep discussion during this call but a few things to think about. So one thing that we wanted to do is to come up with an agreement amongst the group around a consistent set of definitions and terms. And so to start that off what (unintelligible) is shared a simple survey with the committee that had a few questions, and you should have received a link to this.

And the questions were just asking whether you agreed with for example the CDC definition of maternal morbidity or we also shared the definition of pregnancy-related and pregnancy-associated mortality. So gauging whether the committee, each member, and then certainly looking at these results as a whole but gauging whether the group agreed with those definitions and if not, if they could explain or share a different working definition that they would consider.

The other thing that we also asked the group was to share with us kind of your top 10 publications. The intention is to understand amongst our stakeholders what are those key publications that we need to comb through, it's likely on our list already, but are there any additional existing articles whether those be published or unpublished that you all feel are critical that we should consider as we begin to populate more of the content for the scan. So just to be aware of that, if you haven't done so already if you could complete that survey.

Also we wanted to hear back from the group if there are any existing frameworks or any supplemental resources that would be helpful in the work that we need to continue to do amongst the project. You can send that information directly to our maternal inbox if you have any specific points that you'd like to mention related to those.

I am going to circle back since we do have some time, I'm going to circle back to Dr. Howell, you had a question at the top of the call.

Elizabeth Howell: Oh yes, I just - I just had wanted, since we have the folks on the call, Elliott being one and I'm forgetting the person's name from the Joint Commission who spoke also about your involvement in that project and just how you guys might both the NQF team and Audra as well as them speaking about how this work could be, you know, complementary to that work and sort of give us a little bit more details around that work is my question.

Susan Yendro: Yes, hi. This is Susan Yendro. I'm happy to sort of start off. So the Joint Commission started to look at the need for a maternal measure looking at morbidity complications and the like. And so we have a long standing collaboration with Elliott and his team with measurement that we've adapted for the Joint Commission.

And so we started looking at this and we also learned in the fall that CMS was also looking at maternal morbidity measures and had engaged with Yale Corp. And so we sort of all kind of coalesced together to looking at how we can create a measure. The measure is specifically to look at an electronic clinical quality measure, or an ECQM, in the inpatient setting.

So I think that's where it fits in is just to realize that this measure is not going to be covering all settings but that there are other settings that we need to certainly be looking at I think as part of this committee to think about how can a measure or measures look at the other issues and aspects and how can we leverage the work that we're doing to help inform our - us help inform the work of this committee as well as this committee can help inform work that we're doing as well.

So I think we're excited to be part of this group in order to learn and share from each other. And, you know, certainly to realize that this won't be the only recommendation for a measure coming out of this group. I think we've heard enough interest in certainly a lot of other areas that will need to be looked at.

Elliott Main: This is Elliott. I think the only thing I'd add to that is there are likely going to be multiple measures in this arena and it will be dependent on the data sets that are available to calculate them on. The severe maternal morbidity measure is immediately available as of now. But it needs risk adjustment pretty terribly for use at the hospital level and I think that's a major part of the process that's just being started. But it is something that can move along very quickly.

This project with NQF has almost a two-year timeline before we even get started with the next process which is actually developing and testing measures. And so this I think - CMS was very interested in having a measure that they could use toot sweet as we are working on reducing maternal mortality and maternal morbidity all around the country. So there's an urgency here.

I'm certainly willing to also say that this is a measure that may be reversed if another one comes along that's better and/or be augmented by outpatient; outpatient measurement is quite a bit trickier in terms of data acquisition, and so those are - that's a whole new set of things to work out.

Elizabeth Howell: Well great. This is Liz Howell. That was super helpful to me. I don't know if others have other questions.

Nicole Williams: This is Nicole…

((Crosstalk))

Woman: I just want - oh go ahead.

Nicole Williams: No, go ahead please.

Woman: I guess I just want to make sure and I don't - I'm just now opening up the slides but I want to make sure, so we're going to be developing suggested measures for measuring maternal mortality and maternal morbidity electronically? And then those are the measures that the Joint Commission is going to advocate to go through the whole NQF cycle?

Nicole Williams: So NQF does not develop measures. What we're going to be doing on this project is providing measure concepts. So themes or ideas on what a measure could be and allowing measure developers and other entities if they choose to do so to develop those measures per the recommendations of the committee.

(Laura Jenoble): Hi, this is (Laura Jenoble) from CMS. So this task order - the output of this task order is going to be two separate frameworks that sort of address how, you know, in the totality maternal morbidity and then separately maternal

mortality can be looked at and views. So it is not specifically about developing or suggesting measure concepts, although there is a companion inventory.

But the frameworks themselves, and there is a priority for maternal morbidity, hopefully those frameworks will encompass all the things that you have just expressed interest in with regard to the environmental scan, you know, for example for those 80% that are low risk for that, you know, life of the survivor, how in a framework can we also think about measuring those areas of maternal morbidity and maternal mortality?

So we definitely are looking for a measure concept recommendation or a measure recommendation, one specifically that can be used nationally so that we can compare states and that we can take a measure to improve maternal outcomes and that includes disparities. And so I think, you know, at this stage we're really looking for a framework, some kind of guidance that we can get all these important issues into measurement.

Beth Ann Clayton: This is Beth Ann Clayton. I have one suggestion as well regarding measurements, and I'm not sure how we accomplish so that it's really in the literature yet. But we certainly know that we've been provided national safety bundles - patient safety bundles that we have implemented and are supposed to be using across our facility. In the work that I've seen a lot of the patient safety bundles are present but you don't see that they're actually - the teams are actually adhering to them.

So they're aware of the patient safety bundles, the steps, but adherence seems to be lacking. And I don't know how we identify that. But as far as measurements, I think we want to see - we've been provided and there's been created wonderful tools but are actually clinicians adhering to them. And I

think that's a big thing. And I know the Joint Commission is looking at our preeclampsia and our maternal hemorrhage bundles and making sure that facilities have them in place, but again having them in place and actually having adherence is two different things.

Debra Bingham: This is Debra, I totally agree with that comment. I also really interested in the work that's happening internationally around the international child risk initiative around healthy mother, baby, family care, respectful care. And the national health system within the UK is actually doing - is funding some research around how to implement and measure those indicators that are included within that - in those principles and some interesting innovation around that.

So I want to - that's one reason I brought up expanding beyond, you know, to expand our discussion to include some of that work as well and kind of learn what's happening in other countries. And I recognize that they are emerging data, more difficult data to capture, more difficult data to measure. I'm not suggesting them instead of the other more traditional measures but as really making sure that we don't lose track of some of the broader international work that countries that are actually much further ahead than us.

Audra Meadows: This is Audra Meadows. Debra, could you say - not on this call but maybe offline could we chat and talk about some of the lists of some of the work that's happening and where some of your cited sources are as well so we can measure the information we have is it up to date with what's out there on that work as well?

Debra Bingham: Yes, I'd be definitely - definitely share that. Thanks, Audra. If I send that to the organizers does that make sense or do I - do you want me to send it to everyone?

Nicole Williams: You can send it to maternal@qualityforum.org. Were there any other comments from the committee either about the outline, the discussion thus far, project scope? Again, we are looking to the group and leveraging your experience, expertise and any existing resources that you do have or are aware of so over the next few weeks we will be asking you to share that information with us at NQF.

Okay, if there's no further questions or comments we're going to move onto the SharePoint tutorial and Hannah will explain that.

Hannah Ingber: Thanks, Nicole. So SharePoint is our document sharing site where committee members can access documents that we share from the team. So our - although we're not doing measure evaluation, our documentation will be around sort of draft of the environmental scan, drafts of our outline, survey questions, etcetera.

This is how SharePoint will appear. It would say Maternal Morbidity and Mortality Project obviously. And we host all our documents on a page that looks like this. We do like to remind our committee members that occasionally documents may not appear but if you hover over the plus sign and click on it that's how you'll sort of like cascade the menu topic down and just make sure that you do that before you, you know, worry that it's not there.

Of course if you have any questions about SharePoint you may message the project box, maternal@qualityforum.org. Are there any questions about SharePoint?

Elliott Main: Would you be able to share PDFs of individual literature documents?

Hannah Ingber: Committee members can't add documents to SharePoint, however they can share it with us, the project team at maternal@qualifyforum.org and we can work internally to distribute.

Elliott Main: The question was will you be able to share out article PDFs from journals?

Hannah Ingber: I think I understand your question better now. We can put PDFs onto SharePoint, yes.

Elliott Main: Okay.

Suzanne Theberge: Yes, there are specific articles under discussion I believe we are able to share those on SharePoint, yes.

Elliott Main: Now there are - sometimes there are some organizations that are shy about sharing things that under copyright, that's all.

Suzanne Theberge: I believe we are allowed to share them but it may depend. We may have access to that for some articles and not others, we'll have to check on a case by case basis. But if there are things that you feel like the committee needs for your work definitely flag that to us via email and we'll see what we can do to get that available to everyone on the committee for sure.

Hannah Ingber: Okay great. If there's no other questions about SharePoint I'd like to now take the opportunity to open it up to the public for commenting on any discussion items we had today.

Timoria McQueen Saba: Hi, this is Timoria again. So I just think, you know, we really need to get to a point where we're able to not sugarcoat any of these issues because we're never going to solve them if we're just trying to make things palatable

for other people to digest. So for me both as an advocate and a survivor of all the things that we're talking about I'm really going to need to see that what we discussed earlier in terms of racism and implicit bias is going to be centered quite a bit in these conversations and in this work.

And also Audra brought up a great point about other groups that I feel like we're sort of leaving out in this like rural, you know, there's also geographical so we also need to think about that as well. And also the intersection of mental health in all of this a bit. So that's something that, you know, as I've been listening to everyone talk that's sort of like, you know, just my summary of how I'm feeling right now.

Kim Gregory: This is Kim Gregory. Can you make this slides available as well?

Suzanne Theberge: Yes, the slides…

((Crosstalk))

Suzanne Theberge: Sorry, go ahead.

Nicole Williams: Oh no, it's okay. Go ahead, Suzanne.

Suzanne Theberge: Yes, the slides are posted on the public website, we'll make sure they're on SharePoint, if they are not already and they were also attached to the meeting invite which I know sometimes doesn't come through for everybody but we'll make sure that you have them on SharePoint by the end of today.

And if anyone is still having trouble accessing SharePoint, please do let us know. You should have gotten your login information for that within the last

couple of weeks, but if it didn't come through let us know and we'll work with our tech team to ensure that you have access.

Timoria McQueen Saba: In relation to what I said - this is Timoria again - is that something that you all think that you can do going forward?

Nicole Williams: Hi, Timoria. I think that what we will do is - our goal is not to ignore those issues or to omit them and so collectively as a committee we've heard that's important and so that will now become part of the (unintelligible) and part of how we will further flesh out some of the details related to the scan.

Timoria McQueen Saba: Okay. And then my other question is about the measure, you know, I think it's pretty obvious that it's difficult to measure someone's lived experiences especially concerning racism and bias, and so I'm wondering how we're going to explore that in terms of measuring it.

Nicole Williams: Yes, so further (unintelligible) project timeline once we have our two frameworks established we will have more time to talk more specifically about measure concepts. And I think that would probably be the more appropriate time to discuss that measure and some of the challenges related to that.

Audra Meadows: This is Audra Meadows. I just wanted to ask if it's a good time to pose a question to the committee about the measures to what you're talking about, just noting the time.

Nicole Williams: Yes, that's fine.

((Crosstalk))

Audra Meadows: Great. So my question is, is, you know, Dr. Declercq, you brought this up, as we're looking at everything about the measure that out there in terms of the morbidity because the priority is towards morbidity and the 21 that we have lifted from the CDC, and then there's others and we list them as severe, and then we talk about, you know, there are others and there's also the outpatient piece, and so as we're expanding this list and sort of creating a list what's the best way for folks to sort of help with metrics or diagnoses that we'd want to include in that to have a broader framework than the ones that are already in existence?

And so, you know, to that point I brought up earlier like for instance mental health disorders, peripartum depression. And so how would we want to move in that direction? Like would folks want to - and so other NQF staff please help, you know, because I'm asking it, would you want to send that diagnosis to us, send a suggestion, wait until we have the variable list to send to you to look at and see what you feel is missing? Like how would you like to that to occur because as we're pulling information together I know the next call is a month and so wanted to sort of move as quickly as possible on that.

Eugene Declercq: This is Gene Declercq. I would assume that what you'd look for is two things, right? One is the measure itself but the other is the process by which the measure would get applied. It's one thing to have a scale which you can use to measure postpartum depression; it's a whole another to think of the mechanism by which that can be applied on either a population basis or more likely some type of probability sampling basis that would give you a representative response. Really thinking both levels.

And I'm sure there's measures out there that we haven't considered that folks have developed for their own particular work and your job and the scan is pulling all that together, but then the serious discussion becomes A, the

quality of the measures but B, feasibility of application of these on a population-basis, again on some kind of representative basis that would give us criteria we can use to measure things that didn't happen in the hospital.

Audra Meadows: I appreciate that. And I also think that it might be also worth having the list of diagnoses and then having the ones that we don't have the ability to sort of make suggestions around measures on population level there to sort of show the breadth of what we've considered and what we've been able to narrow down to within a framework of what can be measured on a population level.

And I'd love to hear other thoughts because I bring that up because what you hear about Austin and the media around severe maternal morbidity and really mortality as well definitely would relate it to morbidity tend to not be the diagnoses that we have listed in the 21 Austin, we're not as parsed out. And so it's nice to also be certain that we're reflecting what are the concerns of, you know, general in the community. I'm just checking the temperature. Am I making any sense? I know it's a little quiet.

Debra Bingham: So, Audra, this is Debra. You're making sense to me. And I'm thinking about - I'm thinking about (Prams) data is definitely one data source that in the United States that I think does have some interesting data already being collected, that might be better utilized or better shared for some of those community aspects if I understood your point I hope…

((Crosstalk))

Audra Meadows: Yes. Because, you know, a lot of the questions that are on some of the - the instruments for respectful care and the instruments that are for - on the - the questions that are on the instruments for (Pram) they start to get at the issues

related to public concern that help us start to identify who are these women that may find themselves on a labor floor facing severe maternal morbidity.

And so wanting to make sure that we're considering for the full breadth of where there is to be considered that's outside of the severe list of 21, to step outside of the general box that we're in on looking at what are other areas of measurement so that's exactly right, Debra. That's what I'm getting at. I'm just trying to restate it to see if other thoughts are out there on that.

LaQuandra Nesbitt: So, Dr. Meadows. This is LaQuandra Nesbitt. I think in listening to the conversation and the - some of the things that people have asked to be included, you know, process measures for how people access care, thinking about the social determinants of health, etcetera, and expanding our thinking around severe maternal morbidity, I guess I would want the group to think about are we looking at measures for SMM on a continuum of the women's health experience and using a life course approach and trying to better understand maternal health outcomes as it relates to the women's health along the life course and thinking about morbidity from that perspective?

Or are we still thinking about severe maternal morbidity as a very time bound concept? And make - having that decision point will force us to refine our metrics. What I mean by that is if we are trying to define - you mentioned conditions, and I was wondering if you were going to elaborate, you know, the list of conditions, the 21 list of conditions doesn't always necessarily correlate to what people are concerned about at the community level.

And sometimes, you know, we're dealing with, within our agency a woman who's 11 months postpartum and died and she's having her exam from the medical examiner yesterday so we're still waiting on the results of that, but a lot of abdominal pain, chest pain and maybe had an MI, 31 years old.

So thinking about SMM, thinking about people who are morbidly obese, thinking about those types of things on a continuum and the overall health of women is a totally different construct or thinking about, you know, whether or not people are having abdominal pain that is missed postpartum. Are we thinking about, you know, 60% of these SMM conditions are hemorrhage and how they're managed, you know, two days postpartum.

So what I'm trying to really get a read for what people are talking about when they're talking about metrics. If we're talking about care processes, we're talking about people not getting access to prenatal care and that having an impact on birth outcomes, that's a process measure. I'm - that's what I was trying to understand, you know, (pram) data is going to tell us if people were smoking, if people were using other substances.

That's a different kind of - it impacts the birth outcomes and is going to impact morbidity and women's health. But what is this construct of morbidity where we're talking about if we're going to scan beyond the 21 things is it because people are having heart failure? Is it because people are having some type of lung disease? Is it because they're having some other chronic health condition that impacts subsequent birth?

Wanda Barfield: Hi, this is Wanda. (Pram) also asks questions about stressful life events and in select states asks about reactions to racism.

LaQuandra Nesbitt: Yes, so, I mean, it potentially opens a Pandora's Box, which isn't a bad thing to do but it creates more of a life course approach to it as opposed to a finite period in time.

Mike Curry: How you doing? This is Mike Curry from United Health Group. Since you laid out your thinking and how you're processing all of this, in a similar vein when I think about the role or the influence of a health insurer and how do we leverage this information that can sometimes be very academic and research in nature, how do we better leverage it?

How do we differently leverage it, practical application and accountability, working with the deliverers of care, the providers that we have these network contractual relationships with, to, yes, make sure that the best evidence-based care is provided, but also add another layer or level of accountability so that it's not just about evidence-based care but it also touches on some of the other aspects of respectfulness and some of the other things that we've been talking about because that doesn't come through on a claim.

Obviously there's work around social determinants of health and using Z codes to bring that kind of information in, hopefully that gets more teeth and adoption over time so that we can leverage that in a different way. But I just wanted to chime in and say as you're thinking about how to gather this information in a more meaningful way and then leverage measures in a more meaningful way, how do we use that information considering the process that we have using claim-based data and contractual relationships with providers to drive a different care delivery process so that it doesn't look, feel and seem just academic and research in nature. I hope that's making sense.

Suzanne Theberge: Wow, I appreciate both of those comments. Thank you so much. It does make sense. And exactly right, like I appreciate Dr. Nesbitt, you bringing the, you know, the hat of the public health officer and the life course approach and, Dr. Curry, bringing it from the standpoint of the insurer, exactly. And so for those of you who think differently, I'm a top down thinker so I'm going to

put that out there, and the NQF staff will say more to encapsulate some of this work.

But I'm casting a broad net with the way I'm saying it and asking questions to make sure that we're not sort of neglecting - shine a spotlight on an area that we should be shining it on. I really appreciate the way you just phrased that like, how do we take information that we'll gather, and encapsulate it in a meaningful way so we'd give it back to people that within their own spaces as an insurer Medicare, Medicaid or other insurers or other care delivery agencies can use it.

I've seen some really nice frameworks that were done by the CDC that do what you just described, Dr. Nesbitt, in terms of putting things in a life course of where in the time continuum does this fit? And often when we're looking at the SMM 21 it seems to fit in the time point, time balance point of being in the hospital system.

So that is exactly the question and so I appreciate having experts and beautifully brilliant people, you know, reshaping my words into something that's helping to drive this conversation forward so that we can hear from you as to how we can create a framework that becomes useful to really doing what we all want to accomplish which is finding the information necessary to help folks in these spaces reduce disparities related to and improve outcomes related to severe maternal morbidity and mortality. So curious to hear more thoughts please.

Mike Curry: Just to add onto that, you know, we did some listening sessions with a number of hospitals in a number of different markets and one of the things that we took away that's really at the core and foundation of work that we're trying to

do not only within the walls of United Healthcare but also influencing the healthcare system as a whole is really related to standardization.

So what got me excited about what we're going to do here and establishing measures is the standardization, the opportunity for standardization of the measure but it's really the process to get to the measure so that you know whether or not you're hitting the mark or not. There shouldn't be much variation in gathering the information associated with the measure, the way you gather the information is the way you gather the information, it shouldn't - shouldn't - vary.

And that kind of standardization, whether or not you're talking about hospitals, whether they're rural or urban in Louisiana, Mississippi, New Jersey, Tennessee, hopefully it's not going to matter and that kind of standardization based on all that information we got in what we're calling our listening tours that's going to be helpful, that's going to be really helpful because a lot of what we heard from hospital - and no one wants deaths in their hospital or when a woman leaves their hospital - no one wants that.

How they assessed it, evaluated it, did something or went through a quality improvement process associated with it, that varied quite significantly across hospitals.

So I guess I'm just sort of opening my brain up to everyone so that you know, as I'm listening to all these really, really smart expert folks talk about this, I'm trying to think about the practical application of both from a claims perspective and how we are involved with and participate with network providers whether it's a OBGYN in the community or a hospital system and also how we could lend support if it's a measure or five measures or 20 measures or whatever it is, how we could lend support in either funding or in

kind services to have that kind of standardization take root to be yet another step in the elimination of avoidable morbidity and mortality.

Audra Meadows: That was really helpful. Thank you. Looking at the time knowing we have nine minutes left in the call, just wanted to make sure we turned it back over to Tamara or the committee chairs to hear more about their thoughts and encapsulating the conversation.

Nicole Williams: Hi, everyone, this is Nicole. So a lot of what we do here at NQF is just as Audra alluded to, is taking the information that you've shared with us, one of the first things that we'll look at doing as staff is modifying our outline based on your feedback, ensuring that we have addressed and begin to fill in some of those missing areas and gaps. We also will be looking for your feedback to the survey and make sure particularly at our next call that we have a strong understanding and a good set of working definitions and terms.

And also communicating with the group on any additional resources. Again if you have any information related to frameworks or additional resources please share that information with us as we will use it to further build out the environmental scans.

I am going to pass it onto Hannah who will talk about our next steps. We appreciate - greatly appreciate the discussion and the open and honest conversation.

Hannah Ingber: Thanks, Nicole. So as we've mentioned, our next steps are primarily concerned with web meeting 2, which will take place on February 24 from 12:00 to 2:00 pm. Again, the environmental scan draft report be due to CMS on March 18 and we'll be looking for your input prior to that date. Our web meeting 3 will then take place a little later in May on the 27th. And our final

environmental scan will be due on August 11. We'll be getting your input in between that time as well.

Again, as we said, please feel free to always email maternal@qualityforum.org with any questions. The entire project team has access to that box. We encourage you to ask any questions that you may have. Our project page is linked here with the meeting materials that we presented today and the SharePoint site is also linked on this slide. We thank you as always for taking the time to give us your thoughts. And we look forward to working with you over the next few months. Thanks again for joining us.

((Crosstalk))

Woman: Bye-bye.

END