NATIONAL QUALITY FORUM

Moderator: Kim Patterson
May 27, 2020
12:00 pm ET

Nicole Williams: Good afternoon everyone. Can you hear me? This is Nicole Williams with NQF. We have in our agenda, you will see a link to join us on the webinar and we'll be protecting the site. And if you are participating in the meeting and would like to talk during this discussion as a committee member, you then also need to dial in and that information is in the agenda for the meeting.

Hannah Ingber: Got it, thank you.

Nicole Williams: So, we're going to go ahead and get started. This is the National Quality Forum Maternal Morbidity and Mortality Web Meeting 3. Thank you everyone who is joining us today.

I am Nicole Williams. I'm a director on this project and I'm joined by a great team in NQF, which includes (Tami Funk), Hannah Ingber, Maha Taylor and our new clinical consultant for the project Dr. Sarah Rae Easter.

The NQF team would like to welcome our committee members and the public to this web meeting. As an organization that works with many health care

entities and frontline workers, we also want to express our gratitude for those working on the front lines and hope that everyone is safe during this pandemic.

Our few best practices, we'd like to mention for using the web platform, the first is that if each committee member can place themselves on mute if they are not speaking. For many of us, we are working from home right now. And if you're like me and you have kids, we know that there could be some more background noise so again if you're not speaking to place yourself on mute.

Also, please make sure to announce yourself before contributing to the discussion. For our public participants, please note that later in the web meeting, there will be an opportunity for a public comment.

In addition, for our committee members, if you are on following us along online through the webinar, there are functions where you can provide questions and messages in the chat box. There's also a raised hand feature on the web platform if you would like to speak. Our staff is monitoring that and can call on you.

The team here at NQF, we do have an update for the committee, our clinical consultant (Dr. Roger Meadows), who many of you have worked with in our and know, she unfortunately has resigned from the project in February due to some other work obligations.

Since that time, we have hired a new consultant Dr. Sarah Rae Easter. She is an obstetrician and intensivist with a dual fellowship training in Maternal Fetal Medicine and Critical Care Practicing at Brigham and Women's Hospital with an academic appointment at Harvard Medical School.

And you all will be hearing from Dr. Easter today. Dr. Easter, did you have any comments you'd like to share with the committee?

Dr. Sarah Rae Easter: Other than to say that I'm very excited to be involved in this really important work that's not only very relevant to my clinical practice but also near and dear to my heart. So thank you for allowing me to join and I look forward to hearing the thoughts of the committee during today's call.

Nicole Williams: Great, thank you.

So our next slide shows our agenda, which looks quite simple on this slide but we do have quite a tall order ahead of us. There's quite a bit of content that we would like to present to the committee and review today.

Our meeting objectives are to review our project accomplishments to date. Much of that includes a large update to the environmental scan since the committee has passed five. We have also highlighted some key sections for the committee to discuss related to the scan. And finally wrap up with some next steps for the committee.

I will now pass it on to Hannah who will go through a quick roll call for the meeting today.

Hannah Ingber: Thanks so much Nicole. This is Hannah with NQF. I will go through the roll. Please just unmute yourself and let us know that you're here when I call your name. (Lekisha)?

(Lekisha): Hello, I'm here. Thank you.

Hannah Ingber: Thanks, Elizabeth?

(Elizabeth): Yes, I'm here.

Hannah Ingber: (Tomaria)?

(Tomaria Thompson): I'm here.

Hannah Ingber: Angela?

(Angela): Yes, I'm here.

Hannah Ingber: Katie?

Katie Barrett: Here.

Hannah Ingber: Katie Barrett, thanks. Deborah?

(Deborah): I'm right here, thank you.

Hannah Ingber: Emily?

(Emily Briggs): Yes, I'm here. Thank you.

Hannah Ingber: Thanks. (Beth)

(Beth): Yes, I'm here. Thank you.

Hannah Ingber: Charlene? Okay, I believe she told us that she'd be a little delayed. Julia? Okay, Michael? Okay, Eugene?

(Eugene): Hi, everyone, I'm here.

Hannah Ingber: Thank you. Marianne?

(Marianne): Good morning everyone, present.

Hannah Ingber: Thank you, Don?

(Don): Here.

Hannah Ingber: Wonderful. Kim?

Kim Patterson: Good morning, I'm here.

Hannah Ingber: Morning Kim. Thank you. (Kay)? Okay, I believe she might have been a little delayed as well. (Deb)?

(Deb Caldy): Did you say (Deb or Beth), this is (Deb Caldy), just in case it is that

Hannah Ingber: (Deb Caldy) yes.

(Deb Caldy): Thank you.

Hannah Ingber: Thank you. Elliot?

Elliott Main: Present here, good morning.

Hannah Ingber: Morning, Claire? Kate, Kate Menard?

Kate Menard: I'm here, good afternoon.

Hannah Ingber: Hello. Katrina? I believe she is also a little delayed. (MC Roger)? And she as well. Nicole?

(Nicole Williams): Good morning, I'm here.

Hannah Ingber: Good morning. Diana -- Diana Ramos? (Elizabeth Roshan)?

(Elizabeth Roshan): Hi, good afternoon.

Hannah Ingber: Hello. Rachel? Amber?

(Amber): Hello everyone.

Hannah Ingber: Amanda?

(Amanda): Good morning, I'm here.

Hannah Ingber: Hello, thank you. Tiffany?

Tiffany Willis: I'm here.

Hannah Ingber: Great. And Susan?

(Susan): Hi, I'm here.

Hannah Ingber: Thank you everyone. I'll now move to our federal liaison. (Girma)?

(Julia): Julia, I'm sorry, this is Julia.

Hannah Ingber: Thank you Julia. And (Girma), you were saying you were here as well.

(Girma): Yes.

Hannah Ingber: Wonderful, thanks to both of you. Wanda?

Wanda; Yes, I'm here.

Hannah Ingber: Thank you, Renee? I believe she is a little delayed as well. Aaron?

(Aaron): Hello, I'm here.

Hannah Ingber: And Marsha.

(Marsha): Hello, I'm here.

Hannah Ingber: Okay, wonderful. Thank you everyone. I will now pass it to (Tami) to go through our environmental scan.

(Tami Funk): Thank you Hannah. Good morning everyone. So, we wanted to just highlight the feedback we received from that first draft of the scan we sent out via email a couple of weeks back. Thank you to all of you who had a chance to read it and thank you for everyone who provide us some comments.

We received comments from about 11 of the 30 members, so close to a half. Many of the comments we addressed in the most recent draft that you received last Friday. A lot were corrections, edits, added information that was really helpful to us in clarification.

A number of the comments also advised us other articles and programs to look into, most of which we are able to address in this draft. A couple, we are working rapidly on this week to make sure they're included. And a lot of them touched on the sections that we sent you mainly the standard processes of care and then a lot around the measure, methodologies, concepts and programs providing those measures.

A few of the comments we felt warranted additional committee discussion. So you'll find that some of our discussion points in today's agenda reflect some of your feedback. And so we'll be going through those shortly.

On the next slide, here we go. We have just a high level of the environmental scan outlines, just the high-level bullet points for clarity. And we just wanted to call your attention to a small shift in the order of the outline. So the fourth bullet point down over a chain influencing factors so it's new next to it.

And we shifted that up to occur earlier in the scan after some conversations with our co-chairs and some additional thought into the order of the scan. But we would like to invite additional feedback on the order and the flow of the scan either during this call if you had a chance to read through it or in the next few days via email if you haven't had a chance to review the entire thing yet.

As we are really trying to make sure that the content flows, it makes sense. But we do want to make sure that we aren't accidentally or inadvertently, I guess burying some concepts into the middle of the scan that we really want to make sure it get called out early on. So I just wanted to bring that to your attention.

And then the next slide, I just want to walk you through what our discussion items will be for today. So, as you can see, we do have pretty full agenda.

We are thankful to our co-chairs who are going to help lead us through some of these discussions and we'll be starting with that overarching influencing factors section and spending a good amount of time on that.

After that we'd also like to talk through a bit about the morbidity and mortality prevalence and incident section. We received some comments around the AIM bundles. And so we would also like to discuss the way that we have represented the AIM bundles in the scan with you the committee.

And following that, we would like to touch on the outcomes assessment. And then time permitting, we'd also like to jump into some of the scan findings. So just to walk through existing measures, measure concepts and gaps with you.

As I said, this is a pretty packed agenda and we do want to make sure that we have enough time to really do justice to these discussions. And so, please speak up and use the chat function if you have anything to contribute to this discussion. And if you feel like you have additional comments that you didn't have a chance to express to us today, please send them to us via email. Reach out, we would love your feedback.

We do have a short timeframe for incorporating it. But definitely over the next couple of days if things come to you, please reach out to us as we are encouraging and welcoming hearing anything additional from you.

Okay, and with that, I will hand it to Nicole to kick off our discussion of the overarching influencing factors for Maternal Morbidity and Mortality.

Nicole Williams: Thank you Tami. So I wanted to sort of help introduce this section before (Tamoria) leads the discussion with the group. In talking with our co-chairs

as well as the NQF team, we felt strongly that one of the first sections to bring to this committee were these overarching influencing factors related to Maternal Morbidity and Mortality.

And these, the components that you see listed around racism, discrimination, implicit bias and social determinants of health, we felt very strongly that these are very intertwined with the clinical risk factors. And as you can see within the recent copy of the environmental scan draft, we really tried to place these influencing factors upfront within the document to emphasize the importance of them as contributors to maternal health outcomes.

So again, I'm going to turn it over to (Tamoria) who can share some more insight and lead the committee through a discussion.

(Tamoria Thompson): Thank you Nicole. Good afternoon everyone and thank you for joining the call today. So when we first reviewed all of these, the first thing that I noticed that was missing was the actual word racism. And I think, you know, at this point, this is now, you know, we've had several calls with each other.

And, you know, I'm just looking for people to be more bold in not only what they're stating but also their intentions. And I think that we are sitting in a time in history and each of us with our own platforms and the positions we hold, where we are really charged and called to do and say what is necessary to improve outcomes and so we can't burry the language anymore.

If we truly want to improve outcomes and eliminate racism and disparities, we have to be bold in both our language, intentions and our actions. It's not enough just to talk about anymore. We really have to put this term over to people and do the actions required behind them.

So in looking at this, I started thinking about, you know, what's still missing, what's still missing. And so, for me looking at this again, the first thing I look at and say what's missing is institutional racism, because it's important to look at the distribution of resources, power and opportunity that benefits people who are mostly white at the exclusion of people of color.

So, at the end of the conference you can add to this, it also forces us to look at our own organizations and institutions - I'm washing my hands, they're going to be looking at why are these occurring. And they are occurring because quite simply put the black people, black and brown and negative people in positions of power within these institutions.

And that to me is one of this overarching influencing factors for Maternal Morbidity and Mortality. So with that said, I just want to lay the groundwork to open up the dialogue around that a little more and any other influencing factors that you may have all thought of over the last several weeks.

(Deborah): Hi, this is (Deborah). I totally agree with what you said. I think it might be helpful to even, you know, look, I need to look through this more template but I think it is important completer in the document talks about, it talks about risk factors and race being a risk factor.

And I think we have to be consistent throughout the document and have this concepts around racism and the different types of racism explained pretty clearly in this document because they do, they are overarching to all of the ways in which we understand how to interpret the disparities and the inequities in currently in the system. So thank you.

(Tamoria Thompson): Thank you Deborah. And we did have that conversation in the co-chair call about those definitions, about that language. But for me, I didn't want for

you know, people who aren't in the know if you will to have that confusion of race itself being the risk factor. So, you know, that does need more clarification.

(Deborah): Yes, I think it needs to be re-edited.

(Tamoria Thompson): So, are you suggesting reducing re eliminating the word race from the top and just having racism.

(Deborah): Yes.

(Tamoria Thompson): That's a good stuff. Thanks you for your quotation.

(Kay): This is Kay, I sent you all a copy of the work that we did in the social determinants of health learning network related to measures for maternal and infant health, for the infant mortality coin. I don't think I clarified all of those measures work at the state level. And almost all of them work at the county level.

And I'm not suggesting that you put them all in, but I do want to just take the framework and the work seriously. It's a much broader lens on social determinants than the list on the screen would indicate. So I hope you'll spend time with that.

(Tamoria Thompson): Thank you so much for sending that Kay. Does anyone else have anything?

(Liz Howell): Yes, so this Liz Howell and I just wanted to add to the last statement about social determinants. And I haven't had a chance and thank you so much (Kay) for forwarding that.

So, I was going to add in, as I was reading through the definitions around racism around, you know, that whole section of the report and you went through social determinants, there's nothing about the impact of residential segregation.

And I think that's a really important part when we think about outcomes for maternal health. We know that there's been a lot done on it in terms of its association with the infant outcomes. But I think residential segregation and you can map in New York City redlining, residential segregation, you can map infant outcomes, maternal health outcomes, and now you can map COVID.

And I don't think we can emphasize enough about how important residential segregation is when we talk about maternal health outcome.

(Tamoria Thompson): Thank you, (Liz).

(Julia): Hey (Tamoria) this (Julia), I just want to reiterate the idea that replacing race in the rest of the document with race with the word term racism. And then explaining what that means and why would totally be transformative for our field and would show leadership that we understand as a quality initiative that we are not blaming and shaming black people but really looking at the underlying structures that cause inequitable outcomes based upon the value in blackness.

So I think it would be great if we could continue with this work and replace the language at the rest of the document as well.

(Tamoria Thompson): Thank you so much (Julia).

Wanda Barfield: Thank you. Yes. And hi this is Wanda, I think Kay says such a great point because the social determinants of health design includes some of the policies that impact all of these things as well.

(Tamoria Thompson): Thank you Wanda. What's that everyone think about in terms of influencing factors, the language barrier, that's another area that I think is worth exploring that I really see when in these discussions.

Ann Williams: Hi, I'm Ann Williams from Kaiser, I would echo that proper use of interpreters can be a major barrier. And we see that with the outcomes all over the country that some of our highest risk patients are those who aren't native English speakers and our units aren't using interpreter services optimally.

(Tamoria Thompson): And can you elaborate on maybe why they aren't using them.

Ann Williams: I think that there are lots of different reasons why people don't do it. Some hospitals, I'm not speaking specifically to ours, but some hospitals don't have access to get interpreter services. Some people think that they can get by with their, you know, high school Spanish or whatnot.

And so, and then many patients will nod and nod and, you know, appear to understand but not actually understand. So I think it's important for organizations to take a look at themselves to see what those barriers are.

Wanda Barstow: Yes. Hi this is Wanda. It also depends on the policy, right? For example, a state like Massachusetts actually has a requirement that if there's a certain population percentage of your hospital, you must have interpreter services. So

some of it is what our facilities intending to do in terms of offering these services and it is a resource that does far.

(Tamoria Thompson): Wanda did you say that it is mandatory that they have a certain percentage?

Wanda Barstow: Yes. So I can't remember the exact number. I must want to say, you know, that it's 15%. But if it's above a certain percentage that is being served in that facility, they must have interpreter services within that hospital. And I think they also have some stipulations about, you know, before COVID, whether that was in-person versus from the resources.

(Tamoria Thompson): Okay, thanks Wanda. So they did on how much of that particular population they are serving determines how many interpreters they're going to get that speak a certain language?

Wanda Barstow: Correct.

(Tamoria Thompson): Okay.

(Emelie Briggs): This is (Emelie Briggs), oh I'm sorry…

(Tamoria Thompson): Oh, that's okay. Oh, go ahead.

(Emelie Briggs): I was just going to highlight the need for explaining to the best of our abilities that multi-factorial reason for the language barrier that it is that there are institutional components to that barrier. There are provides for components whether that's nursing staff, physician staff, even ancillary hospital staff.

But there are also patients considerations as well are patient factors that barrier is something that needs to be addressed on all sides rather than what in other documents has been highlighted more perhaps from the institutional side. There are other components within and the more that we can do for best practices, the better.

Nicole Williams: Oh this is Nicole Williams. I just like to remind the committee if you're not speaking, please place yourself on mute.

(Tamoria Thompson): I can hear someone's conversation that I don't think it's for us. Did anyone else have any other comments about including some factors?

Woman: So again, this is (Dr. Briggs). I think implicit bias is also including. It has a component of that language barrier as well. You know, we have many aspects and thankfully implicit advisors becoming something that's higher and higher of a priority in the United States. But the language barrier is a significant, it has a significant component there as well.

So there are some of these (unforced error) combined the overarching factors.

(Tamoria Thompson): Yes, I agree. And one of them, you know, I thought of it obviously because I know a lot of people who have a language barrier. And I also thought about it just as he was speaking American, the fact that sometimes, you know, especially when my kids were super young and I would take to the doctor and I was just so rushed.

I would just be guessing to that. But when I got home, I still have a bunch of questions. So, you know, then I thought about people kind of take care and how much more difficult that would be for them and I think that it's a two-way street.

But I think that the responsibility does fall on the physician to make sure that the patient does understand or they need to have a system in place in their office to make sure that all of their patients understand what's going on with their health. You know, really important to do that.

Woman: Anyway, (Unintelligible) it's important as you've highlighted that this is not just the institution, it's not just a hospital, you know, there are many birthing centers. There are outpatient offices. There are places that are not federally involved, that might not have those rules imposed on them where we would be benefit. It's just like in project to really have that models for the interpretive services that an outpatient might otherwise not have access to.

Woman: Yes, a big part of it is Dr. Brigg's, great point, a big part of it is the access issue, right? So if you look at less, you know, think about a birthing center, you know, and we can look at it geographically, right? Birthing center in Washington, DC can be much different than a native American birthing Center in New Mexico or something, right?

And they're going to have much different needs for their clients in terms of understanding language and culture and all those things. And so, you know, what can be done across the board to make sure that no matter where you are that you're going to have access to physicians who have that competency in language or access to an interpreter, you know, that's a real tall order for some of those.

I don't want to use the word smaller but I guess I want to say it's like a large institution, like a hospital or something that has a lot more resources to be able to employ interpreters. So then the question for me becomes, well, you know,

our doctor at some point going to be required to learn, you know, what be incentivized to learn another language.

If they're going to work in a certain area with a large population of non-English speakers, isn't it their responsibility to either (a) speak that language or (b) make sure that they can provide an interpreter who can do that work for them. Otherwise, what are you doing there? That would be the question from me so...

(Tamoria Thompson): Keep in mind rural facilities and places that are as she commented on the access to care can be intense to in a physical sense or in a cultural sense. And so, you might have a culture in one of our more remote areas that is very heavily populated in that culture but the providers of medical care might not be from that culture.

And so again, if I'm trying to and obviously that gets back to a huge pipeline issue of trying to - but that's the implicit bias, that's institutional bias. That's the structural racism. That's all of these things that we're talking and touching on that they all have a component to this. And so just keeping that access in mind that it is a very broad topic.

(Tamoria Thompson): So now, do you think when we were looking at this list of influencing factors, should health literacy be added to this list including assignments there, right?

Woman: Yes.

(Tamoria Thompson): Anyone else have any thoughts going once, going twice? I just want to say thank you to everyone who contributed to this part of the conversation. And I really appreciate all of your comments and all of your dedication to this

work. I'm now going to pass it over to Dr. Liz Howell. And she's going to be going over maternal morbidity, prevalence and incidence.

And she will lead the discussion, questions on any other risk factors of maternal morbidity.

Dr. (Liz Howell): Great, thanks so much and thank you all so much for your participation. And I also wanted to thank the NQF folks. And Sara, you just had a chance to review the document again this morning and it's really coming along. You guys have put in a lot of work so far and I just wanted to commend you for all that hard work and sort of listening to what everyone has been talking about.

I know it's a number of things that have been integrated from the last version. So thank you for that. So we're going to talk now on about the medical risk factors. And for those of you I think in the report, if you haven't had a chance to look at sort of broken down by looking at the main causes of severe maternal morbidity, it's main buckets, according to sort of more of a CDC or cardiovascular DIC, it goes through different clinical topics, et cetera.

And then the next section, which we'll get to. But anyway, I wanted to understand first how you guys felt about the medical risk factors that were reviewed and if you had any additional thoughts that or framing that you thought needed to be added to the section.

(Deborah): This is (Deborah). One thing I think that would be very helpful would be to have within the different sections is to have some information about how race ethnicity can be tracked for those particular categories or some general guidance.

Maybe it's in a supplement because they know people who want to track race ethnicity by different types of causes of morbidity and mortality, struggle with exactly what are some ways of doing that. And so, just kind of integrating the whole topic of how visualizing the race, ethnicity, disparities and inequities would be, I think would be helpful to have that.

I also was wondering about and Carla I think I know why, I but I think it might be helpful to have the categories top titles be as similar as possible. So in one it says deficit and in other it says infection. So I think that might help the reader kind of, you know, kind of keep some of the same bucket, but maybe there's reasons that I'm not thinking about that would make it easier to call them differently. But anyway those are a couple of thoughts I had.

(Tamoria Thompson): Great. Thank you so much.

(Sarah): This is (Sarah) just speaking to the categories. And we were drafting the document, we tried to choose the reporting categories that the CDC puts for us and recognizing that they are, there is sort of overlap a discrepancy between the maternal morbidity factors and then the maternal mortality etiologies, if that makes sense.

But I agree, I think sort of trying to use consistent terminology could help link what parts of severe maternal morbidity may be causal on the pathway to maternal mortality. I don't know if the committee has thoughts about sticking to the republished vocabulary used by the CDC or, you know, straying from that a little bit to try to help make more connections for non-clinical thought.

(Julia): This is (Julia). I think that that brings up for me though, the overarching frame. And after watching the last NIH webinar around the clinical causes, there's a separation kind of between what's perceived to be like the core

clinical reason to maternal mortality versus the things that we actually looked at the data that shows there's a lot of other causes for death.

And I think your question around trying to tie the CDC language and the morbidity leads into this kind of hierarchy that we're even doing in this project, kind of promising the clinical indicators, as separate from the social determinants of health and racism. So I appreciate that that was earlier statement around framing it within the same context and helping people to see that there's not a difference in many of them.

And I learned through a majority of rambling right now but it was clear to me during that two days of talking that many researchers when they're talking about hypertension or hemorrhage, and they talk about black.

Well, they still think that they're looking for some biological difference as to why they have inequities not and how patients are treated when you get to the hospital or access to care or assumptions if you don't have different filtration in our kidneys because of melanin production.

So those things, no we can't replicate that same difference and ideas around how we have health disparities, how connected these any clinical phase is. That said separate from face overdose or a homicide which I think all of those, it's the same pathways, how we get to the inequities and having a knee surgeries in millions of dollars looking for problems that was broken inside of people versus fixing those pathways becomes deeply problematic for me.

Wanda Barstow: Thank you, Julia. This is Wanda Barstow. We can't repeat what we've done for infant mortality for many years.

(Julia): Yes that's Wanda that's what I am basically trying to get to. But I don't know how to fix it in our way of it the best way.

Woman: Well, I think just calling it out…

Woman: …this is an important issue. So, you need to keep aside of it.

Elliott Main Hi, this is Elliott. Couple of comments about morbidity, maternal morbidity. First of all, I absolutely, strongly support Julia's comments. And we have some data that would support that, it's empress currently in American Journal, OB/GYN is actually online showing that for hemorrhage, which is acute inpatients.

So it's a special case of morbidity. For obstetric hemorrhage, you are seeing a standardized bundle for care actually strongly reduces the disparity between black and white outcomes. It's not biological, it's really about the care that's received and it's about the lack of attention to anemia prior to coming in for delivery. Black women have twice the rate of anemia and that's a failure prenatal care.

The second point I'd like to make is, I think, in the whole discussion of maternal morbidity and this I think is sort of framed it in a way that it is, that may not be helpful, which is - all the discussion is about indicators and they were conflated with risk factors.

These are not risk factors. These are actually the manifestations, categories of manifestations of morbidity and how - and they have many different underlying causes.

And in fact, there's a couple statements in here that are factually incorrect about things like pulmonary edema, the largely cardiovascular in nature and reflecting the underlying cardiovascular disease, where pulmonary edema in most cases is the maternal morbidity is actually a result of obstetric hemorrhage or severe preeclampsia.

And so, I think you have to take it with - you have to really analyze what goes step earlier in the analysis of, okay, you have these end organ dysfunctions. But what's the cause of them? And then what's the cause of that? So, you have to take us back couple of points.

When we started analysis on a couple of very large data sets in collaboratives to almost three quarters of severe maternal morbidity is when you get down to the cause obstetric hemorrhage and hypertension - hypertensive disorders is the underlying reason that you have severe maternal morbidity at the end.

And that's not really reflected here. You know, we are looking at the dysfunctions themselves but not what's the step, even one step before what's causing the dysfunction. But then, you get into the whole issue about what's causing, what are the underlying social determinants and so forth of the causes. But until you take that step earlier, you are not going to get into the action steps.

Pulmonary edema is really driven by what causes the reason for the pulmonary edema. You can't just go straight from social determines for pulmonary edema. So I think with that in mind we talk about morbidities here.

(Tamoria Thompson): Yes, that's a really great point. I mean, I think Elliott, it'd be really helpful if you take the document and give a couple of pointers to help the

NQF folks think about this throughout the different categories because I think that's a really good point.

And I guess it, especially when I'm thinking about we are ultimately trying to get to quality measures and we want to understand what's actionable, and what are the things that can actually - what are the underlying factors that we can address.

And then I also want to thank everyone else for their comments and joining us. So understood, stand your point and agree with you about sort of this artificial, we are doing the same thing when we sort of separate everything as if there are these clinical factors. And then everything else and it's a bit arbitrary.

And you don't understand how they are combined and work together. And so, I thought that was a really good point as well. Anyone else want to add to this discussion that we are having around the categories for severe maternal morbidity?

Okay. The other portion of this discussion is really going to just talk about the - here we go. So here is a section on maternal mortality. And as you heard from Sarah, she started with somebody that - you heard from Sarah that she sort of talks about each one of these.

And one of the points was really to think about - we talked a little bit about this before but about the addition of suicide and how we should be thinking about not only suicides but homicide, IPV, et cetera in this environmental stand and how we think about this issue. And I don't know if anyone wants to comment on that.

Elliott Main This is Elliott again. I wanted to make a general comment about mortality and morbidity. And particularly on morbidity we could not - there isn't really a discussion anywhere about how you are going to collect the data. And that's a really important issue for some of the alternative measures for morbidity.

And that's also really true for mortality. So the maternal mortality review for California, we see again and again, all the different definitions and how they come into play. What's pregnancy related, what's not. It has tried to retreat particularly around suicide, retreat into whether it's just calling everything that's pregnancy associate value that deaths occur during pregnancy within a year after as pregnancy-associated suicide rather than trying to make the pregnancy related or not in different committee members.

Different committees will have very different opinions about what's pregnancy related or not, particularly as you get up to three, six, nine, 11 months after delivery. So that is the pregnant-related versus pregnancies.

The pregnancy-related may be an artificial thing that gets in the way. But then that separates you out from the CDC diagnosis of pregnancy-related mortality or the WHO maternal mortality, that's an issue which does require relatedness to be a factor. That's a tough one. I think that we struggle with the same for overdose.

Wanda Barstow: Hi, this is Wanda. We are working with a lot of the states to really try to decipher some of those issues in terms of looking at particularly issues around domestic violence as well as suicide and how they may or may not relate to pregnancy.

(Tamoria Thompson): So I was like I was just going to ask you to chime in Wanda so thank you. And Elliott, so are you guys saying that you are now considering using

pregnancy-related deaths in the usual way that we understand that language? And then including however in that category uses all pregnancy-associated deaths that are either suicide overdose or IPV as all one bucket.

So those three types of categories associated plus pregnancy-related death. Is that how you guys are doing in California?

Elliott Main We were looking - we just published a big report in suicide, 99 suicides in that pregnancy in the year after. You know, it was a very big challenge to determine relatedness and probably really wanted to report them as a whole. And so, we did report them all.

But in terms of, you know, you can't change the WHO definition. So we had to really go outside and say we have pregnancy-related death by WHO. And then we had a pregnancy-associated suicides and pregnancy-associated overdoses test. So it's a matter of wanting to be sure everybody is counted, which is really important. But do it in a way that you can still piece of (unintelligible) so you can compare to some other countries et cetera.

(Tamoria Thompson): I think is ((Crosstalk)).

(Kim Guidry): This is (Kim Guidry). I do think that they cannot be ignored. What we call them, how we call them and the bucket we put them in. But this is another major contributor that is potentially preventable. And if we don't count them or track them, we won't do anything about it.

((Crosstalk))

Woman: Report that there are a substantial proportion of deaths that are occurring in the late postpartum period. And many of them are these factors that do relate to social determinants of health.

Woman: And this is (Unintelligible). Sorry, I joined in late. But also, from California, you know, I think the work that we are going to be doing through the race maternal mortality review that focuses on maternal deaths and having the opportunity to really look at the social determinants of health.

We can hopefully tease some of these issues out and understand more of these aspects. And I think everyone…

(Tamoria Thompson): Kate Menard had their hand raised too. Sorry, just in the …

((Crosstalk))

Woman; Go ahead Kate.

(Kate): I just thought I'd add what, you know, what we are doing in North Carolina with our maternal mortality review is reviewing, you know, in alignment, I think with the, you know, the guidance from the CDC and race worth group. We are looking at all of the deaths including the homicides, suicides and overdose and kind of digging into the sort of the factors to determine whether we could, you know, align them as pregnancy-related.

We are not necessarily getting as much detail about preventive ability to report to the CDC with our current forms that we fill out. But we are doing that in our own manner to have that local in North Carolina, the contributors and the suicides and even the motor vehicle accidents in the first year postpartum. They are very much on our radar.

Woman: We are also looking at data with opioid funds from injury in terms of looking at overdose-related deaths as well. And we have six case that are involved in that. Collecting data and hopefully to report very soon.

Elliott Main I think were the challenges though, this is already again, is that overdose deaths and suicide are among the leading causes of death for non-pregnant reproductive age women. So these are the - these are up there and growing particularly over dosage for women between 15 and 45 in a totally non-pregnant population.

So then the challenge is either what's related what's not. But we have the, either Kim's point which is what we've taken to heart is that we have the opportunity to have interventions because we are there in the healthcare system for 9, 10, 12 months. And we should have the opportunity for identification referral to counselling.

In our California State, especially the suicide rate was significantly lower during pregnancy and postpartum than it was in for age-based reproductive age women (Unintelligible).

So they've already following the track. But they are a little different.

(Julia): Okay, this is Julia and I just want to add on to that that when we did it in Louisiana, the rape, you know, the homicide was increased by pregnancy. And so I do think understanding the framework of determinants is important and how it cause around domestic violence, access to guns. And the role that helps in public health and CDC and others play and being able to articulate them and you have places that have better access to mental health care services that are access to gun laws and protections.

We do have lower rates of pregnancy-associated and related deaths from homicide and suicide. And we don't have those things, so you have higher rates and so those are the - that's why it's important to track the status because policy bigger than what happens inside of a hospital matters.

Woman: Absolutely.

Woman: This is (Unintelligible). (Tamoria), do you have your hand raised? Do you want to speak,(Tamoria)?

(Tamoria): Yes, I do. I was just, you know, if everyone else is okay. So just to piggyback a little bit off of what Julia just said. I'm curious about how everyone is looking at suicides. Are you considering it in sort of its own box? Are you looking at postpartum mental health as a separate category for this? Because for me, it would be two completely different things.

If the suicide is a result of a woman suffering from a postpartum psychosis versus someone who had a pre-existing condition such as depression or whatever that would cause her to want to commit suicide or if there was another factor that occurred after giving birth that might not be necessarily related to birth, whether it was stress in the household or something else going on.

But I don't think - I think there needs to be a separate cause and that for me would be postpartum. And I just wouldn't label that as only a suicide. So I don't think that suicide, overdose, I mean, I see that under accidental incidental causes. To me those are three completely different things going on. So I think that postpartum, mental health should be a separate category.

(Dr. Briggs): And (Tamoria), I think that we are even trying to do that. I guess we are just whole like, when we added mental health to the conversation, we struggle with where that plays out. And so, if you are watching real time on this call, that - as we know that women are prone to homicide and suicide.

And then they have postpartum depression and anxiety and we haven't ever worked on it. How do we build the infrastructure in this country to work on that? You know, and so that's - I don't know.

((Crosstalk))

Woman: One second, this is (Tamoria) and here's the thing, the infrastructure is built. The problem is that a lot of work is done in silos. So, OB and psychiatrists and LCSWs and counsellors, they don't talk to each other. And I know this because I have meetings about this all the time.

These infrastructures are - it just a matter of people actually forming connections to each other, to improve the lives of all within a certain community because there are places where there are examples of MDs and all the other people I've mentioned, permissions and mental health where they collaborate. And they are able to provide all of these things for their clients that help bring down these numbers of suicide and help women when they are diagnosed with a postpartum mental health disorder.

Under that as well, I would also include trauma as a separate category. That would be morbidity sort of going into this other piece. But that's another thing that I rarely hear discuss is the trauma piece of all this, including PTSD, because that's something.

So when you are looking at postpartum mental health concerns, it's not going to be in the same category as anxiety or depression and the other ones. So I just wanted to make that point real quick.

(Sara): This is (Sara) I think, you know, again this, you know, (Tamoria's) wonderful point in the sort of discussion highlights the struggles that the NQF team has had with sort of situating this specific issue in the report. And I don't know if, you know, folks have - I think part of the scan is to try to present, you know, available kind of evidence and in terms of both existing guidelines and practices related to what the CDC does and what the WHO does. And sort of the published literature.

But then also establish a document from which, you know, we can make recommendations. And so, I'm not sure if we'll catch after that sort of the tone of this section as written. I think by calling it out again, it's raising it as an important aspect of the maternal morbidity and mortality framework that hopefully we can incorporate into our recommendations.

So I think that the reality of - including these causes is pregnancy-related versus pregnancy-associated and what that would do to our ability to compare our maternal mortality ratio reliably is safe for between countries and some of those data issues is a real challenge.

So folks have thoughts or recommendations, you know, about the best treatment of this within the scan and ways to resolve this tension?

Woman: I don't know about the tension. But I think - so I'm just converting. I think what I'm hearing and what I'm feeling is that it's not just this bucket over here. It's a bucket that needs to be under surveillance.

And then as with all research, there's lumpers and splitters. So you flip things and you really stratify things and you really want to get down to a level of detail about something either mechanistically or - and because you are trying to develop a toolkit around it and you (love) all the detail about something, either mechanistically or - and because you're trying to develop a toolkit around it. And you love things and need the numbers big enough to show that you've made a difference with that things.

So I think that we're all in agreement or at least, I think I'm hearing that we're all in agreement that this should be included. And the extent to which we segregate specifically, the pathophysiology related to pregnancy causing it or the fact it is tied around pregnancy.

I think we could let the people who are researching that or, you know, planning the interventions around that to take that level of details forward.

(Jean): This is (Jean). I want to make two separate points. One, relating to the earlier discussion around pregnancy-associated deaths. And that's simply that if you look at death rates for women of reproductive age, they're actually going up faster than the pregnancy-related mortality rate is.

The reality is the pregnancy-related mortality rates are pretty level for the last decade. Death rates for women overall of reproductive age are actually going up. So I think it's important in the context of maternal mortality reviews that this is the place where we're actually looking at those steps.

Now, we look at them in the context of eliminating them in a lot of cases, as we moved from pregnancy-associated to pregnancy-related. But there's still deaths. And I think we're pretty much the only people who are looking at

them in any detail at this point. And so I don't want to move back completely in this discussion.

But the other point is more relevant for this report overall, I think it's wonderful. At the end of the day, we need actual concrete measures of maternal morbidity that we can use.

I'm in a bunch of groups now that are trying to wrestle with this. And everybody falls back on the CDC measure because it's simple and it's ICD codes. And you can just, you know, code the algorithm into your hospital discharge data. And we needed more sensitive measures. And at the end of the day, this is what the NQF people do really well.

I think we need to say these are the measures we have and they're reliable. But then here are the measures that need to be incorporated to go beyond the birth defects because the CDC measures just at the birth defects. And we need to incorporate some of these things including mental health, information that is conveniently captured.

So ultimately, we need a measure that isn't just driven by the data that's available now. So if you guys could just fix that that would be really great.

Woman: I think our time is running out. But I'm going to allow just one more question or comment.

Tiffany Willis: I did want to make a comment if I could. This is Tiffany Willis. And I think I'm one of few or maybe the only psychologists on this committee. And I want to just go along with (Tomaria)'s comment that the perinatal mental health really needs to be pulled out and separated.

As we know, black women are at the highest risk for this category of maternal morbidity and mortality. And they also are three times more likely to experience perinatal mental health disorders and are at least likely to be treated. And so it's really underlying cause behind the suicide, overdose and IPV. And it really needs to be looked at separately in my opinion.

Woman: Thank you very much. And thank you, everyone for your comments. I think, it's now time for us to move on to the outcomes assessment, which I'm going to turn it over to (Lekisha).

(Lekisha): Thank you. And, you know, I think that last comment provided a very nice segue to the outcomes assessment piece. So for this section of the report, there's really a focus on those risk factors as it relates to outcomes.

Currently, it's divided by patient-provider hospital and system-level categories for influencing factors. Among the ones, incorporated under patient factors are those, such as health literacy and mental health but also rural morality.

Although I think one could argue that that might be perhaps better incorporated under systems level for some of the reasons that are talked about in different other areas within the report as well as just the information that we have about workforce and other challenges in those communities.

The other section provider factors includes a placeholder for training on implicit bias and social determinants of health. But I would think that we might also want to talk about, you know, perhaps, other training or practices, you know, reliance on certain kinds of interventions might be appropriate here as well.

And, you know, certainly moves on into hospital level, which, you know, I think there's a really good beginning there as well. But I think for me, anyway, and the way I think about things that hospital level as well as the system level in some respect begin to kind of bleed together.

And so, you know, under systems, you know, I'll just kind of skip over the system. I think, again, you know, we have a really good start. But we may want to talk about a few other things. So I think perhaps elucidating, a little bit more on the workforce issues. I think, also talking about continuity of coverage, whether that is as a part of Medicaid or more broadly.

And then also, you know, as we're thinking about coverage, certain benefits, you know, that might - that are not universally available to women might be some other aspects for us to explore within this report. And also, I think they kind of lend themselves potentially to Dr. DeClark's comment earlier about, you know, our ultimate goal here, which is to get to, you know, some outcome measures. And I think specifically some outcomes and some process measures.

So I'd like to open it up to the group - oh, I guess before that, maybe we also should note that this section also includes some additional outcome areas of interest such as caesarian delivery rates, surgical site infections, ICU admission, patient-centered outcomes and hospital readmission rates. So I'd like to actually open it up now to the group's feedback on the section.

Kim Gregory: So, this is Kim Gregory. I think that on the provider level, I think that we talked about health literacy. I think that it needs to be some community literacy at the provider level. And I think another - we talked earlier about translators.

But I think that sometimes doctors don't speak the language that people can hear and/or their own English proficiency isn't as good as it could be. And this is particularly true at some of the institutions that there's a large number of women of color. So I think that that's another opportunity that is not listed there.

(Emily Briggs): This is (Emily Briggs) to tag on to that. I like the idea of community literacy. I like that term. And it brings at least in my mind, the cultural literacy, I think is the component that I would want to highlight in that definition of what community literacy might be, because agreeing that providers whether it's physician or other provider English proficiency is one component, speaking at a level of health literacy that is not conducive to the patient understanding.

But then also in the culture, recognizing that you need to, perhaps ask questions in a different way depending on the culture of the patient. So all of those components to it would be at that provider level.

(Ann): Hi, this is (Ann). I also wanted to comment along with the cultural literacy and the providers is that, I think that the providers have to - we'll make aware that oftentimes, so I can tell you that in the Hispanic culture, it is the standard to speak in very medical lease language, even amongst the docs, amongst the patients. And that's the culture of the way that you communicate in medicine in, you know, Spanish in the Hispanic community.

And so I think some work needs to be done to help bring self-awareness to the providers that this is part of the way that you communicate in the medical community among physicians. But you have to bring it down to an understandable of terminology when you're speaking with patients. And it's just part of the culture.

And so, many times physicians don't realize that. And when I'm watching something in Spanish and I'm hearing a medical presentation by a physician, sometimes, I don't even understand the terminology because it so high level. And so, you know, at the medical level that you can't understand. So some self-realization for the providers is also needed.

(Katrina Nardini): Hi, this is (Katrina Nardini). I joined the call a little late, I wasn't on the roll call. But my comment is related to, are there any other risk influencing factors? And what I noticed under patient factors that I thought was missing, I scrolled again just to make sure I didn't miss it somewhere.

But I noticed that there is mental health and postpartum depression. But there is nothing about substance use disorders or opioid use disorders, which I think is something that maybe I don't know, I feel like that's probably a pretty important outcome assessment often because it does go hand-in-hand with mental health. And as we've been having this conversation about suicide and mental health.

But I find that in a lot of our maternal deaths on our MRC, a lot of them even -- the ones that are medically related substance use disorders often take or play a hand even if that's not the cause of death by overdose in a lot of these deaths as well.

And so, I think it is a confounding factor. It's a reason why people don't seek care. It's an issue related to access of care, coordination of care. There's a lot of things around that, that I feel like it should be included in this as well. Thank you.

Hannah Ingber: Hi, this is Hannah. Oh, we have a couple of hand raised. I just wanted to highlight them, (Kay Johnson), and then Kate Menard and then Deb Clayton, in that order, have their hands raised.

Deb Clayton: Do you want me to raise hand?

Woman: Yes. It'd be great.

Deb Clayton: I also think, I'm just curious about maybe including some kind of information around structure and process measures, just as, whether, you actually include them or not, like, specific examples, per se.

But I think it might be helpful to point out some examples. So maybe not necessarily an exhaustive list. I also think, (Kramer's) paper and looking at maternal mortality reviews from the health equity lens is also would be really helpful to talk about.

And so, anyway, if you broke it by structure, process and outcomes, then types of measures then you could look at structures from like, what makes up a healthy community or in place, you know. And what are the structures that need to be in place to help if some of the best outcomes, like, reducing overuse of C-sections, you know, structures in place of, in a way thinking about structures at multiple levels.

Woman: Thanks, (Debra). So, I don't recall who was in or what order.

Woman: I believe, (Kay Johnson), who had her hand raised next. If not her, then Kate Menard.

Woman: Okay. Kay or Kate. I'll unmute and if Kate come, she can come back at lunch. Kate Menard, I want to respond to the second discussion question as the committee was organized and influenced at this levels from patient provider and then hospital system.

I've heard it said that perhaps, hospital and system are the same. And I'm not quite sure how to do this. But I don't think of it that way, actually at all. And I think it's really very helpful to identify things that are patient level, identify things that are provider level, identify things that are hospital level to help us really craft solutions right.

But the system piece, I think that the system piece is, how it all fits together, including public health, influence and interface with each of those components of patient-provider hospitals. And so, the system kind of makes it all work together. And then I think in the narrative, it's just under system factors that describes a number of things that are indeed, issues that are separate from the hospital.

So I guess my pitches to inclusive some factors, but that's like public health, working with hospitals, working with patients providers and making it all fit together.

Woman: Thank you.

((Crosstalk))

Kate Menard: This is Kate. Can you hear me now?

Woman: Yes. Okay.

Kate Menard: Okay. You may hear my dog in the background, I apologize. So, one of the thoughts that I had about this I was, for another purpose, I was looking at the Cap, a measure related to children yesterday.

And I really thought about it in terms of, you know, is there a way to get to something that perinatal, maternity, pregnancy-related, in terms of a question, they get that satisfaction and interaction around some of the things that we're talking about.

We have an adult measure, we have a child measure. But if there was a perinatal of pregnancy-related measure, it does seem to me, it might help to several levels.

Woman: Thanks, Kate. And I just wanted to just make a comment to Kate. So I think you may have been reacting to what I said. And I think, in terms of like hospital and system being the same. And so that's not what I meant to imply. It was more so that sometimes, when I'm thinking about systems level issues, I think about - I'd absolutely agree with you about, you know, kind of those broader systems, which is why I noted information about coverage.

But I guess for me, the way I sometimes think about things is the impact of the broader system on the facility. So I think that's all I meant about that.

Woman: Okay. So maybe just a comment or comma

((Crosstalk))

Woman: Exactly. Yes. I think it's just a matter of…

Woman: We use hospital systems, so often to think about our business systems, right?

Woman: Exactly.

Woman: Yes. And that's not what we need.

Woman: Yes.

(Liz Howell): So this is (Liz Howell) and I just had one additional thing around - one thing I noticed, there's a discussion about morality. And it kind of plays into levels of care and that discussion goes on.

But I don't think there's an acknowledgement just like, you know, about urban hospital differences. And that they're not related to necessarily level "level of care" that there are resource differences. And that there are other differences that exists that explain such measures broad, wide variation that we see in outcome and that we…

Woman: So I think it's really important to talk about role. But I also want to say that we need to talk about hospital level factors. And not act like, it's just about level of care and volume because those are just too of many things that impact outcomes.

And similar to what we see in sort of education as how certain schools are under resourced and it's black and brown children that are going to those schools. We see the same thing in hospitals in large urban centers as well. And so we need the cost, I think we need to sort of add that in as well.

Wanda Barstow: Hi, this is Wanda. I think you're making a great point. I think about it in terms of operations. So take, for example, the issue of blood resources in a blood bank. If you can't get blood quickly enough because your operational

issues are poor in a given facility, you know, that's the problem. And we know that system wise that is a problem for some hospitals.

Man: That's clearly an issue for rural hospitals as well as figured in hospitals. But there are social issues within hospitals that are clearly part of the drivers of what we're in mortality.

(Joy): This is (Joy). I had to raise my hand (unintelligible) can you hear me?

Woman: Yes I can hear you.

Woman: Yes. Go ahead.

(Joy): Okay. Can I go and (unintelligible)

Woman: If you're ready, go ahead.

(Joy): Okay. Great. So I was viewing this question more around thinking about this risk influencing factors because whenever I hear the data that I even say out loud to people that 60% of the deaths are preventable.

I know that that comes from this specific question. And this patient-providers system like factors and how important it is to educate people who are making those determination around what those differences in factors are. And these influencing factors, the things that we can do to improve outcome. So I love the robust conversation we've been having about this for the last 20 minutes or so.

And thinking about how this document can help inform review committees and policymakers on the influencing factors. And delineating what is really

the patient impact and what is really the provider, what is really the hospital, what is really to sit on because I can tell even when I'm seeing that data out, I know that the people who are answering that question at the level of the committee members, who don't necessarily have a clear understanding of the differences between those influencing factors.

Woman: So, (Joy), just one question that I have in my head is, how do you take some of these factors and translate it into action in terms of mental quality improvement? Because, for example, I'll use the blood example.

You know, facilities and believe me, I care for patients, you know, make it sort of an issue of learned helplessness, oh, we can't get the blood fast enough oh gee, you know, hospital, this is always a problem. But there's no real action in terms of remedying that problem. This is where, you know, quality improvement needs to look at a variety of factors in terms of making a difference.

(Joy): Well, truthfully I have learned a lot of this one with people right on this call, you know, albeit and the folks in New York. And they have worked the system to identify, if you are slow and your body is fine, you know, that is a cause of harm.

And once again, I learned a lot on that last NIH thing because I realized that for Dr. - what's her name? It's Columbia, (Mary Dalton) that the goal for (FMs) was really around improving hospital care. And there is still a great need for that. So, (unintelligible) recognize that your hospitals need support, that they need leadership, they need quality improvement. And I think it's a false tension between that being the only thing versus the community stuff too that we - that both things matter.

So when I use -- when I think of the blood example, I think of it both a hospital, like learned helplessness but also community that has the ability to hold that hospital accountable for not having blood available, you know. So like, it's a mixture of both things.

So if the community knew that that reason that women were dying is because they don't have a mechanism for getting blood in a timely manner, you would see accountability. Does that make sense Wanda, what I'm trying to…

((Crosstalk))

Wanda Barstow: Yes, very much so. Yes. Very interrelated.

(Joy): Yes.

Woman: I think - has her hand raised.

Deb Clayton: Yes. This is Deb Clayton. I just want to make a comment. Really, there's been a lot of discussion of communication needed for the patient. And - sorry, I'm not sure in that going. There's been a lot of comments regarding the communication with the patient and a lot of physician direction on their sole responsibility.

And I think you want to be aware of the fact that there's many care providers that interface with the patient either in the clinic setting or the hospital setting. And we want to make sure we're inclusive of those individuals, such as nursing and case managers. It can't be all on the physicians when they're trying to manage acute situations to think about that full picture of the patient and what needs to happen.

So, you know, we're talking about true quality improvement, it means to make sure that we're including a variety of care providers at all levels. And our patients also feel they can connect with different individuals based on their role. So that may not have been the intent by the communication here today.

But I just want to make sure people are encompassing all providers within that system because they all can impact in a positive way.

Woman: Yes. Thank you for your comments about the care team and the values of all those members. I think (Emily Briggs) also has her hand raised.

(Emily Briggs): Yes. Thank you. So that's actually, Deb Clayton had made my comments. So, I appreciate that greatly because I just - I wanted to highlight the system at the system level that when we are organizing the influencing factors by the level specified patient provider, hospital or system rather than the timeline of that continuity of care.

In the system level that is, I think, where we would address the patient going back into her community and needing an improved access to care. We have found, of course, that many of those factors that influence maternal morbidity and mortality are happening after the first, you know, 45 to 60 days, immediately postpartum.

And so, in that system level, I think we need to make sure to highlight the access to care, whether that's with the pro-mentors, with the community providers, with their primary care physician, even at whether that's an obstetric providing primary care physician or not, with their primary care team, however, that looks to highlight that component of the system level for that late postpartum time.

Woman: A quick question for you. Do you think that the issue of the transition needs to be focused on those of highest risk based on the pregnancy or just generally?

(Emily Briggs): I would say, in general because, specifically, in maternal care, we know when somebody is going to be high risk until they already are in many cases. You know, we have patients that are lost to whether they have access to care or not, they might become lost to that provider that would know how to watch for those risk factors.

And so I think you need to broadly paint that with that brush in order to capture the women that are not being followed otherwise until they're past that point of prevention and now into needing treatment.

Woman: Absolutely I just wanted to, you know, capture some of that feedback as we're thinking about the framework and what kind of measures and things that might be needed. Okay, thanks. So I just want to check if there are any other comments before we transition to the next part of the discussion.

Michael Currie: Hi, this is Mike Currie from UnitedHealth Group. Can you hear me?

Woman: Yes.

Michael Currie: I just - it's really more of an ask in a comment than a question.

Woman: Sure.

Michael Currie: And that is, you know, obviously, we all understand the importance of focus around patients and providers and the healthcare system and hospital systems.

I would really appreciate the comments of this expert group, around how payers can and should be more involved in the process as well outside of just, you know, paying claims and doing retrospective analysis. We're going to do that every day, all day, that's what we do.

But I'm really, really interested in any thoughts as we continue to talk about this. And how payers could be or more involved or somehow partnered with others. You know, I have thoughts in my mind but I don't want to bias any of the conversation with those. I'd love as you are, as we continue this conversation to include in your comments, what payers could or should, would do. Thanks.

Woman: So I think this is the opportunity to include some of your thoughts about that. I don't know that it's bias per se. But it will, you know, provides the opportunity for us to address the gamut of systems issues. So if there's something you'd like to share specific to that, feel free to it. Otherwise, I can share a couple.

Michael Currie: Media part of you.

((Crosstalk))

Woman: Well, so, you know, hearing that you're from UnitedHealth Group, it just kind of reminds me about some work that at least, that optimists doing, I guess one of your business units, is doing with one state. And so, you know, they are beginning to support, looking at the data around severe maternal morbidity and mortality.

And presumably, that is to help inform and develop specific interventions. So, that could be carried out by different groups. So depending on where they

are, you know, some kind of care manager at the state level, state Medicaid level - I'm sorry, my glance tends to be Medicaid.

If you all, do not already know that or, you know, that can also be implemented via the managed care organization. So whether that is providing doula as an example, for certain women.

But I would really like to hear what your thoughts are, because I think the last time you had some comments, but I don't think you fully shared them either, so…

Michael Currie: I appreciate that and thank you for that. I co-lead our addressing maternal mortality efforts through this enterprise wide effort. So we have leaders and clinicians across the entire enterprise from commercial Medicaid, Medicare, Optum. And we've convened a work group and brought those experts together and spanning from experts from Elliott Main in California to Wanda Barfield in DC, and everywhere in between.

So, when we get the input and feedback from providers, government regulators, hospital system, you know, there're something that we're working on that would be akin to a maternal mortality checklist. So let me call it that just for the sake of simplicity and discussion today. Thinking of like to give folks feedback and it follows the approach and framework of what will be good for the industry.

So think about, you know, I hope this doesn't come across as morbid. But just think about when there is a plane crash, their representatives from NTSB that show up on the scene, it's always the same unit. It may be different individuals but they've all gone through similar training. And they go through

that crash from the tip of the nose of the plane to the tip of the tail and every nut and bolt in between.

And we started thinking about what is it that makes that process so thorough, so that they can go through figure out what happened, report on it. Folks learn from it, so that it hopefully doesn't happen again. There's got to be a process, a learned process that they went through, that they leverage and utilize in reviewing the crash to figure all that stuff out.

Is there a tool, whether we call it a checklist or something else that not only we could use internally for our retrospective analysis of cases, but something that also could be leveraged by the industry as a whole that allowed providers, hospital systems to essentially go through a checklist when there is any cases, severe morbidity or mortality to do a self-check on what they did, where opportunities do a better arise and sort of follow that process.

So we've been thinking through that developing a template or something. We've even - we started, you know, pre-COVID. We started the vetting of a draft tool with some experts to see what they thought. And it's, you know, with COVID having come upon us, we've had to table some of our conversations for a couple of months but we're going to get back to that in June.

So I'd love to get your thoughts and ideas for just that one thing that it is we're thinking about and doing and that's aside, you know, regulation aside, there's always opportunity to weigh in on support of different types of regulation. So, I'm going to sit down on the side as it relates to regulatory matters that's payment.

And you mentioned doulas. How do they get credential? Where do they sit within the healthcare system so that they can get some sort of payment? I'd love to hear your thoughts on that as well, outside of regulation.

If regulation comes that says they are credentialed. And here is how they go through their credentialing process. And they become part of that sort of traditional provider system with ID number no less than S easy they can be can be included there.

But if that doesn't happen, how do they get leveraged in the system and then paid, so that it's a sustainable enough model and not just something that is sort of leveraged in various places in low key where you have a system or provider that can afford to do. So let me stop there.

((Crosstalk))

Woman: I just want to - because what this highlight is a deeper structural issue. When we talk about risk and these influencing factors and the patient provider, we don't have the payer listed. And such as the MMRIA system is supposed to be built so that people can analyze. You can form a community and you can then come up with a way to address it.

If our current infrastructure for parents who're having insurance for people, does not perceive that it's a part of this MMRIA system of analyzing death and coming up with a response.

And that's a structural breakdown in what we're trying to create as a country like we should be able to use the same system to see what happened and that payers should see themselves as a part of a larger community. It's also the patient the provider. And what are the things as a payer should doing

differently to ensure there isn't another maternal death. So that's what I hear when I hear this conversation.

Nicole Williams Hi, this is Nicole. I appreciate the comments and I'm sorry to cut in. I think, Mike, he bringing up some great points that we can include in the current scan to some extent. And also likely say some of that information within our recommendations report, if it doesn't already exists.

And I would like us to transition on to the next section, which you should know if you have any last comments or.

Woman: I was just going to say, as we're - as NQF team is working on that section I have, you know, couple of thoughts that I can contribute. That's all. Thank you so much.

Woman: Okay. Great. Thank you.

(Tamara): Hi, this is (Tamara). And I'd like to make a comment if that's okay.

Woman: Sure.

(Tamara); Okay. There was a gentleman who just spoke. I just want to be able to address to the gentleman who just spoke. I just didn't catch his name.

Woman: Oh, that was Mike Currie.

Michael Currie: I'm sorry. Yes, Mike Currie. Yes, sorry for that.

(Tamara): Very, very quickly, I'm a maternal health advocate and a person with a lot of experience. I'm also known for being very blunt. So I'm not going to hold back right now.

As you were speaking, one of the things that I felt like was really lacking. You mentioned, (unintelligible) this information from, you include it government, hospitals, all these regulatory bodies that you failed to mention, actual patients and their families. And that to me is the crux of the problem.

And we're seeking this type of information as to what's happening, how can we improve things? You're never going to be able to answer the question fully, unless you improve patients and their family.

So what's good for the industry, I would challenge you back and say, the best thing for the industry is forming true partnerships, partnerships with community, advocate to a patient or patient advocate or their family. And having them included in some of the work that you're trying to do and answering some of these questions. And that's -- since we're limited on time, that's as much as I'm going to say. But it really had to get that in there.

Michael Currie: Thank you for that.

Nicole Williams: Okay. We are going to move through our agenda in 56-B. The next section that we wanted to discuss with the committee and this might be a briefer discussion, it was around the AIM Bundles.

There were quite a few comments from the group. As the AIM Bundles were really placed within several areas of the scan. So we have them listed under the maternal standards of care. We also have been referenced again as a federal initiative that has impact on measurement and the staff wanted to get

some clarification to make sure we're representing them consistently in the document.

And so, some of those questions that we came up with that we'd like to discuss with the group is understanding how the AIM Bundles are primarily used within the maternal care community.

So, are they viewed as a preferred preparatory tools and accountability tool or something used more specifically for measurement? And also, wanting some validation on how they're placed within the scan documents if we should keep them referenced in several areas or if they are more applicable to just the measurement assessment piece.

Elliott Main: Okay. This is Elliott. One of the lead for the AIM initiative, I guess I need to chime in here. It's none of the above. AIM is really designed to be a quality improvement project rather than a prescriptive, reflective. It has an internal reporting. It was not meant to be a national reporting tool.

We do use a lot of process measures that are generally used internally because they are very difficult to collect. And that's the problem with a lot of process measures, which is why you don't see many of them being used beyond specific QI projects.

So this is a partial, sort of, meant to be a partial solution for some of the issues that we've talked about. It's not going to be solving maternal mortality but it's going to adjust some of the hospital failings, particularly as we blend in respectful care, addressing racism within the existing bundles.

So they do use measures, like, severe maternal morbidity. But they, you know, and they are being adopted by the Joint Commission, for example, as

standards of care for hemorrhage and hypertension in building a micro carriage last comments.

There are number of pairs that are asking hospitals or incenting hospitals to show that they've adopted the bundles as a step that a payer can take, which is really important because payers need to step up and show this maternal morbidity, mortality is important. And there's no way better to show that then putting some incentive dollars on the table for hospitals because the hospital pay attention to.

So it's more in the key wise side of what you can do to reduce maternal morbidity and mortality rather than any of these areas that you've identified here.

Nicole Williams: Thank you, Elliott. There was also a specific question around whether Elliott if you could share any more data on the implementation or challenges or metrics to use.

Elliott Main: I'm happy to provide you some things.

Nicole Williams: Okay. Any other comments from the group?

(Tamoria): This is (Tamoria) I just have a comment, Elliott, you might remember me from the (unintelligible) conference that I had presented at. In that meeting there - it was presented that 8% of the hospitals to participate in AIM are actually implementing that race and disparity bundle.

And so, is that something that you'd like to elaborate on in terms of the accountability process or, you know, a way that maybe insurers to get involved in terms of accountability?

Elliott Main: Sure, couple of comments on that. First of all at the time the survey was done there was an equity bundle had just come out, some hospitals weren't adopting it. Secondly, there aren't really many action steps in that bundle, which has made it more difficult to implement.

And thirdly, it was felt that what we really wanted to do to integrate the issues presented in the equity bundle into the other bundles. And that's the process that's going underway right now. And that's what we are trying to do in California.

You know, there are some overarching issues like, educational modules and so forth that has general principles. But then when you get them to hemorrhage or hypertension, you really want to be sure that you are impacting everyone in an equitable way.

And you know, we've started as a pilot of which I think should be reflective or should be adopted around the country of all the measures being stratified by race and ethnicity so that no one is left behind. And it's in your face, that you can't deny the truth, treating everyone the same.

Nicole Williams: And we have Kate Menard, we see that your hand is raised. Did you have a comment?

Kate Menard: Just to sort of complete the thought, I agree with what Ali have said. You asked if the AIM bundles are kind of properly placed in the report. And I think given under the heading of the standard processes maternal care alleviate, I think they are properly placed.

And, you know, I think that we can probably expand certainly on some, you know, potential measurements. And that I think they offers a lot of good guidance for measurement for the labor delivery section. But not, we certainly still of course, need to figure out how we are going to do some measurement for preconception and prenatal cases.

And they are - I can offer a reference authenticity or regarding some pre-conceptual measures.

Nicole Williams: Okay. There are no other questions specific to the AIM bundles. So I'm going to try to quickly walk us through some other components here. Obviously, a large part of the scan is a scan in existing measures and measure concepts.

And so, right now, as far as existing measures, we have about 25 total and that are NQF measures and about six of those carry endorsements. And so what the past did as you'll see in the subsequent five is, we have identified specific sub-domains for morbidity and then sub-domains for mortality.

So you'll see some suggested sub-domains for morbidity, which we found this to be these sub-domains to be very consistent with a number of existing frameworks and represented that life course perspective that the committee had previously shared with us.

And you could scroll through to the next two slides. We have our existing morbidity measures that we have found organized by each of those sub-domains.

Next slide. And you'll see here that sub-domain that first one is preconception. So we've listed those measures. And the next slide then

shows that same sub-domain of preconception and these are measured concepts.

These measure concepts were based on the comments and discussion that we've had with the committee earlier on and also based on some of the research that we have done. This isn't meant to be an exhaustive list but we are encouraging you to share additional feedback on measure concepts with us via email.

There will also be an opportunity a little bit later on in the project lifecycle. So, to speak, when we get closer to the recommendations report that the committee will have an opportunity to explore measure concepts then as well.

So I'm going to scroll through the next few slides, you'll see again, it's organized by the next sub-domain. So prenatal, labor and delivery, existing measures and measure concepts. And then postpartum existing measures and measure concepts.

We then get to mortality and I have some suggested sub-domains. Again, if there's some specific feedback on those subdomains, please share that with us via email. But we have organized according to those suggested sub-domains, any existing mortality measures and then measure concepts.

This is found within the environmental scan report. We do have a question from Wanda.

Wanda Barstow: Yes. So, I'm glad that you mentioned that we can send information because I think we can think about some other measures outside of contraception for preconception health. And there are several other measures that we can share.

Things like hypertension control, also thinking about prenatal care aspirin use for prevention of preeclampsia. And then with regard to pregnancy, transfer some data on discrimination during pregnancy, from a few state to pick that up. New York City's really leading the way in that area.

And then also I can get a dimension previously, residential segregation is the metric for non-medical risk factors. Thanks.

Nicole Williams: Great. Thank you, Wanda.

(Joy): This is Joy. I raised my hand but I'll be quick. Just that and Wanda probably dig some I'm about to say.

So we've been struggling with the term preconception an odds that it kind of take and I know that there's been a lot of that we've been working on reproductive well-being, which leads into what she was just talking about where you don't worry about contraception. But you are also talking about, do they have hypertension or diabetes and what is the (unintelligible) as we've been talking about a lot on the call.

And so, just considering that there is a little foot which were much smarter than me to no longer use the term preconception. I'm happy to use some information around would be reproductive well-being, see if that resonate with me. But it feels like using a term that focuses only on contraception or (unintelligible) might not be the way to move forward in this document. This thing isn't stepping out inside.

Nicole Williams: Thank you. Any other brief comments on the morbidity and mortality measures and measure concepts? And again, later in the project, we will have some time to explore this.

((Crosstalk))

Nicole Williams: Go ahead.

(Jade): I'll just be brief. This is (Jade). I think, particularly in the case of the prenatal ones. It's mostly, those are process measures. They are not actually outcome measures. So we could use to say one state is at a higher rate of morbidity than another.

And so, I think in finalizing this we need to conceptualize them differently. There's nothing wrong with these measures. They don't necessarily capture what I would think is maternal morbidity or ultimately what people talk about severe maternal morbidity. So I do think it's important to capture measures around the prenatal period.

Nicole Williams: And are those existing measures that you are referring to or would those be more measure concepts?

(Jade): Quality concepts at this point, I don't think people have them. So the measures - well, they might have them in individual studies but they don't have them as regularly reported in a way that we can use to do a comparisons.

Nicole Williams: Okay. I think you are discussing an important point that might be noted for clarification. Are you requesting existing measures or are you open to potential new measures?

((Crosstalk))

Woman: …NQF?

Woman: Yes. So, historically, often we are looking at existing measures.

Woman: Yes. So, we are looking at existing measures as a part of identifying what is out there. And also identifying where the gaps are. And using those gaps as a way to then look at measure concepts. So we are looking for both.

Nicole Williams: Thank you. Also PCCs may be an opportunities to identify metrics based on the implementation of AIM bundle for example.

(Jade): At least those have seen some track record with them. Did you have any criteria for your measure concepts because some of these are pretty out there like the percent of women with night blindness in the last pregnancy? You got to have some triage there.

Nicole Williams: So, we are kind of loosely defining a concept we - this is consistent with other framework projects where we identify measure concepts just as an idea for a measure that includes a description of the measure. And it's ideally also included identifying the planned target and population for that particular measure.

And this list that we've presented as I stated before is based on what we have found in the literature. And also, what we have heard is some early feedback from the group. One of the exercise is that, we will carry through with the committee as we prepare for our recommendation's report next year is to really narrow this down and identify more specifically, what concepts are more found.

(Jade): That's a really…

Nicole Williams: So, did you have a - I'm sorry.

((Crosstalk))

(Jade): No, I have nothing more to add.

Woman: Now, just - my quick question is just about those measures that are currently in development. So I know that you've listed some of the NCQA measures that are no longer endorsed. But the replacement measures are - and I know that they are not yet fully vetted. But they represent some important changes, I think.

Nicole Williams: All right. So with about three minutes left we wanted to again, just let the committee know that you have the current document we shared with you last Friday on the 22nd. So, please mark that up with any edit suggestions that you have. We are expecting additional edits and suggestions through June 1 from the committee. I know that's pretty quick.

As we prepare for submitting the first draft to CMS by the eighth of June. So just so you all understand kind of that timeline. I am going to turn it over to on Hannah to open our lines for public comments.

Hannah Ingber: Thanks, Nicole. Yes, so, if you'd like to make a public comment at this time, please unmute yourself. All lines are open.

Okay, hearing none I'll just move on to our next steps. But before I do that, we'll just clarify a few timeline changes that we made. As you can see on this slide, we've made some changes to the topics of our web meetings and the number of web meetings.

These changes include swapping the discussion topics of web meetings four and five. During web meetings four, our next web meeting, we will begin our discussion of the recommendations report and the measure frameworks. Then during web meeting five, we'll discuss the comments we received on the environmental scan. We have cancelled web meeting six, originally scheduled for October. And we've shifted that topic to the November web meeting.

So, our timeline for the reports is laid out in some detail here, due to the impact of COVID-19 CMS and NQF work to adjust the timeline to increase the length of commenting periods and move some topics of discussion as I just mentioned.

This really ensures that our stakeholders have ample opportunity to engage with our work during this difficult time. And adding to what Nicole was mentioning, our immediate next steps are preparing the environmental scans to send to CMS. Our draft number one, as again as she stated, the committee will have until June 1 to send us any further comments on the report prior to us sending it to CMS.

And we'll incorporate all the feedback from today and any additional feedback that you send by next Monday June 1 into the environmental scan. We will then send the scan for CMS's review on June 8. And our next committee webinar as mentioned will take place on the 25.

We will continue making revisions to the scan and we will discuss those comments. I'll pass it back to Nicole for some closing remarks. Thanks everyone.

Nicole Williams: I just want to say a tremendous thank you to our co-chairs and our clinical consultant for leading us through this discussion today. And certainly, the committee's time to help us through this environmental scan and all the discussion. So, kudos to you guys for getting through quite a bit of content today and we will be in touch with some next steps. Thank you, everyone.

Woman: Thanks. Bye-bye.

Woman: Bye-bye. Thank you.

Man: So long, everyone.

Nicole Williams: Thank you.

Woman: Thank you.

END