**NATIONAL QUALITY FORUM**

**Moderator: Kim Patterson**
**February 24, 2020**
**2:00 pm ET**

Nicole Williams: Good afternoon everyone. This is Nicole Williams with the National Quality Forum. Welcome to the Maternal and Morbidity and Mortality Web Meeting 2. I know that we still have a few folks still joining the call but we're going to go ahead and get started.

So welcome to our committee members, co-chairs, to - and our federal liaisons who joined us for our call today.

We'd like to just quickly recap the NQF mission. So our mission is to be the trusted voice driving measurable health improvements. We have quite a large committee with many new members. So it's also worth mentioning that again that NQF is a nonprofit, nonpartisan membership-based organization that's recognized and funded in part by Congress and entrusted with important public service responsibility of bringing together various public and private sector organizations to reach consensus on how to measure quality in healthcare as the nation work to make it better, safer and more affordable.

Our vision is that every person experience high value care and optimal health outcomes. And our values include collaboration, leadership, passion, excellence and integrity.

The Project team for this project includes myself, Nicole Williams. I'm a director here at NQF in our Quality Measurement Division. We also are supported by Tami Funk, our project manager; Hannah Ingber, our analyst; and Dr. Audra Meadows who's our consultant.

We do have quite a bit - quite a packed agenda for our call today. We'll start off with just a brief welcome from our co-chairs. We'll review the meeting objectives. We will also need to go through disclosure of interest for those committee members who are not on our orientation call.

We'll review the project scope again with the committee. And then talk a little bit about our environmental scan outline and some the revisions made since our last conference call.

We will open it up for committee discussion around maternal standards of care. We then will review the definitions around morbidity and mortality and share a little bit about some results from the survey that the committee has been given. Following with our public comments and next steps.

So I will now turn it over to Maha Taylor who is a managing director here in Quality Measurement and she will go through our disclosure of interest.

Maha Taylor: Good afternoon everyone. This is Maha Taylor. Thank you, Nicole.

So I will quickly walk through the disclosure of interest. And as Nicole mentioned, you know, a lot of you have already disclosed on the last call. So

I'll just call on all of the names just so, you know, so we know you're present on the call but then I will call on those that was specifically need to disclose.

So you received a disclosure of interest form from us before you are named to the committee. In that form we asked you a number of questions 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 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.

A few reminders. You fit on this group as an individual. You do not represent the interest of your employer or anyone who may have nominated you for this committee.

The other thing that I wanted to mention is that we're not only interested in your disclosures of activities where you are paid but also unpaid.

Just because you disclose does not mean that you have a conflict of interest. We do oral disclosures in the interest of openness and transparency. So I'll ask that you tell us your name, the folks that will be disclosing, your name, the organization that you're with and if you have anything to disclose. But I'll do roll call now for the other members that are on the call and I apologize in advance if I mispronounce any of your name.

So Ms. Lekisha Daniel-Robinson?

Lekisha Daniel-Robinson: Good afternoon. I'm here.

Maha Taylor: Thank you. Dr. Elizabeth Howell?

Dr. Elizabeth Howell: I'm here.

Maha Taylor: Thank you. Ms. Timoria McQueen Saba?

Timoria McQueen Saba: Hi everybody. I'm here.

Maha Taylor: Thank you. Angela Anderson?

Angela Anderson: Hello. I'm here.

Maha Taylor: Katherine Barrett?

Katherine Barrett: Hi everyone. I'm here.

Maha Taylor: Debra Bingham?

Debra Bingham: Hello. I'm here.

Maha Taylor: Emily Briggs?

Emily Briggs: Hey guys. I'm here.

Maha Taylor: Thank you. Beth Ann Clayton?

Beth Ann Clayton: Hello. I'm here. Thank you.

Maha Taylor: Charlene Collier?

Charlene Collier: I'm here. Hi.

Maha Taylor: And, Joia Crear-Perry, could you state your name, your organization and your disclosure, if you have any.

Joia Crear-Perry: Oh, okay. This is Joia Crear-Perry. I'm the - can you hear me?

Maha Taylor: Yes.

Joia Crear-Perry: Yes? Okay great. I'm the President and Founder of the National Birth Equity Collaborative. I guess the big risk flow here would be that I am recipient of a grant from the Robert Wood Johnson Foundation to work on risk for maternity care and creating a measure. I hope (unintelligible) patient-reported measure and we're working on tools to hold systems accountable for it.

Maha Taylor: Thank you. Michael Currie?

Michael Currie: Present.

Maha Taylor: Eugene Declercq?

Eugene Declercq: I'm here.

Maha Taylor: Mary-Ann Etiebet?

Mary-Ann Etiebet: Present.

Maha Taylor: Thank you. Dawn Godbolt?

Dawn Godbolt: Present.

Maha Taylor: Kimberly Gregory?

Okay. Kay Johnson?

Kay Johnson: Present.

Maha Taylor: Deborah Kilday?

Deborah Kilday: Good afternoon everyone.

Maha Taylor: Elliott Main?

Dr. Elliott Main: I'm here.

Maha Taylor: All right. Claire Margerison? And if I could have you state your name, your organization and your disclosure please.

Claire Margerison: Sure. I'm Claire Margerison. I'm a - with Michigan State University. And the only disclosure is that I have a grant proposal under review about maternal mortality and - or pregnancy-associated mortality and morbidity but it's not funded currently.

Maha Taylor: Okay. Thank you. Kate Menard?

Kate Menard: Here.

Maha Taylor: Katrina Nardini?

Katrina Nardini: Present.

Maha Taylor: LaQuandra Nesbitt?

LaQuandra Nesbitt: Present.

Maha Taylor: Nicole Purnell?

Nicole Purnell: Present.

Maha Taylor: Diana Ramos?

Elizabeth Rochin? (Rachin)?

Elizabeth Rochin: Present. Sorry.

Maha Taylor: Okay, thank you. Rachel Ruel?

Amber Weiseth?

Amber Weiseth: Hello.

Maha Taylor: Amanda Williams?

Amanda Williams: Good morning from Oakland.

Maha Taylor: Tiffany Willis?

Tiffany Willis: Hello. I'm here.

Maha Taylor: Susan Yendro?

Susan Yendro: Hello, present.

Maha Taylor: Thank you. Is there anyone that I did not call or may have joined after we did roll call?

Erica Taylor: Hi, this is Erica Taylor.

Maha Taylor: Thank you.

All right. Thank you for Joia and Claire for their disclosures. I just like to remind you that if you believe that you might have a conflict of interest at any time during a 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 a meeting, approach the chair or go directly to NQF staff.

We don't want you to stand in silence. If you believe there are any irregularities due to conflict of interest or a bias, please speak up.

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

All right. If not, thank you all and have a great meeting.

Nicole Williams: Thank you. This is Nicole Williams again. We also, in addition to our committee members, we also have five federal liaisons who are supporting this work as well.

I'd like to do just a quick roll call just to see who's here. So Girma Alemu?

Girma Alemu: Yes, present.

Nicole Williams: Wanda Barfield?

Wanda Barfield: Yes, present.

Nicole Williams: Renee Fox?

Renee Fox: Present.

Nicole Williams: Erin Patton?

Erin Patton: Present.

Nicole Williams: Marsha Smith?

Okay. Great. Before we jump into our project - overview of our project scope, I want to just to open it up to our co-chairs and ask if they have any welcoming comments for the committee.

And if not, that's - oh, go ahead.

Woman: Oh no, I mean, we can dive on in. But I was just going to welcome everyone and thank them for joining and I look forward to a very fruitful discussion. As you mentioned earlier, the agenda is pretty tight. So I think we can dive in.

Nicole Williams: Thank you. So our first agenda topic is the environmental scan. And we wanted to quickly recap with the committee our full project scope.

And the scope of this project is to assess the current state of maternal morbidity and mortality measurement and specifically provide recommendations for short and long-term innovative actionable approaches to improving maternal morbidity and mortality measurement.

To do this work we will examine morbidity and mortality separately with maternal morbidity being a primary focus. And the output of our work include an environmental scan which will synthesize information regarding measurement again around morbidity and mortality as well as creating two frameworks.

We will identify existing potential measure concepts and culminate that work with a recommendations report.

To complete our environmental scan, we again wanted to highlight what components of the scan will be included. We plan to review and analyze the peer review literature to assess the prevalence and incidence, outline a standard processes for maternal care delivery and identify gaps where patients could be placed at greater risk.

We will conduct an outcomes assessment that reflects the current outcomes and landscape with respect to mortality readmissions and complications specifically looking at rural communities, access to care, disparities and the

impact of race and implicit bias, highlight innovations and measure methodologies and identify current measure concept and fully developed measures.

Since our last conference call, we thought it was important to share with you all since our last call based on the committee's feedback several changes that we've made to the outline of the environmental scan based on your feedback.

So this first slide here just simply presents the outline from a very high level overview. Much of it is self-explanatory. What we want to focus on in this section is to share with you what we've heard from the committee at our last call and that was really to include more information around race, racism and implicit bias as it impacts morbidity - maternal morbidity and mortality.

So within the slide first, the orange text denotes the changes from the previous scan outline and our intention here is to simply show the group the areas throughout the scan that we would specifically include some more of - some more information related against incidence and prevalence, highlighting those - that data by race, ethnicity, geographic area and also comparing it to other countries.

We also would be including many influencing factors within the outcomes assessment portion of the environmental scan. And within that section of the scan we'll have an ability to build more of a narrative around what those influencing factors are but felt that was the best placement to include more language around again the impact of race, racism, implicit bias, geography, including rural communities.

I'm going to pause for a second and just open it up for any questions or comments.

Girma Alemu: Yes. This is Girma from HRSA. Thank you. On Slide 16 and 17, is there any thinking that speaks to the socioeconomic factor? I see of course, you know, geographies. Rural is very important for us. But what about the general socioeconomic factors?

Nicole Williams: Thank you, Girma. We will include that as well that our intention wasn't to admit it but we will make sure that that's included.

Girma Alemu: Thank you.

Nicole Williams: Any other comments from other committee members?

Eugene Declercq: This is Gene Declercq. Just one on outcomes assessment. The reference through morbidity outcomes seems to presume everything is postpartum. Are we also looking at morbidities during pregnancy?

Nicole Williams: Yes that is a great comment. We are planning to look at morbidity during pregnancy.

Mary-Ann Etiebet: Hi. This is Mary-Ann from Merck for Mothers. Just related to that and thinking about where the temporal endpoints would be of our definition and, you know, how we think about long-term morbidity and including that, over.

Nicole Williams: Absolutely. Thank you for that. And that will - we may circle back to that comment when we review the Definition section.

I'd also like to request if you are not talking if you could place your line on mute. We're getting a little feedback.

Beth Ann Clayton: Hi.

Nicole Williams: Go ahead.

Beth Ann Clayton: Hello. It's Beth Clayton. I had…

Marsha Smith: Hi. This is…

((Crosstalk))

Marsha Smith: …from CMS.

Nicole Williams: Thank you, Marsha, for announcing yourself. Beth, you can continue with your comment.

Beth Ann Clayton: Sorry. When we're adding - looking at socioeconomic factors, some of the research that has been done so far regarding race and ethnicity has demonstrated that it's irregardless of educational level. And I'm just wondering if we want to further explore the education piece because I think sometimes people assume it's something that goes with education is lack of education can place them but actually so far been shown that that hasn't been the case.

Nicole Williams: That's an excellent point.

Dr. Elizabeth Howell: This is Liz Howell and I'm so sorry I missed Mary-Ann's comment just because of the background noise. Could she repeat it or could you guys repeat that? So that's two comments ago. I just wanted to hear that.

Nicole Williams: Mary-Ann, do you mind repeating your comment?

Mary-Ann Etiebet: Sure. This was a follow-up around - I think we have more discussion to do defining what the temporal points of the morbidity definition would be, how long postpartum, how do we think about transitory versus long-term morbidity impact, over.

Dr. Elizabeth Howell: Great, thank you.

Tiffany Willis: This is Tiffany Willis. I was just curious if under mortality influencing factors if we're considering mental health related factors like suicide.

Dawn Godbolt: Silence on the line.

Nicole Williams: This is Nicole at NQF. Yes within our original scope we did have mental health included. And so thank you for making that suggestion as an addition to that particular section.

Tiffany Willis: Okay, great.

Nicole Williams: Do we have - Dawn, do you have a comment?

Dawn Godbolt: Yes, I'm sorry. I was just commenting at the line continues to fade in and out.

Nicole Williams: Oh.

Dawn Godbolt: It's difficult to follow the conversation.

Nicole Williams: Okay. Noted. Apologize for any system issues you're experiencing.

((Crosstalk))

Woman: I just want to know if that commenting that other people are having issues because it's clear on my end. I just want to know.

Woman: No. People…

Woman: No. I'm not having any.

Woman: …come in and off, yes. I'm having it.

Tami Funk: In this case, it's Tami, do we have people that logged off and just logged back in or…

Woman: It's an option.

Nicole Williams: That is an option if folks are having some issues.

Woman: Yes.

Dawn Godbolt: Okay. Thank you.

Nicole Williams: Sorry about that.

Were there any additional comments to the revised environmental scan outline specific to the sections we highlighted?

Debra Bingham: So this is Debra Bingham. We had a robust discussion last time about the whole aspect around respectful, dignity, Congressional, all of those elements that are softer to measure. And so maybe a little beyond the committee but I didn't want to lose that conversation and I think it would be important to

know where we can move this major key aspect of, you know, how we better support women. So it's not just tracking illness, not so much in illness frame but also looking at how in general we support healthy pregnancies as well to present morbidities.

Anyway I think - I'm still struggling what's the best way to word it. So maybe others can help me with that. But I think that whole idea around how do we measure respect at a minimum within the system and we talked about, you know, some of the ways - some of the data that is available through (unintelligible) and other sources. So I would - we don't want to - would at least like to try to look into that component where we elevate women's experiences around dignity and respect.

Erica Taylor: Hi. Hello?

Nicole Williams: Yes, go ahead.

Erica Taylor: Hi. This is Erica Taylor. I'm wondering - I have a question around the comparison to other high-income countries. Are you making considerations for having comparable countries that have significant amount of diversity in their population as well - and not just about high income but the mixing who's in, who's out kind of combination that we may have here in the states so that we get as close to kind of this comparable in those kinds of ways?

Woman: Yes it speaks to the universality of other countries' approaches among other things.

Nicole Williams: Hi, Erica. Thank you for that comment. This is Nicole Williams. We are accepting public comments at the end of the call. So if you don't mind holding your comments to the end.

Erica Taylor: Will do, thanks.

Nicole Williams: All right. Thank you everyone. Oh, go ahead.

Mary-Ann Etiebet: Sorry this is Mary-Ann from Merck for Mothers again. We had also had a conversation around looking at this in ways that we can work with pairs, you know, to drive change and transformation. And so as I'm looking at the outcomes assessment, will there also be the scan that's looking at impacts on cost?

And also from a quality of life perspective from a life force perspective impact on quality of life, impact on other potential comorbidities, over.

Nicole Williams: Thank you, Mary-Ann. We will talk a little bit more about that in more of the background of the scan. We also - just keeping in mind we do have our frameworks that will be the next component that we'll go through with the committees later on in the project. And so it will be important - or we'll be looking to the group to help us understand how cost could be integrated within the bigger framework of addressing morbidity and mortality as well.

Mary-Ann Etiebet: Thank you.

Joia Crear-Perry: This is Joia and I've been relatively quiet because I missed the last call. I don't - trying to get a sense of what's going on but this is a scan you're going to do with what's already currently out there, right?

Nicole Williams: Yes, that's right, Joia.

Joia Crear-Perry: Okay. So another thing on the respectful care idea even though I'm trying not to talk much about it, you could scan what's happening with implicit bias and measures around that and where we are so we can have a base for what we would need to build on to build some more evidence around how people are treated and healthcare system impacts outcomes for morbidity and mortality.

I don't know where that would fit but it's an important part of the conversation especially when we're talking about race and ethnic differences and even in the sense of looking at high-income countries. It's not just that they have different populations in them but that how the countries that have monolithic populations also support things like universal healthcare systems and public education, free college.

So just thinking about as we frame the work that we're moving forward for maternal health in the context of how people are treated based upon their gender or their class or their geography or their race.

Nicole Williams: Yes, very important. Thank you. I think, you know, our goal, which the committee is doing, is to hear from you all and get the input on what needs to be included. And once we begin to flush out the scan more, there will be opportunities to figure out exactly where it makes sense to place certain things related to like what you just mentioned on implicit bias just as an example. So thank you for that feedback.

Joia Crear-Perry: Thank you.

Nicole Williams: Any additional comments before we move on?

Okay. The next section of the scan we wanted to talk through was the standards of maternal care. And this first slide just simply highlights what

we've shared already but just again show you all with one of the specific objectives of the scan was to outline the standard processes for maternal care delivery and to identify gaps.

And so what we've done as staff is to specifically bring some questions to the group on how to not just identify the standard processes in maternal care but really begin to - how do we begin to unpack it and flush it out even more.

And so these are questions to spark discussion. We are using these just as a tool for that. And if the committee certainly has any comments or other questions they'd like to pose to the group to help think about this, we welcome that as well.

So our first question on this slide is, how best do we assess the standard processes for maternal care delivery? And that could mean either sharing resources, again thoughts on how to address it.

Emily Briggs: This is Emily Briggs. So we have across the nation varying awareness of standardized maternal care delivery. And so one of the ways to assess that standard process first would be to identify which states have more robust and well-defined standards as far as a designation process, for instance, for facilities whether that's a level of care - levels of maternal care - maternity care established versus even the - some have been to Level 0 care, meaning centers and facilities that are not a Level 1 as defined by ACOG.

And so I guess where we need to start is even to have a definition or a - an awareness of what states are doing that at the higher level and maybe be able to share best practices with other states.

Dr. Audra Meadows: This is Audra Meadows. I want to just get your name of who was just making that comment.

Emily Briggs: Sorry I've said it at the beginning but I might have cut out, Emily Briggs.

Dr. Audra Meadows: Emily Briggs, sorry. Thanks, Emily. I was just making a note and also wanted to comment and ask a question if anyone on the call from the - from CDC is on that works in the maternal level of care project because that might be a way that we could think about looking for the definition and standard definitions for levels of maternity care facilities in terms of standard processes around acceptance and care for level of maternal care and then also probably looking at that including levels of neonatal care within that which is you've included in the definition. But just wanted to know if anyone from CDC is…

Wanda Barfield: Yes. Yes. Hi. Hi, this is Wanda Barfield. Can you hear me?

Hello?

Dr. Audra Meadows: Yes we can. Thanks.

Wanda Barfield: Okay. So yes. So one resource is Guidelines for Perinatal Care, the 8th Edition, which has both maternal levels of care as well as neonatal levels of care and talks about, you know, facility capabilities by level.

But I guess when the question was raised, I was wondering about sort of the broader process. So for example when we look at the standards for infant care, we know pretty much what is the body of, you know, sort of assessment that's done, say, for example, at the, you know, two-month visit. And the question is, do we have a process for maternal care that's standardized?

Now we do have what I call Bright Futures for Women currently but the question is, how consistently is it being used in terms of maternal care? And then I think another question which I'm sure many have discussed in this audience and that is, in the postpartum period, is that adequate?

Kay Johnson: This is Kay. Thank you, Wanda. That was helpful. So to me and I assume into the NQF staff, this is Kay Johnson, so I think in some way putting a few more qualifiers even into your question and obviously into your reporting - your exploration, your reporting of them because a lot of what we've just been talking about -- and Wanda's comment points to it -- is what happens inside the birth facility, what happens inside the hospital. You know, it's not that we're necessarily talking about, you know, we just have those rough guide measures around quantity and timing of both the prenatal and the postpartum visit.

So, you know, in some way segmenting out those three things and making clear, you know, where we have good standards and where we don't I think that's, you know, helping in the scan to think about, you know, that our - where our standards or our measurement systems only allow us to get at, you know, again the number and timing of prenatal visits, the number and timing of postpartum visits and not satisfactory results on postpartum.

But, well, the - what happens in the birth facility is so important I don't think we can allow ourselves to overlook how important the other elements are as well.

Kimberly Gregory: So this is Kim Gregory and I echo that and that it's one thing to be certified at certain level but even though, like, let's say we all know that the nurses have a standard and I'm going to say A1 because I don't know exactly what standard they're using but, you know, they're supposed to be monitored

every 30 minutes in latent phase and every 15 minutes in active phase and every 5 minutes during pushing.

You know, we can probably assume that that's happening because those are the rules but to what extent do they respond to changes, what are the standard processes that mitigate something happening and we know that when we start to put processes in place we make a difference out of the toolkits for hemorrhage. We've seen hemorrhage rates - not necessarily hemorrhage rates go down but the response is better.

When we started saying that, you know, when you get hypertension, you have to treat it in 30 minutes. We started to see a difference. So to me those are the processes that I'm more concerned about rather - I mean, although I think the certification process is important. But I want to know what are the standards that are happening, you know, at the bedside that makes a difference.

Kate Menard: This is Kate Menard. I just want to jump on to what Dr. Barfield described. You know, I think the guidelines are a really good place to start in this. But it's really just the place to start. And I think our next question is where the gaps and if we study the guidelines and think about where the gaps are we'll be able to flush out many other things that Dr. Gregory has described and things like that and find the things that we really kind of need to ensure safe maternity care.

There's a good resource on the CDC Web site related to the Locate tool which is a self-assessment that many states have done statewide to do - to identify, you know, self-assessment with respect to levels of neonatal care and levels of maternal care and it's on the Web site as to what states have participated in that.

But that's not a certification thing. That's just really a conversation starter. It's the way the CDC folks describe that.

We did do a (unintelligible) of - with a colleague of mine in conjunction with a lot of people from public health that a (unintelligible) of states to find out whether they had maternal level characteristics written into their state regulations and that's now probably 18 months old but it's published and available and - but the number of states that have actually done certification for levels of maternal care is few.

You know, Texas is deep into that right now but then - and a couple of other states have passed laws planning to do that. But it's really just a handful of states at this point.

Dr. Elliott Main: Hi, this is Elliott Main. In terms of safety bundles, I think we do have a fair amount of evidence as Kim was talking about for hemorrhage and hypertension. And those are now also being observed by the joint commission. So those are becoming standards for accreditation for the 85% members of the joint commission.

And there are a few of those that are really critical like timely treatment of severe hypertension. The - you know, I think we all agree that there's an importance of the care before the hospital and after the hospital and opportunities for improvement there. But that area has been incredibly difficult to get data on.

It's very hard to even get the postpartum visit data in HEDIS to get that done accurately. So I love to have some standards there but I think we have to be

mindful about whether it's collectible. And that's the challenge throughout a lot of the areas that we work in.

You know, one of the things maybe, you know, that we have to have new data sources.

Dr. Audra Meadows: This is Audra Meadows again. And so for those that have just recently commented, I want to appreciate the comments. I wanted to ask a question in respond from that is, you know, Dr. Main, you also mentioned measures we have in some of the safety bundles as well.

And so when you think about standard processes, it's one thing to talk about the standard level of maternal care based on the hospital type and what is expected that even within each of those hospital systems the care that's carried out in terms of standardization of maternal care and then getting - taking it further, thinking about measurement, do we feel that the process measures that are listed in the safety bundles are a great place to start and do you think that they missed the mark?

Do you think that they're decently comprehensive of where we stand right now to help us start to look at some of the gaps because that's what I would think of as some of the way to begin to measure the standardization care and that is looking at not necessarily the outcome measure particularly like the broader focus of the actual frameworks are but the actual process measures that are in place in possibly some of the structural measures that they somewhat overlap with the process measures.

Dr. Elliott Main: This is Elliott Main again. As you suspect, you may know the process measures generally tell the story. However process measures are typically the most painful to collect. And so they're typically done in the midst of a QI

project and then done only episodically afterwards. So the best we might get for, let's say, joint commission standards is, are you doing checks on your timely treatment? Not through percent but are you collecting it? It's about the level of data that might be replicable but there's no dataset that gets that reproducibly currently.

Dr. Audra Meadows: Okay. Thank you.

Joia Crear-Perry: Hey, this is Joia. I'm building on all of that is that what has happened since those joint commission recommendations it's possible they're starting to actually do think that they didn't do before. I want - I would hope that this committee would think of our recommendations and the scan is not what we can do but what we want people to start doing.

And so you pointed out what other data sources that people start to have to do. When you start asking for and saying it's quality to look at pre-partum and postpartum, magically people start doing it.

So I hope in the scans you will see that all the things that everybody graciously listed up to you as a staff here at NQF and then also the opportunities that we would have in looking for postpartum measures and other things that don't exist yet.

Beth Ann Clayton: When we're talking - it's Beth Clayton. When we're talking about measurement to the protocols, what we really need to do is have a tool for measurement and adherence. So what's the adherence to the protocol and are people following it which, as Dr. Main mentioned, I don't believe on a large scale we're capturing that data.

The joint commission we're going to be looking at are the protocols in place. But I don't think it's going to allow us to know whether the protocol is actually being followed and what's the barriers if they aren't being followed.

So that may be a measurement piece that we would want to look at in some way.

Dr. Audra Meadows: I appreciate that comment. You know, make sure I heard it correctly too because that was interesting. So you're saying you're thinking of tools to measure adherence to protocol more so than just the details within each of the protocol that may be more difficult and you want to collect that. Am I hearing you correctly?

Woman: Yes.

Dr. Audra Meadows: Okay.

Woman: I think looking at this is the protocol and are we adhering to the steps that, you know, we're in within the protocol. And if we're not, why is that? Is it resources? And what are the resources we're missing or the ability to follow?

The joint commission with the new requirements is a fabulous first step by making sure that these things are in place. But then the next step is, are we actually following them?

Dr. Audra Meadows: Thank you.

Emily Briggs: This is Emily Briggs again. I think it's - this is excellent. Moving forward though I think we do need to recognize that as I alluded to at the beginning when I commented before that our states are at different places in this process.

So having the joint commission set that standard and then having the next step be to then evaluate the adherence to those standards, we have states that are not get implemented - that are in the infancy of implementing those standards that haven't yet come together as a state. Maybe facilities within their state are implementing those but we - but not necessarily statewide.

And so just recognizing that the scan might need to also view where states are or however it needs to be broken down but that might be an appropriate way to break it down where certain states are - that way the states that have come along a little bit more robustly already might be able to support those states with best practices of how they move other facility, move their own facilities through that process and help the states that have not yet gotten that to that place.

Wanda Barfield: Hi, this is Wanda Barfield. Just a point of clarification to what you just said, are we just focused on inpatients or are we also talking about outpatient in terms of care and standards?

LaQuandra Nesbitt: Wanda, I'm not - I didn't make any of the previous questions but I - this is LaQuandra Nesbitt. I would like to make an argument for it to be across the care continuum because part of the challenge that we have is that a lot of the care that gets received is not in a health system environment. A lot of the care that is received happens in a outpatient setting and the only action that occurs in an inpatient environment is the delivery.

So for us to really be able to assess the - contributed to the patient outcomes is to have it - have us be looking at standards and metrics across the care continuum.

Wanda Barfield: Thank you.

Michael Currie: This is Mike Currie from UnitedHealthcare. I would echo and second that. And as I'm listening to the conversation, the one thing I'm thinking about and I share this with you all to see if you all share the same feeling or you have a different thought is the one thing that's universal across inpatient, outpatient and all the settings is the fact that people want to get paid and you submit claims to get paid.

So how can we leverage the claims payment process to measure and monitor adherence or compliance with protocols or whatever it is we want to measure adherence to, either they currently exist or leverage this body to bring forward innovative recommendation, something that maybe doesn't exist but should be developed as tied to the claims payment process that we know as universal.

Debra Bingham: So this is Debra Bingham. Related to the previous comments, I think one of the sort of more macro questions around data is what data are actually available for people that act within or to a review or be aware of. So in that scan, identifying what's being released by the Department of Health and what are hospitals doing or any birthing facilities frankly or clinics, what kind of data are they routinely capturing and measuring.

So I - that gets to that whole idea of, like, not only addressing the current problems but how do we move forward so that we are able to track and identify new emerging issues like, for example, when we had the - all of the women who died from the flu epidemic back in 2010, we really struggled with having a way to accurately capture those data across the state where using really pretty archaic data systems to track that.

So there may be new emerging issues that we need to be able to actively work collectively both at the facility as well as at the state level and there's a quite a

few states that have done a lot of work to build their capacity in this regard and their data capacity what they're releasing and what they're monitoring. But I - we're a long way from having that be where it needs to be.

So I think having a scan to kind of point out what those data limitations and what the idea would be I think would be very helpful.

Susan Yendro: Hi, this is Sue Yendro from the joint commission. And I would also tack on to that would be in terms of scanning what's coming from the electronic capture of data through electronic health records or through standards, through HL7 work and what kind of processes need to be laid down in advance of measurement in order to have that data to be able to be captured electronically and through the natural workflow that clinicians - through their documentation and so forth, much along the same lines of the comments about the claims process so that you have things that are organically documented and in place that can capture the data.

Deborah Kilday: This is Deb Kilday. Can I jump in here? The - I just wanted to echo many of the comments made around delineating the difference between process on the internal or on the hospital level versus the pre-delivery, the post-delivery period. The delivery period process is maybe a little easier to define and measure. Those on the outpatient side maybe a little bit harder. So we need to be very clear about what the standard process definition may be because I know that, you know, providers particularly cause the continuum and so do our patients and they need to understand what those processes that'll be measured will be.

In terms of hospital-specific processes, my thoughts are, just to echo what Susan just mentioned, is try to identify sort of that very visceral level of what comes out of documentation that makes it very reliable for the clinicians, the

hospitals and others to follow. And then making that data more reliable, find what those outcome measures should be in a way that is easy to capture for those hospitals, easy to capture for those providers.

So again I'm just going to circle back and echo what everyone said but that bullet point of how best do we assess standard processes for maternal care delivery is so broad that I can probably sit here and list out about 50 bullets that might help but it would cross the continuum of care which has been stated.

Nicole Williams: Thank you. Any additional comments or thoughts about the definitions of standardization of care, standard processes?

Girma Alemu: Hi, this is Girma. I just want to say it before. I think it's very important to look for care coordination. As said, you know, continuum of care from outpatient to inpatient and also from inpatient to outpatient. You know, there's (unintelligible) to the topic we are talking.

It's very important to - at least to find measure concepts or, you know, data supporting, you know, the care coordination and I think that needs to be an important point.

Katrina Nardini: This is Katrina Nardini. The other thing I - since we keep talking about systems and hospitals just as a reminder too that not all birth and/or maternal care delivery is happening in the hospital setting but also in community setting, so freestanding birth centers as well and women's homes. So just a reminder that while it's not a huge percentage in the US, I think it's important that we also try and think about ways that we may be able to capture some of that data which I think is even - maybe even harder to capture but just a reminder of that as well.

Kate Menard: This is Kate Menard. Just related to that comment about birth settings, I think choice in maternity providers is also an important thing to keep on our radar, you know, particularly, you know, access to (unintelligible) option in rural areas, family physicians that have privileges and are able to practice in rural hospitals, those sorts of things on a broader radar for standards.

Charlene Collier: Hi. This is Charlene Collier. I've spent my whole morning reviewing maternal records for our mortality review and I can say that one thing I can't walk away from is did the mom get good care and did anyone listen to her complaints. And there's lots of record that have many checkboxes that get checked off at every visit. You can tell that's generated within EHR. It's made for efficiency. Certainly it captures the diagnostic codes but the connection between a maternal complaint and what happened in the visit and then was it reheard or responded to. It's actually really hard to just pull from a lot of different records. And these are records across different health systems that I'm kind of soaked in and I walk away just saying, "I just have to talk to someone," because I can't tell at all did the mom get good care although there are abundance of records.

So I guess I'm just saying that to say there may need to be new defining of how things are recorded and making a connection between hearing moms' complaints and that they are responded to and a bit more subjective notes in records because I think the move within EHRs is - and efficiency then I certainly suffer from that too having to complete that for patients and having things be automated is nice but there's definitely a loss of what was really happening for women.

And so I fear a little bit depending upon just data point center easily click for medical records because I don't know that they capture good care. So let's just…

Emily Briggs: This is Emily Briggs.

Woman: Thank you for that…

Emily Briggs: I just really like to…

Woman: …comment. Thank you.

Woman: I would like to highlight that because that's so very point end. We use EHRs as EBRs. That's electronic billing records. We're not really using them to describe the continuity relationship between a physician and the mother. And so using those records while for efficiency we can use those records, the coding and all of that to be able to more quickly get an idea for the care that was provided, we definitely cannot use those EBRs to describe the continuity relationship. And so yes we definitely need a different way of assessing that component of whether a mother was listened to.

Man: This goes…

Timoria McQueen Saba: Hi everyone. Hello?

Woman: Hello?

Timoria McQueen Saba: Hi. This is Timoria. I have to go soon. So I would just like a few minutes to make a couple of comments if that's okay with everyone.

So the very first thing is as the only patient advocate in this group and the co-chair of this group, I just feel it's really important again to venture the patient voice when we're having these conversations. So I've got that for the last hour and taken a lot in.

One of the things that makes me super uncomfortable is labeling - and I know whoever made this comment just now that means it sort of label it as a complaint. But I think it's how we frame a mother's experience. And if we use language like complaint, it already has a negative connotation.

So I think when we talk about this, it's really important to use a mother's lived experience. How can we capture a person's lived experience with their healthcare providers through the perinatal period? And I think if we start to look at it more of that type of a question as, you know, then we're going to come out obviously with positive and negative.

But, you know, when we use the word "complaint," we're already, you know, we're already putting the patient in a certain way. We're already saying - kind of just inside there's this, "Here we go again," whereas what is this person's lived experience. It's more of an open-ended way to have and to allow people to have conversations about what actually happened to them.

The other thing is how can we actually capture the patient's perspective. So when we report they're filed, whose perspective are we getting, you know? If they're filed in a hospital, how are we really getting the patient's perspective on what the care was? How can we make sure that the patient experience isn't tainted or, you know, misjudged or misreported? It has to be a two-way street.

The other thing in terms of, you know, second question, I'm actually in my car, so I don't have it in front of me right now, the gap in standard of care I'm really surprised that I haven't heard education come up. You know, to me, the lack of education particularly in terms of cultural competency and bias and, you know, education at LGBTQ, all these different things that, you know, are very prevalent, these physicians aren't being educated while they're in training to take care of people. So I think that's a really important piece that we need to look at as well.

In terms of postpartum mood disorders, I don't know how many of you know my story. Ten years ago I had a postpartum hemorrhage and was diagnosed with PTSD, yada, yada, yada, now I'm a maternal health advocate. So just wanted to give you the quick background for those of you who weren't on the last call.

You know, in terms of looking at the education piece, for those of you who are in California, I'm sure you're aware of the Senate Bill 464, Assembly Bill 241, which is, you know, going to require that org to certify physicians required and to take, you know, racism and - anti-racism, anti-discrimination education.

So it's really surprising to me that we have not really talked about this, that this is not - this is really a core issue. How do we learn anything in life without an education? You know, this is really a big piece of everything that we want to accomplish here and it all begins there.

Last conversation we talked about bundles, right? So yes, all - there's resources there, right, for hemorrhage and hypertension. Why aren't people incentivized to use that? And remember - I don't know how many of you remember the last conversation I specifically said over the summer when I

was at the Council on Patient Safety Meeting at that AIM Conference, only 8% of the hospitals participating in AIM are implementing the racism and implicit bias bundle. And we have to face the facts here.

If people aren't going to be incentivized to implement things that don't pertain to them or they don't perceive pertain to them that aren't important to them, so what is going to be the incentive to make this important for people? And for some people, it's just not going to be.

So then you have to think outside of the box a little bit. As a patient sitting here listening to the conversation, it's - I hear the same things over and over again. What I'm not hearing is, you know, sort of anything really where we're taking a leap here and saying, "How can we be different?" because whatever has been working is actually not - as we can see, whatever that has been tried before, excuse me, is not working.

So what can be the change, you know, and, you know, I don't really think a lot of this is actually hard. I keep hearing the word, "Well it's going to be hard to gather the status." It's about what you want to do and how you want to go about doing it and creating a plan that can work for different types of communities, whether they're - no matter what their race, their socioeconomic but that does involve work.

So when I hear the word "hard," to me it's already sort of giving up. So in listening to the language of the call, I'm really concerned for - so there's a lot of, you know, there's good ideas but then there's also, like, "Well I don't know, you know, that might be hard." And as a patient who's actually lived through that, it's not only what I want to hear providers saying.

So I just have to put that all out on the table. I'm done.

Dr. Audra Meadows: Thanks, Timoria. I also wanted to ask others out there who are patient reps on our committee. Maybe even Katie Barrett is thought to…

Timoria McQueen Saba: Oh, yes that's right. I'm sorry I forgot that Katie - I apologize. I forgot that Katie is also a patient rep.

Katherine Barrett: It's okay, Timoria. You do a really good job of representing us.

Timoria McQueen Saba: Well I try.

Katherine Barrett: No, I very much agree with Timoria's reaction to kind of, you know, folks saying, "It's hard," or like really focusing on, you know, the challenges of data collection and things like that. It's, you know, it's - I think we are here to drive to focus the conversation on why we need to do this as opposed to, you know, kind of dwelling on how far we'll be able to do this. Yes, it will be very hard to do. I'm totally aware of that.

But, you know, here to continue to try to push the conversation forward to say, "This is the kind of information that we need to collapse." You know, Timoria had a hemorrhage. I had a hemorrhage. You know, a lot of us are here because of the great quality improvement efforts that the facilities that we've received at but it's not nearly enough.

And so, you know, I agree with everything she said and thanks for calling me out, Audra.

Dr. Elliott Main: This is Elliott. I'd like to go back to the beginning comment that Joia made and I think that's a direction that really should be supported which is the Patient Experience survey as that looks at dignity, respect, trust, where you

listen to, where you treat it with kindness, all those things should be true for every woman in the care continuum and that can be done, outpatient as well as inpatient. It's something that's restricted to one care setting. You know, we're helping on that process in California and I think that's going to be - could well be an important piece of this process.

Amanda Williams: Hi, it's Amanda Williams from Kaiser. As we look at our gaps, I do want to highlight Timoria's comments on the two new bills - two new laws now in California around implicit bias training.

As she said, people - many healthcare providers will assume that this is not applied to that. And they are not going to voluntarily do this deep internal work but it's our internal work that allows us to be healthcare, you know, mindful, culturally humble providers.

So I think an important part when we look at our gap analysis is what are we doing with our legislative partners in order to move some of this education forward.

And then also my own organization is working with GME for residency not just in OB-GYN but across the spectrum on bias training so that trainees, medical trainees can get some of this in their training before they start regularly seeing patients.

Joia Crear-Perry: Hey, this is Joia in NQF team. I think you're in the middle of an evolution of a conversation that we've been having in the maternal health world for the last few years and you're hearing kinds of our own evolution as a body of people. I mean, one of them is that, A, we learned that we couldn't just focus on hospitals and data came back and showed that that was - where the dash happened only.

And so you're hearing us say - asking when you look at the scan and look for things that are happening outside of inpatient (unintelligible) delivery system because we're only doing things in network.

B, you're also hearing that we - data showed us that even when you do bundles, if you're not working on racism, classism, if you're going to still have poor outcome and you'll see worsening actually in the outcomes. And so when you do the scan you're going to see that and what we need and what I get - I get pushed back to the person who does and as organization who does (unintelligible) and anti-racism (unintelligible) and all that stuff, if people keep telling us "We need more data" that it works.

So I'm suggesting that if NQF said that it's something necessary, in addition to the fact that California - the state of California is saying that "We do a lot of things and we don't have data for it including prenatal care," but that we would like to see that via evidence-based for something to move forward, it will be nice to see "You won't help us with that," then we can build on that as a country that we're clear that those biases don't just come that we're not born with them every year. You see them in our media. We see them in our law. We see them across not just in healthcare but all the way that we think the value groups of people and the world.

So anyway. So I just think you're hearing kind of the pushback of not lifting to the Timoria's of the world, of not - wanted to change how we educate not only medical students but people who are chairs of departments. We're using my (unintelligible) and everything and they don't need any - they don't have any biases.

So, you know, a lot of opportunities to work across all those things. So welcome to our world. Thank you all for coming.

((Crosstalk))

Mary-Ann Etiebet: Thanks, Joia. This is Mary-Ann Etiebet from Merck for Mothers. I just wanted to follow up on another opportunity to include - better include lived experiences. So I believe this is coming out of (Lynn Friedman's) group at (unintelligible) University survey on these issues which were actually integrated into the New York City Department of Health and Mental Hygiene's PRAM survey. My understanding is that they were also in talks with CDC and maybe other agencies distinct about how that could be integrated into more PRAM surveys. I don't know where the status of those talks are right now but another kind of institutional way to collect data on this important issue, over.

Wanda Barfield: Yes, hi, this is Wanda Barfield. Yes we're - we are now exploring those questions around respectful care. Thank you for raising that issue and I think just to go back to what Timoria was saying, I think, you know, we really do need to hear from women. And so using the approach of survey is going to be important. But I think we're also going to need to think about how this information is rapidly sent back to communities so that action can be taken whether that is in training or practice, changes to really make a difference.

I think I also want to acknowledge Timoria's point about, you know, trying not to be negative. What we really need to think about are those creative approaches. There will be challenges but it's going to charge us to be more creative.

There was mention earlier about measuring process and process measures. It has been successful in other areas. I know in neonatal care we're seeing a lot of opportunities to better measure issues around process to understand disparity. So I think we can do it.

Michael Currie: This is Mike from UnitedHealthcare again. As we think about what we could, should, would do, especially as it relates to moving for adoption, whatever it is we're going to agree on. I don't want to speak for my other managed care organization colleague who's on the call from Kaiser but there's an opportunity to leverage both UnitedHealthcare and/or Kaiser and some sort of pilot to really test and validate whatever this is that this group will come forward with and potentially recommend.

So I'll go ahead and sort of get out in front and put that on the table so we can measure or evaluate the effectiveness of what we're talking about. I'm sure we're going to come up with some really nice things. But if they're not going to be effective and not going to be adopted and implemented across the healthcare system especially as it relates to integrating whatever it is as part of the claims process because that kind of becomes the incentive in the engine to drive some implementation and adoption. But I'm happy to help speaking with UnitedHealthcare. Happy to help on that piece.

The second piece, as it relates to cultural competency and addressing implicit bias, want to just share with the group and I'm sure others have heard this as well. One of the things that we hear because we just launched in November of last year just what we're calling "Advancing HealthEquity education." And we called it that on purpose because when you mention cultural competency, you get some level of kneejerk reaction from some providers when you focus on implicit bias or just call it implicit bias. To Joia's point we get some providers to say, "Look I don't have any bias. I'm good and other providers."

So we put it under the frame of Advancing HealthEquity because it wasn't - I don't want to say it wasn't scary but just didn't drive some of the same kneejerk reaction in some of the other worlds and places used. But that's not the point. The point about making is we have what we have. Joia has what she does.

Quality interaction has what they do and one of the reaction -- or the reaction -- that I've received from a number of providers is, "Tell me which one you want me to do." What is the best-in-class one and that's the one I'll do.

Now other than that they approach it with the right heart and the right frame of mind, you know, we can't really control that.

But as we think about what we're doing -- and I totally agree -- that that kind of cultural confidence, you know, implicit bias, Advancing HealthEquity education in medical - outside of medical school and advanced training is important. If we can think about -- and I'll keep bringing it up -- what is the standardized approach that we can bring forward for adoption or suggestion or something like that so we don't leave providers just sort of wandering around either trying to figure out which one to take or doing some training that we all know is just the checkbox.

Woman: You're here.

Claire Margerison: Hi, this is Claire Margerison. I just wanted to add something which I want to acknowledge that is, you know, there - in terms of priorities, I completely agree with what's been said so far in terms of listening to women and the importance of focus on equity.

But one thing that I haven't heard and I also missed the first call so I don't know quite where it sits but I know that it was mentioned that mental health and suicide would be considered.

And so in terms of gaps in current care, one area that might be worth examining is, you know, the connection between mental health services, psychiatry and other resources for women that are linked to obstetric care or linked to postpartum care. So I think, you know, the sense is that those areas of care are separate and it would be - but I don't know, you know, how much we know about where, you know, are there places where there is a good example of how to link, for example, you know, psychiatric care, social workers to women in the obstetric clinic or, you know, it's that - are there places where it's more likely to be, you know, separate.

So just another thought about something that could be looked at in terms of gaps.

Eugene Declercq: This is Gene Declercq. I'd like to build on that. It seems to me that we're talking about three worlds here that are separate for the most part and they shouldn't be but they are. And if you're going to develop a measure, you may need to grow on people who are expert in those respected world and one which we've talked mostly about is hospital care. And that's fine and that needs to be addressed in trying to come up with a measure of this.

But the second is community healthcare, the outpatient world for which we have much less accurate measurement and much less consistency.

And then the third is - comes from my maternal mortality review committee work which is the social services world because when we look at some of

these cases, the reality is they haven't interacted with them that helped system at all. But they have interacted regularly with the social system.

And if we really want to get a good sense of both what are the nature of morbidities and what are the steps that might need to be taken to address them, then we have to incorporate some elements of the broader social system because honestly when we try to wrestle with the question of, was this particular depth preventable?

Oftentimes it comes down to the question of, (unintelligible) might be preventable. But we don't have one. And so I think in trying to conceptualize how you're going to approach this, you need to have consideration of all three of those elements which ideally should all be related and should all be part of a continuum of care but in reality are not.

Diana Ramos: Hi, this is Diana Ramos. And I just wanted to share that in California, (unintelligible) and CDPH have done that suicide maternal mortality review and we looked at the disparities in terms of ethnicity and interestingly enough the highest incidence was in Asian population.

And going to the speaker who just made a comment, we actually identified opportunities for intervention. So what is it that we need to do as a state to address some of these issues and we definitely had some experts as part of the review committee, mental health experts in terms of reviewing the cases because we knew, as somebody else has commented, that you want to have people who have the experience. So definitely reviewing and coming out with recommendations as to what to do next is a critical piece.

Nicole Williams: This is Nicole Williams. Thank you everyone for your comments thus far. We would like to transition over to the definition section of our call but want to honor any additional comments related to the standards of care.

Okay? So moving on to the definitions for maternal morbidity and mortality, again this - we wanted to present feedback from this survey that was sent out to the committee in helping to shape how - or not shape but to think about some consistent definitions that the group would utilize and certainly have included within our report. So what we did is just presented some of that information in a graphical form to give you an idea of how the group responded to the questions that we posed.

So for this first slide here, we shared a definition on severe maternal morbidity. And the majority of the committee agreed that that would be acceptable working definition for the duration of this project. We also did receive some comments from several members around things to think about when we're talking about severe maternal morbidity. Specifically someone noted that to date, there's not a complete consensus amongst systems and professional organizations on what - as to what conditions should represent severe maternal morbidity. And some other members commented on other things that could be included, different ways to talk about certain terms.

So what we wanted to bring to the group for a discussion was simply thinking about how to define maternal morbidity. This project is - will focus on maternal morbidity overall, not just severe maternal morbidity. And as staff at NQF, we've tried, through our own research and using some of the resources shared by the committee with us, have tried to find just the definition only on maternal morbidity.

There are a few that we've been able to populate. They're usually very general. For example, one definition that we found defines it as any health condition attributed to and/or aggravated by pregnancy and childbirth that has a negative impact on women's well-being. And that's from the World Health Organization.

So wanting to first have the committee give us input on how we define maternal morbidity versus severe maternal morbidity and how we could address morbidity of course more broadly, which you shared a little bit of that in the last conversation as well. So again, I want to open it up for discussion amongst the group.

Dr. Elliott Main: This is Elliott. If you could go back a slide, I think the definition is okay. An impairment, a significant short or long-term consequences to women's health. It's just that severe maternal morbidity is only a piece of that as the CDC has defined it in their 21 conditions. I mean, you could have a third - and fourth-degree lacerations. It has significant issues for short or long term potentially. But that would dominate it. That's 3% or 4% or even a little higher.

So you could have separate measures. One for that, one for the other, potentially. You could have pre-partum mood disorders. That's not in any of these, you know, with the proportion of psychosocial or psychiatric issues that have happened after delivery. So there's a lot of broader things that could go into this but it would fit that definition that you have on the screen.

Kate Menard: This is Kate Menard. I just wanted to echo a comment I see on the slide about comments that the qualifier's unexpected outcomes…

Man: Yes.

Kate Menard: …is I think potentially problematic. You know, if we have women with significant health issues, you know, that are going to experience long and short-term consequences, I think we really need to capture that.

Joia Crear-Perry: This is Joia. I'm pacing back and forth. But I was thinking about why we picked - some of the measures we picked currently are the definition of SMM. And a lot of it is based upon what we can measure with this conversation we had earlier today. So I do like the broadness of the definition for maternal morbidity. And in the hopes that we can then pull data from that entry, what else we should be considered as severe, also leaning on what women, kind of birthing people say is severe to them.

So that's a very different (frame). But that's when you get into the mental health, you know, pre-partum anxiety. We might not view that to be severe but, I don't know, patients might. And so same thing how we think about what we label and who has the authority to label.

Nicole Purnell: This is Nicole Purnell. And I just echo that statement by Joia is that we often say that charm is in the eye of the beholder. And I think that's part of it is going into the - there are different aspects of it in how you classify that in the criteria. So it kind of needs to be a broad definition so that all of those possibilities could be captured but - and not discrediting anything that can happen.

Dr. Elizabeth Howell: This is Liz Howell. I think we need a little more conversation. I think these are all excellent points, you know, especially the point about hearing what women think of as sort of more severe. And I also think we had a conversation in our last call that even the language "severe" didn't necessarily work for many people. And I get that. But it does still feel to me that we are talking things very, very broad right now unless we come up with a way of

narrowing so that the extreme or whatever we're trying to capture here in what was the old term, "severe maternal morbidity" is captured and whether that's around, you know - I don't have the answer but I do feel like we need more conversation around this because what we're talking about right now is really, really broad.

Nicole Williams: This is Nicole again. And part of that is it's hard because coming from a little bit of the experience side of things, also being the patient in the room is that you'll have patients that will - almost going to compare some name of, like, who had worst outcomes or who had the worst experience. And so it really does - the comment like I've been called out for not considering fourth-degree care a morbidity. And it's not necessarily a morbidity in my mind or severe morbidity but the implications of it longer term and the PTSD and the mental health aspect of it that it can contribute to need to be considered. And that's where it's, like, you have to be able to capture things that you might not consider to be severe or really even qualify but they do impact the mom in that way.

Woman: Completely get that. That makes sense.

Woman: Any additional comments from the committee?

Kay Johnson: Hi. This is Kay Johnson. You know, given people's comments about things being quite broad, I'm almost wanting additional comments from NQF to say is there something - is there a smaller question here that we can help you answer because we are pretty far out at a pretty high level?

Nicole Williams: This is Nicole. That's a good question. We are really looking to the committee to help narrow this as they see fit but we - our scope and charge for this project is to look at maternal morbidity. And so again, trying to define

that for the group and understand what that will look like going forward as we flush out more details related to the scan and on the framework.

Woman: So I think this is (unintelligible). So we talked about this concept of - well, one of the questions asked about defining maternal morbidity versus severe maternal morbidity and if we're thinking about the list of 21 and then comparing that with the live course which we had a discussion about before, and I think so much of what happened as a function of being pregnant and women's overall health before they become pregnant, during pregnancy, when you think about the list of 21, for example as it relates to heart health and heart disease and there's so much they're trying to learn or better understand about heart disease and these cardiomyopathies, they may not necessarily be associated with the heart diagnoses that are part of the 21, things that are part of SMM.

And so how do we think about maternal morbidity like no one would disagree that having hypertension as a diagnosis in the general population is part of morbidity. But we don't think about that as maternal morbidity. We only think about if someone has a heart attack or if they have heart failure, what is the implications of gestational hypertension or pregnancy induced hypertension long term because it doesn't resolve in a significant part of the population. So are we thinking about those things, and the same for diabetes in that population, and its long-term effects for the women's overall health in her long-term morbidity.

Because - but for that pregnancy, those conditions may not have occurred.

Kay Johnson: This is Kay Johnson. I think that's very helpful.

Woman: Any other comments or responses to anything that's been said?

Mary-Ann Etiebet: All right. This is Mary-Ann for Merck for Mothers. I'm just wondering, given, you know, the extensive unexpected discussion that we've had around how to capture the experiences, can we add that as a specific goal for the landscape analysis looking outside of the maternal health space to see if this has been done, you know, more effectively in other areas? Over.

Woman: Mary-Ann, are you referring to the example that was made about heart conditions and…

Mary-Ann Etiebet: No, I was actually going back…

Woman: Oh.

Mary-Ann Etiebet: …to the previous conversation and what I took away from that was a real desire by the group to better incorporate and include information data around lived experiences as we're thinking through this definition but also a recognition that we are, you know, moving into, you know, previously uncharted territory within the maternal health space.

So what I wanted to propose is as part of the landscape, you know, analysis that is being done, can we use that as an opportunity to see if in another, you know, field, folks have tried - you know, have answered this question or have made more progress than we have in the space that we can learn from and encapsulate in our thinking? Over.

Woman: Yes. I think that if the committee is aware of another space that has through this through, we are willing to use other examples and understand how that could apply to our scope of work and what we're tasked to do. The other thing I wanted to mention is that what we can do regarding the definition is

certainly mention, for example, severe maternal morbidity as a definition that most of the group agreed on but recognizing that there are many other factors that contribute to how morbidity is defined. And so we can lay that out within the environmental scan or the final recommendations report so that other stakeholders who are not part of this group really have a clear understanding or a clear picture of the different caveats that the committee has talked through.

Mary-Ann Etiebet: Hi. This is Mary-Ann. I don't know if anybody else has comments or points around this but I do think it's been such an important part of the call today and to not at least move us forward around some sort of alignment when we come out of this committee would be a wasted opportunity.

Woman: Any responses to Mary-Ann's comment?

Woman: Sorry. Could she repeat just the last portion of that?

Mary-Ann Etiebet: It's - I mean, the proposal on the table is basically for the environment scan. Do we want to use, you know, do we want to include in an objective of the environmental scan to understand if there is best-in-class, best practice work around how to better integrate lived experiences into these - into how we better measure and define maternal morbidity. Over.

Lekisha Daniel-Robinson: So while we haven't heard a response to that particular proposal on the table, it sounded like the conversation from earlier between, you know, earlier today and our previous conversation that that lived experience is an important component and could potentially help to balance out the more - the other measures. I hesitate to call them like objective but, you know, the other measures that we might be looking at to assess the care and outcomes.

Mary-Ann Etiebet: And this is Mary-Ann. And yes, I totally agree with that. But I also sense a, I don't know, struggle is too strong a term but that there's - we're still not a place where there's consensus around what - how we measure that, what exactly we measure, how broad the scope is. And so can we learn around, you know, if other fields have done this and can we learn from that?

Lekisha Daniel-Robinson: So, you know, for me -- and this is Lekisha speaking -- an unrelated but potentially related discussion has been happening around contraceptive care and thinking about that experience, you know, in relationship to the care received. And so, you know, again I think we should put it on the table for all of the reasons that other committee members have mentioned earlier. I personally think we should put it on and scope it, you know, help to define that scope. Because again, if we aren't going to do it now, it's going to be something that I think we'll just have to do later or someone will have to do later.

Woman: Yes.

Woman: And I think just to support what Lekisha said, the committee has talked about that quite a bit, the lived experience and how that contributes to outcomes. And so our role as staff is to in some ways, figure out the appropriate placement for some of that within, again, within our environmental scan but certainly including it as part of a recommendation as we will have alluded to, which there're not being measurement around that space just yet.

So we will make sure that's highlighted appropriately and looking to the committee to, you now, make sure that that's included.

So we have a little over 15 minutes left. I wanted to also share there are some other definitions and we don't have to go through these in great detail with the

group. But we also presented to the committee definitions around pregnancy related mortality and pregnancy associated mortality. And our - most of the committee members who responded - and we had about 27 people respond, so which was excellent. And so most of the group agreed and were comfortable with accepting our definition that we presented around pregnancy related mortality and then same for pregnancy associated mortality.

What we asked toward the end of those questions were whether you believe we should focus our work on either pregnancy related mortality or pregnancy associated or both. And that response is split between the group. So as you can see on that slide there on - there's a split between pregnancy related and addressing both.

So we wanted to open this up to the group if there were any - if there was any additional feedback around looking at pregnancy related or pregnancy associated or both throughout the scope of the work.

Kay Johnson: This is Kay Johnson. I think because these terms haven't been strictly defined particularly by researchers, I mean there are people who have the clear definitions for them. But a lot of people are using them in less specific, maybe less accurate ways. I think that calls for both.

Woman: I'd agree.

Dr. Elliott Main: This is Elliott. This is an area of current dialogue nationally. The issue is not all pregnancy associated mortality may be something that we want to - the biggest factor is, besides pregnancy related is motor vehicle accidents in most states and then other cancer deaths and other medical causes of death.

I think where I see the opportunity here in something we're working on categorizing - I wouldn't change the definition because these are picks by the CDC and we're trying to make them standardized in the literature. But you could have pregnancy associated substance use death and pregnancy associated suicides. Because the trouble with pregnancy related for both of those categories is, and I term Maternal Mortality Review Committee, it's very hard to tell what's related and what's not as you get 6, 9, 11 months out for suicides or for substance use.

Nonetheless, those are all important causes and, you know, we want to count all the women. So I would focus on pregnancy related deaths and pregnancy associated suicides and pregnancy associated substance use deaths, would be my recommendation.

Woman: Ellie, isn't there a discussion though to not classify those, you know, those deaths only to not - no longer use the term "pregnancy associated" just for those because sometimes they are related?

Dr. Elliott Main: Well, it's - but different committees and different people had different judgments about what's related and what's not. So it gets messy real quickly. So I would put them into a single category. If you have a suicide, you know, in most - we just did a big suicide review in California. Eighty percent of the suicides happened after 42 days. So they're all in late postpartum period, most all of them. And likewise, most substance use happened - deaths happened after 60 days.

And so it's - you get into a very messy area in terms of judgment. And different committees are coming up with very different approaches to it. So it's again very messy to try and have that as the number.

((Crosstalk))

Dr. Elliott Main: So that's our recommendation, is that we look at all the suicides, all the deaths from suicides, all the deaths from substance use and all the pregnancy related deaths, as classically defined.

Angela Anderson: This is Angela Anderson. I actually voted for both. And just for that reason because in our state, 45% of our maternal deaths were suicide or overdose. And so I was concerned that we might actually be capturing those deaths if we just looked at one or the other.

Claire Margerison: Hi, this is Claire Margerison again. I wanted to ask and maybe Dr. Main can speak to this or clarify what your thoughts are on homicide. If, you know, if suicide is going to be included, is there a justification for not including homicide? And I'm thinking specifically about - well, I'm thinking about the recent study that came out showing - I'm looking at it right now, showing homicide during pregnancy being, you know, a large contributor to pregnancy associated deaths. And this was just in Louisiana, so my sense is there's probably a lot of geographic variation.

Man: There's…

Claire Margerison: And then, you know, that kind of just makes me think about domestic violence and what, you know, what's the relationship and what makes, you know, things in or out.

So I just wanted to hear your thoughts on that. Thanks.

Dr. Elliott Main: So there is huge variation state to state. For example in California, suicide is only 4% of pregnancy associated deaths and homicide is about the same.

What it reflects is what are the causes of death in reproductive age women who were not pregnant and if that cause of death is high in that category, like substance use, it's going to be high in the post - in the pregnancy associated delayed period of time.

So it's reflective of bigger issues in women's health, which is important, but is it related to pregnancy is the issue at hand. But there is huge variation in homicide around the country whether you're pregnant or not.

Wanda Barfield: Hi. This is Wanda Barfield. I think you're all raising really good points and, you know, at CDC, the National Violent Death Review System also looks at those deaths related to homicide. And I think Elliott's point is well taken. And there have been studies, one by Angela Nannini that had shown how issues with regard to, you know, when we talk about sort of morbidity, ER admission for abuse of women varies by trimester pregnancy. And so we saw a higher rate in the postpartum period once the pregnancy had ended.

Nicole Williams: This is Nicole. So thank you everyone for your feedback. It sounds like for now, the committee agrees with keeping those pregnancy related and pregnancy associated for many of the reasons that you stated.

I would like to - it's 3:50, so I'd like to open it up for any public comments that we - comments from our audience or public.

Okay. Next steps. I am going to turn it over to Hannah.

Hannah Ingber: Thanks, Nicole. So just as a small reminder, our next Web meeting will be on May 27 from noon to 2:00 pm, Eastern Time. We'll be reviewing our work on the draft environmental scan at that point moving forward. And we'll be

looking for your input on that. Please also watch out for e-mails from our team regarding more details for the next steps.

Nicole Williams: And again this Nicole. I do want to thank this committee for a really amazing discussion. You all have given us a lot of really great information and our job - we now have the hard part of collating that, unpacking it and flushing out the details that you shared with us to begin to further build out the environmental scan. So as Hannah just said, please watch for e-mails from us as we want to share some early drafts with you prior to our May 27th call to give you ample time to review that and comment. And so that way we can use that Web Meeting 3 in May to discuss some of the key issues that arise as members provide comments from the scan.

Any final comments either from the committee members, co-chairs?

Woman: I just want to say it's a really great conversation and I really appreciate all the additional insights moving forward with the work. Thank you.

Nicole Williams: Thank you. All right. Thank you everyone. Have a great afternoon.

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