NATIONAL QUALITY FORUM

Moderator: NQF
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12:00 p.m. ET

Hannah Ingber: Hi, everyone. This is Hannah with NQF. We'll be getting started in about five minutes. We're just waiting for a couple more people to join. And so if you can just put yourselves on mute while we're waiting for others. Thank you.

Elizabeth Howell: Hello.

Hannah Ingber: Yes. Hi, this is (Hannah) with NQF. We'll be getting started in just a few minutes.

Elizabeth Howell: Thank you.

Nicole Williams: Good afternoon, everyone. This is (Nicole Williams) with the National Quality Forum. Welcome to the Maternal Morbidity and Mortality Web Meeting 4. I am joined by our team here and you can see their names listed on our (Insta Slide).

We hope everyone is continuing to do well in these days. We definitely have a full agenda for today. After we do our rollcall, we'll go through a few of our

objectives for our meeting. And this meeting is really meant to be where we pivot to the next phase of the project which I'll talk about with the committee shortly. And then as always, have a group discussion and open our - open up for public and member comments at the end of our Web meeting.

So we're now entering into our second phase of the work for this project. And we will pivot slightly in terms of our objectives and discussion. I think for now our committee and group has been focused on developing the environmental stand for maternal morbidity and mortality. And while we're still working in that scan. It's still in a draft form, and we're still working (unintelligible).

We are transitioning our conversation...

((Crosstalk))

Operator: ...by the pound sign.

Nicole Williams: One, you know, housekeeping - a few housekeeping things I have forgotten, and please forgive me., A few best practices before we jump into this. For our committee members, we'd like to remind you to place yourselves on mute if you're not speaking. When you announce yourselves, to make sure - excuse me, when you're ready to speak, please announce yourself before.

For any of our public participants, please note later in the meeting there will be an opportunity for public comments, so we ask that you hold your comments until then. We are using a Web platform so there is the option to raise your hand if you wish to speak, and the staff is monitoring that can call on you. There is also a chatbox feature that messages can be sent to any of the staff, and we'll do our bring to bring those messages to the attention of the

group or the co-chair's as needed.

So apologies for not mentioning that before.

So that's sort of our meeting objectives. I was explaining this is a moment of pivot for the committee and for the project as a whole. Again, our thrust environmental scan is still being completed, but we are transitioning our conversations to focus on developing measurements framework. For this project specifically, we are tasked with developing two measurement framework; one for morbidity and one separately for mortality.

I also mentioned that we have made some small updates to our agenda since pretty sure order in the last few days, and we have invited the TDC division of reproductive health to present, to briefly present and participate in our discussion with the committee before we jump into our bigger discussion on measurement frameworks.

So our main objectives for today will be to review, discuss, and come to an early consensus on the content for the measurement framework, and the measure concepts that will stem from those frameworks. And we will share some more specifics about that in a minute. I will no hand it over to Hannah Ingber, who will complete our rollcall for today.

Hannah Ingber: Thanks so much, Nicole. Good afternoon or good morning, everyone. I'll just go through the rollcall. If you could unmute yourselves and just say if you're here, that would be great. Lekisha Daniel-Robinson?

Lekisha Daniel-Robinson: I'm here.

Hannah Ingber: Wonderful. Thank you. Elizabeth Howell?

Elizabeth Howell: Yes, I'm here. Thank you.

Hannah Ingber: Timoria McQueen Saba? Okay. She notified us she might not be able to come. Okay. Angela Anderson? Katie Barrett?

Katie Barrett: I'm here. Thanks.

Hannah Ingber: Debra Bingham? Emily Briggs?

Emily Briggs: Hey, guys. I'm here. Thank you.

Hannah Ingber: Thank you. Beth Ann Clayton?

Beth Ann Clayton: Present.

Hannah Ingber: Okay. Charlene Collier?

Charlene Collier: Hi. I'm here.

Hannah Ingber: Thank you. Joia Crear-Perry?

Joia Crear-Perry Hey, guys. I'm here.

Hannah Ingber: Okay. Michael Currie? Okay. Eugene Declercq?

Eugene Declercq: I'm here.

Hannah Ingber: Thank you. Mary-Ann Etiebet? Okay. Dawn Godbolt?

Dawn Godbolt: Here.

Hannah Ingber: Thank you. Kim Gregory? Okay. Kay Johnson? Okay, she notified that she might be a little later as well. Deb Kilday?

Deb Kilday: Hi, everyone.

Hannah Ingber: Hello. Thank you. Elliott Main?

Elliott Main: Good morning, Hannah.

Hannah Ingber: Good morning. Claire Margerison? Kate Menard?

Kate Menard: Present.

Hannah Ingber: Thank you. Katrina Nardini?

Katrina Nardini: Present.

Hannah Ingber: Thank you. LaQuandra Nesbitt?

Woman: If you guys read it, you have to read the article I sent.

Hannah Ingber: Okay. I think she's (unintelligible) she might not be able to join. Nicole Purnell? Diana Ramos? Elizabeth Rochin? Rachel Ruel? Amber Weiseth?

Amber WeisetHannah Ingber: Hi, I'm here.

Hannah Ingber: Hello. Thank you. Amanda Williams?

Amanda Williams: Hi. Good morning.

Hannah Ingber: Good morning. Tiffany Willis? And Susan Yendro?

Susan Yendro: Hi. I'm here.

Hannah Ingber: Thank you. Okay. I'll now go through the federal liaisons. Girma Alemu?

Girma Alemu: Present.

Hannah Ingber: Thank you. Wanda Barfield? Renee Fox? Erin Patton? And Marsha Smith?

Marsha SmitHannah Ingber: Hi. I'm on the call.

Hannah Ingber: I see Nicole Purnell you have your hand raised. So I'll mark you as present, but I didn't hear you so you may want to call in again if you're having troubles with the audio. Just tell us now if you need any help.

Nicole Purnell: I'm back (unintelligible), but I'm back. thank you.

Hannah Ingber: Oh wonderful. Okay, great. Okay, I'll pass it back to Nicole now. Thank you, everyone.

Diana Ramos: Sorry. Diana Ramos joined late.

Hannah Ingber: Oh wonderful. Thank you, Diana.

Angela Anderson: Hi. This is Angela Anderson. I missed my name too. I'm here.

Hannah Ingber: Oh okay. Were there others who didn't get to say yes when their name was

called? Okay, great. I will hand it back to Nicole then.

Nicole Williams: Okay, thank you. So what we'd like to do is review our structure for the measurement framework and recommendations report and really share a little bit more about hotlinks about the purchase measurement frameworks.

So as I mentioned, we are transitioning to the second part of our work and developing two frameworks. And ultimately (unintelligible) along with the list of measures, measure concept and approaches for measurements addressing maternal, morbidity and mortality will be included in a larger recommendations report, and it will be that report that will be presented to CMS.

In the interest of time, I am not going to walk through the detailed requirements of the recommendations report right now. That will be something that we will come back to at a later Web meeting.

Slide 10, please. So for NQF, our framework is really a conceptual model for organizing ideas about what is important to measure within a topic area, and in close consideration for care settings, how measurement should take place, individuals and organizations that should be included.

The framework also provides a roadmap on how performance measurement can be used to improve a health outcome. Framework is an area of work that NQF have been involved in since its inception and there are several frameworks across various topics that we have worked on, a few include health equity, person-centric planning, trauma outcomes, and population health.

Next slide.

What we thought would be helpful, and I apologize some of the etexts on here are a little small, but that would be helpful to share with you a visual of a framework that we have developed previously around diagnostic error. And what I like about this is it's encompassing and kind of shows some of the key components that we're planning to focus on for our projects in particular.

So the circular shape in the middle outlines the specific domains that are looking to be addressed to review diagnostic harm, so you'll see patients, families, caregivers as a domain, diagnostic process and outcomes is another domain, and organizational and policy opportunity.

And then from each of those domains, on the left side are what we call the subdomains and simply just the further delineation of that larger bucket. And so there are several subdomains again listed out. Within each of those subdomains for most of the frameworks, you then will find a list of existing measures and potentially measure concepts, depending on the scope.

That will be our goal for our project. Again, it may not happen for each of the domains or subdomains for their 2D measures and measure concepts, but we'd like to just highlight and mention that as typically the flow for most of our framework.

The other important thing to mention is the cross-cutting themes that are shown on here. I think everyone's familiar with concepts within measurement or components within measurement that are often difficult to measure but certainly big influencers of outcomes and health.

So things like transitions of care, health literacy, to name a few that are on here, patient engagement. There are (loose figures) of cross-setting themes

that's typically how we share that type of information and I imagine we'll do something similar for our framework.

Slide 14, please.

So here I thought might be helpful for the committee to really understand what the transition will look like from the environmental scan to our framework. So, so far, as the group knows, our environmental scan really sets the stage and the foundation if you will in terms of our content.

We designed maternal morbidity and mortality. They - we provided a summary of the literature around the risk factors related to that, and also shared a starting point of measures and measure concept. That same content will be used to populate our framework.

So we don’t want the group to think that we're sort of starting over. We're using all of the information that we have collated this far and repurposing some of it so it fits within the structure of our framework. Again the framework will have domains, subdomains and measure concepts.

And then finally our recommendations report will include those measurement frameworks, along with a set of final recommendations around measurement.

And so before we have a discussion with the group around existing frameworks and kind of start that brainstorm, this is the time we thought it would be helpful to have Dr. Wanda Barfield and a few of her colleagues to share information on maternal - some of the maternal measurement needs and existing the frameworks that the CDC has utilized to help provide some context before we have a broader discussion with the committee.

Dr. Barfield, are you on the line? If not, I am going to turn it over to (Dave Goodman).

(Dave Goodman): Yes, I'm here. Can you hear me all right?

Nicole Williams: We can.

(Dave Goodman): Great. And then you'll advance the slide for me, is that right?

Nicole Williams: We will, yes. Thank you so much.

(Dave Goodman): Awesome.

Well let me say that base on that roll call, I'm pretty humbled to be speaking to this committee. It's a lot of folks who I know and respect well. So I appreciate this opportunity to speak with you all and share, you know, a little bit on what it is that we need first to review the (unintelligible) from some of this work we expected that there will be two frameworks needed from this committee work; one focused on the mortality and one focused on the morbidity.

And while that may not convince you over the next couple of slides, at least maybe you'll have a better understanding where we're coming from and give you a little bit of something to think about and need to cover.

Next slide.

So I think this is not new but this is sort of a grounding for everyone is, you know, frameworks I have learned are really important and useful and that they really help the scope and parameters and those parameters commonly get set

through the specifications of domains as have been discussed a little bit already.

And it really creates a nice (angle) point for you to reference as you're going forward and just mixing easier and more efficient and I just provided some examples here of some kind of high-level domains that, you know, (unintelligible) really clarify for yourself as well as others of what it is that you're looking to achieve.

Next slide.

And so here we have the two focus areas for this committee to work mortality and morbidity. And you can see that pregnancy-associated and related (unintelligible) and you can also see the (unintelligible) morbidity. And looking at some - from this sort of simple standpoint of this timing that's built into their definition, you know, during pregnancy and (unintelligible) and during delivery hospitalizations with morbidity events.

There is some overlap in timing but since a lot of these differences in their purpose, also in their timing and then a lot of the other potential days. You know, including that when we hear maternal morbidity, you have survivors within (unintelligible) health risk.

And so if you're thinking about in discussing (unintelligible) course incorporation into your framework, then that's something to be thinking about. That would be different things to address and now that there is a release of potential (unintelligible) even within death is just - that like core featured in the thinking of (unintelligible) no partner left behind, no child or children left behind and what might be important to measure a little bit (unintelligible) going forward.

Next slide.

So now taking that previous slide and adding some simplified timing domains and then some subdomains, you still may have a lot of overlap at that higher level at this point. But also it may be that the subdomains there are already some important differences for you to consider. You know, maybe recognition and response is a greater priority for pregnancy-related depths that occur after pregnancy in that time period.

Well for morbidity, it's access and quality that might be more important areas to focus. And I think that it's, at this point, helpful to think about focus because you can't have 100 or 50 or potentially even 20 measures in your framework if you really are thinking ahead to implementing it and using it. And we've learned that from the pre-concept (unintelligible) indicator works (unintelligible).

We learned from that that about 10 is where our focus are at in terms of feeling like it's an approachable framework for them and actually wound up with separate pre-conception health and pre-conception care framework for folks (unintelligible).

And so as we move into the more specifics of identifying measures and beginning to think about those measures even with the domains, and the subdomain, we were already looking ahead and expecting that that was very likely the important differences that drive both the concepts given - concepts and stakeholders and also single availability on - from a very tactical side.

Next slide.

So here are just some examples of some of us with specifics that you may get into with the measures and some considerations for them where, again, there's still may be some degree of overlap between the framework, but expect that it's more likely that there's going to be increasing diversion between like the (unintelligible) measure for pregnancy and (unintelligible) to, you know, morbidity.

And, you know, some of the things to think about are, like, you know, the quality - if it's quality or provider care, (hand) or quality of care provided that gives the priority and the need, you know, based on what you know about mortality and morbidity.

Is it important to measure the outcome and/ore the cause and (unintelligible) for getting at, you know, is it important to focus in and measure (unintelligible) or is it more important or important to also capture some of those causes for why maybe that (unintelligible) venture into prenatal and be monitored on those.

And then also thinking about measures that are specific to what we already know about morbidity and mortality and already the priorities within those areas that have been identified that these measures be - maybe able to help hone in on some specific aspects of - and match up to those known priorities.

So we have a lot of considerations and for me this sort of what is needed is an exciting time. It's (unintelligible), right? It's not thinking on the practical side but really in order to do - to identify measures that are being - the importance and relevance really step away in this - what's needed, what would that measure look like. So that then you can look forward and thinking about what might be practical or what's needed and when can it be ready.

And the other thing I'd say here is, you know, on the prior side, I saw equity as a cross-cutting domain across al the others. Thank you.

And so, you know, also thinking about is that - if you're going to make that explicit as a domain, really think about what that looks like within these measures which also may be different within the context of morbidity and (unintelligible) morbidity being measured in a curve versus mortality.

And so it may be that we're looking at the treatment time - treatment or time to treatment differ by race and ethnicity for the same condition but it also means within the data source is you need to be thinking about or you capture and rate race and ethnicity accurately enough, we'll enough to be able to see that.

And then again you exactly endpoint of your measurement or do you also want to measure the drivers for those differences to drive really what you want to be monitoring. Again, it's the thing that can be (unintelligible) you might have some real diversion.

Next slide.

And - the next one. So then, you know, as you progress through and then once you have those kinds of ideal measures and what really would be needed now, you can have sort of heartbreaking (unintelligible) coming back from reality and (unintelligible) looking at what are the - what measures can be done now and easily what we already have data systems in place, what are they capturing that relates to what we had said were (names).

And at what level can those measures either be measured upwards or downwards, you know, and are those then the levels that those data courses

are reaching, are they also matching up to the stakeholders that you want to reach with these measures.

And so, you know, something to be asking is, you know, can - not only can the existing data collections systems be used as they are, but it is an opportunity to start thinking about and existing data collections system be equally modified to then capture these measures which she said are the important matters or linkages of existing data sets be used to help (unintelligible) some of those gaps.

And this is where the frameworks may and I think likely should continue to (unintelligible) from each other and really speak to all together why these - that our expectation was that this committee (unintelligible) two different frameworks.

Next slide.

So that was it. Just kind of again trying to give you a sense about the - where we were coming from when - early on when this (unintelligible) was proposed. We were already thinking ahead that there would be two frameworks from this committee.

Nicole Williams: Thank you so much, (Dave), and the team for pooling these together. So just so the committee is aware, we have about 15 minutes with (Dave Goodman) and some of the other CDC colleagues. So I'd like to allow there'd be time to ask and answer any questions the group may have and I'm not sure if Dr. Barfield has been able to join our Web meeting and if you have any thoughts or feedback, Dr. Barfield, if you're on the line. Okay, any thoughts or questions from the group?

Elizabeth Howell: This is Liz Howell, and I just want to say thank you so much, (Dave). That was really helpful and I think at least for the committee at least when we have an earlier call that - a couple of us had an earlier call they were still struggling with this idea of two frameworks.

So my specific question is around equity. So you should have showed us that one-time win where estimate is - the way you conceptualize it was sort of shorter period or during that delivery hospitalization although (unintelligible) pregnant. And that was one dimension which we could think about differently.

But when you talked about equity, I wasn't - you sort of used the example of data collection getting self-identified with race and ethnicity in the measure. But I would like you to just expand on the way in which you're thinking about equity differently for maternal morbidity and - versus mortality.

(Dave Goodman): So I think at a higher level, I think about them very similar but I think where it has come up specifically for me, I (unintelligible) specificity of the measures and within mortality some of the specificity of the equity features that we've been more thinking about are, you know, late to - this is in a couple - so one is the structural pieces.

And it feels like in maternal mortality, we've been developing and working forward with and refining a framework for identifying the - and measuring the structural contributors to a (unintelligible). And I think in some ways, that maybe something more straightforward to do within mortality than morbidity.

I think in both cases now, there is interest in racism and so we've been rolling out, you know, within mortality documenting and being able to document in this data some from our view committees racism contribute - had contribution to mortality.

And how that is being approached, so, it's a little bit different and perhaps broader than how it's being approached in a context of morbidity where it could - it tends to be more facility-based. And so it depends on what the processes are within those facilities. And so I think when it comes to the specifics of the measures, that's when you may see some divergence in the frameworks and within equity as a domain.

Kay Johnson: This is Kay Johnson. f I could jump in. You know, I think, Elizabeth, you - a lot of your work points to something that I think is really important to follow on to what (Dave) just said.

And I've been long focused and sort of (unintelligible) in the maternal and health field about the fact that we don't do a very good job of being willing to (unintelligible) on equal treatment. And I think, you know, whether it's one frame or two frames, and actually (unintelligible) two frames, but this notion of us being willing to tackle and have measures that get at an understanding on equal treatments.

You know, personally, I think that, you know, every prenatal (unintelligible) collaborative ought to have an obligation to do equities, racism, unequal treatment-specific studies. What I find in public health very often and I again, Elizabeth, your work and some - of others is - will come true on those.

In public health, we're always busy measuring the disparity or we're doing a quality project that's general and in the end, we measure the disparity. I just find in this world today it's totally insufficient. That's what's been going on for 35 years of my career and that we really need measures that help us, help hospitals, help providers, help caregiver quality, collaborative, understand some of those factors underneath.

So, you know, whether it's facility matched level of (wit) and then by race or whether it's about those completed referrals and done by rate. But the difference again to me around - between just measuring the disparity or really looking at the patterns and new ways and I think, you know, the (unintelligible) work is extraordinary as a breakthrough in the (unintelligible) and house in that area and I hope you can do that with maternal morbidity and mortality.

Joia Crear-Perry: Hey. This is Joia. I just want to add on here because I do think it’s important. I was excited that I would use the term framework and I just - you know, I don't know if anybody has ever heard me speak. We talk about the difference between those frameworks and the indicator and measurements and I was (unintelligible) to see on this call, but it's proved the people who are looking (unintelligible) measurements that we're pairing off with a framework conversation but that (unintelligible) framework the current measurements are actually under.

And it's not a default. So when people pick the current measures that we're using, they have a framework in mind (unintelligible) that framework is how you have everything in healthcare and public health measure. But we will highlight (unintelligible) value-based upon many things like clash, like (unintelligible), like gender.

And so if we're going to say the new framework around how we're going to look at maternal morbidity and mortality, that that's under - looking at the - and then understanding racism, gender oppression, clash (unintelligible). We're going to keep thinking measures that get for addressing how we're going to end in equities.

And so we're going to keep calling it disparities because people like to hear but it's difference - makes a difference in - I know (unintelligible) look back and (unintelligible) definitions of disparity, and so some of us being how they (unintelligible) and they missed out access to healthcare because they were like, "Oh we can't improve that because we'll never fix that."

We just - if you want there'd actually be equity we're going to have to - you have to include that as part of our measure, part of our framework. We can 't leave it out because it's uncomfortable or it's not easy.

So I'm excited to what we're going to say is the framework and I hope that it means something bigger than what we're measuring to date and looking at if we can pool data from the current sources that we use because we know data is moving faster than you do and therefore the data that we didn't have and a lot of us went to school and that there are ways to figure out structural (unintelligible) referral, there are ways to figure out access to healthy food with grocery stores and all those things are impediment to morbidity and mortality and it's not the individual provider or patients behaviors.

That's it.

Elizabeth Howell: So this is Liz again. I'm just going to say thank you, Joia. I think you bring up a lot of the very important points and we are going to talk about that when we talk about some of the - just review some of the possible frameworks, really just to make sure that we're capturing a lot of the things that you just mentioned and the way we think about this.

But I wanted to make sure that we - I think the committee, in general, had a little bit of tension around a single framework versus these two frameworks that it's been so helpful for me personally here (Dave Goodman). But I was

wondering if somebody else had another question because I think we need to make sure that we're all comfortable and that we understand that we're good with these frameworks. I think that was - I was just opening it back up.

Elliott Main: Sure. Thanks, Liz. This is Elliott. And I think a couple of comments. I left the slide that's on the screen right now quite a bit. But I think it focuses on, you know, the before and after pregnancy is (unintelligible) and a lot of it is about outpatient care or let's focus on a current condition which is what pregnancy and labor and delivery is about in recognition response.

And the equities we got for are bit different what is around quality of care. And the others around policies and all the end of seasons that Joai was speaking to. So I think that's very helpful.

I didn't know if - concerns about the double framework of death and morbidity because essentially death is the end of morbidity. And as we've looked at trying to improve maternal mortality and morbidity, there really is very different pathways for the different proximal causes.

So cardiovascular disease is late often after delivery as a postpartum up to that year driven by co-morbidities is it does have definite racial disparities that - and outpatient care is very important. But it doesn't carve out much comorbidities.

With hemorrhage, it's the - causes more than half of severe maternal morbidity. It's acute dysfunction even hospital, (unintelligible) current issues, less staff, it's very responsive to quality improvement initiatives, it's less dependent on co-morbidities.

So there are very different measures and that you'd use for those two different

causes of morbidity and mortality that (unintelligible). If you look at mortality, it's a waterfront of all kinds of conditions that allude to it. Yes, there are some underlying conditions that causes that with previous (unintelligible) to have more morbidities than others, but to address it, you have to under - also address the possible causes; you know, the hemorrhage, the inception, the hypertensive disorders, the cardiovascular disease. And I think it's kind of artificial to separate that from this - from morbidity in those.

Elizabeth Howell: (Dave), you want to respond? I think that this (unintelligible) is going through (unintelligible).

(Dave Goodman): So I guess my response is, I mean, it's - it'd be interesting to see how it's (unintelligible) wind up with you identifying this, the same measures that are important for both. Because I think, you know, as I've described, there's a lot of different ways in which I think that the measure you identified as being important maternal mortality within the framework would be different from morbidity.

And then I think when you add in the equity cross-cutting domain and if you overlay life course, I think it creates more opportunities for divergence. And then when you get to the measurements and the data courses, and I agree with you, I think this is an exciting opportunity to rethink some of the severe maternal morbidity and acknowledge co-morbidity and thinking about it in the context of, you know, before (unintelligible) hospitalization, as well as (unintelligible).

I think that's some of what I'll be excited to see emerging from this group, but I (unintelligible) to say, I think I'd be surprised if you're winding up - if you wind up saying that these are - that it is just one thing (unintelligible) and that these measures work well within these (unintelligible) those mortality and

morbidity and these are ones we think are the most important.

But it could be the outcome, but I guess would encourage you not to enter into the process with thinking that that is what the outcome should be.

Elizabeth Howell: You know, things I just want to say that I agree in this (unintelligible) because the (unintelligible) that we're currently using (news) on co-morbidity are (unintelligible) without having even a slight - (unintelligible) hemorrhage is the number one thing is because that's what we've (unintelligible) because that's what we can (unintelligible). We've never thought about what should be the number one thing and how do we get to that.

And so I just want to be clear that for me, (unintelligible) asking about (unintelligible) what are the bigger questions, not what can be counted, what can be measured. And then if we separate out morbidity from mortality, it's going to be worth the goal. Then equal then what would be (unintelligible) to get to that goal, then we say, how do we get those measurements. Instead of starting with, what is all we can measure? This is what we get from claims. So this is what you have to do.

(Unintelligible) up until now, (unintelligible), this is where we get data. Oh yes, (unintelligible) set new things and these are the codes and that keeps getting this and not changing anything.

Nicole Williams: (Jeff Jaden), did you also have your hand raised? Any additional statements from the committee?

Woman: In the past, with your experience with frameworks with things that are complex, the example that you gave was not terribly helpful to me because it felt like it had less complexity than the topics that we're working on.

But in the past when you were thinking about this framework and, you know, and the complexity in this kind of quasi-ecological design, have you been able to use something that, you know, goes big framing a topic and then sort of breaks out well in such a domain? Do you have an example you could tell us about in that area?

((Crosstalk))

Woman: ...diagnostic error is an example, but I don't think this is complex as what we're talking about.

Woman: I agree very much so. The best example which is a little bit older but a project I worked on quite a few years back was addressing well-child competency. So that was, you know, very broad when we first established a framework that had what we called practices so they basically are preferred ways of doing something related to healthcare.

So we started that very broadly from that sense and then began based on the domains and subdomains and kind of the - what we call practices, then further drove down at the separate document or a separate framework, if you will, which is more on adjusting disparities and within those (unintelligible) that we developed what specific areas could be then fit and measured.

So that - the scale for that was a little bit larger because that's probably the best example and again it's in order project set that one example that comes to mind.

Eugene Declercq: This is Eugene Declercq.

((Crosstalk))

Woman: Yes.

Eugene Declercq: Well I was just going to say maybe one of the ways to think about this in stages because we're always in a stage to challenge balancing the measures we want to have that are really difficult to pool together that don't have the existing data for and the measures we do have now and continue to use.

And perhaps one of the ways to approach this is to think of it in stages that what measures - we know that measures are now available and I think in general I think it's nice but they're not adequate.

One of the measures that could be adapted very simply and quickly so that we can start addressing the urgency of the problem and then have an aspirational component of this of what do we really think would be appropriate and what would be the structural and data-oriented changes that we could obey in order to get to them.

Because at the end of the day, as measurement and I believe a measurement but if the actual implementation of the follow-up to all of these that's going to make a difference in people's lives.

Wanda Barfield: Hi, Eugene. This is Wanda. My apologies for being late. I agree with what you're saying in terms of that is the difficult balance of looking at measures that can - data that we have and really trying to understand the data that we desire in order to get the answers and to make the difference.

Nicole Williams: Also, yes, thank you for that comment as well, Eugene. I just personally like to thank (Dave). I believe that he has to leave and the other CDC colleagues

that were able to join and participate and help prepare for this session. So thank you so much for that.

We will transition. I am going to send us off to Liz Howell who will help walk us through this - the very difficult next step of thinking about what's our framework component.

Elizabeth Howell: So I think we heard of - with - really good discussions about some of the things we need to start thinking about. And what we're going to do now is I'm just going to review a couple of different frameworks just to spark discussion and idea that we think about what are the important domains, sub-domains and then cross-cutting themes that we want to make sure that these frameworks, these two frameworks address.

And then our group can together also decide the way in which we think. So for me, it's a continuance so it's hard for me - I was one of the people that have been struggling with the idea that we needed two frameworks. So having that discussion was helpful for me to hear something that the way, at least in terms of measurement, that they may - they could be different but I just want to say we can keep that in mind as we go through these frameworks.

So this is our older (unintelligible). This is sort of health versus research framework and, you know, I used to have (unintelligible) around the last - when I first did this and as you started to realize that this - listening to folks, Joia, others over the years and just really starting to recognize that, you know, this - is not helpful to have that in any frame launches. So sort of talking about all responses sort of the underlying key here.

You can see the patient level, community neighborhood, clinician factors and system factors that we think are important and sort of all worked together to

create (unintelligible) when she gets pregnant. And I think some of the things that when we think about some of the (unintelligible) what we've been hearing, you can see that around education and poverty and literacy, you can see that I think our group is top of that about psychosocial issues, stress, (unintelligible) hypothesis, social support and psychosocial factors.

We can talk a lot about community, neighborhood, social network, (unintelligible) environment. A lot of attention in our field now on clinician factors, bias and, you know, this is really being included - (unintelligible) explicit bias, cultural (unintelligible) evidence (unintelligible) factors and we can extend many more. These are the (suspense) of the factors when we think about, you know, access high-quality care.

It can (unintelligible) health status when she becomes pregnant which obviously she (unintelligible) comorbidity for certain elevated risks. She - there's that continuum of pre-conception and (unintelligible) delivery and postpartum. And then for me, I would think about it as sort of the outcome being completely almost - it's not really reflected well on this diagram but this continuum of morbidity to mortality.

Now it is - for the purposes of our conversation, I think I'm going to stop after the - there's a lot of things that are not on this but I think there are some things on this that are important for our discussion, but again there are two other frameworks that wasn't talked about in terms of the pieces that we all want to (unintelligible).

So we wanted to start just by getting some reactions to this one. I think at the end of the three slides we'll have a more complete sort of overview of I think the factors that we would not need to bring in. But I think for me, you know, I would even brought about with the continuum of outcomes, the right course

which is not - even though you see this (anti part) of pre-conception, you know, life course is really I think an important part of this discussion as well.

So I'm going to stop and let people comment and, you know, reactions to this and then we'll move on to the next framework. And with that, we can wait for the - we can wait until (we get through).

Kay Johnson: Elizabeth, this is Kay. I have - I think I have shared with this group something that we did that was more at the population level for the mortality point social determinants of health and equities, a measurement framework that actually again thinking about public health and population measurements.

It sets out 30 measures across most of the areas that are in your blue zone there as well as picking up some other (unintelligible) and, y this - the exercise - we've identified 450 measures and we narrow down to about 30. we organized them into domains and we included a special set that we consider related particularly to measuring on equal treatment.

I'm happy to send that again but it is the way and we - there are real like, you know, population public health level measures that can be used at every state and most of them down to the county level that represents this kind of factors and domains, a parallel set to one that you have here.

So I favor this and we have more measures in this than we want. The thing that strikes me about what we did and its purpose really being for state, public health and mostly public health agencies is it's not exactly the same thing that NQF would traditionally set measures out for.

Elizabeth Howell: I think that would be really helpful and I do remember. I think the - a couple of or was it a while ago, so we should be - love to have that again.

Kay Johnson: Okay. Yes, I think we have those.

Elizabeth Howell: Okay.

Charlene Collier: Hi. This is Dr. Charlene Collier. I think our framework is great that you have here, but one thing I wanted to just elevate would be what I call medical education as a source of (unintelligible) disparity than in maternal morbidity and mortality and how embedded in what we learn is a (unintelligible) comforts around black women that just this morning I was looking at the - I was thinking about the (VBAC) calculator and how black race is just there. You know, no explanation, no caveat is being brought and no responsibility on the healthcare system for how a woman is educated, how is she accorded.

So there's a lot of ingrained and medicine itself and I don't know - you know, I think that, you know, if it's clinician factors or system factors. I think what we have learned have to be unlearned in some way and that can be brought in because I think that underpins a lot of what happens at that clinical level when, you know, women (unintelligible) there is no word or not paying attention to or pain isn't addressed or different treatment options are made available or not. A lot of it is cultured by some of these things that have been really deeply ingrained in what we've learned in medicine. So I just wanted to put that out there (unintelligible).

Deborah Kilday: This is Deborah. Can you hear me now?

Elizabeth Howell: Yes, Deborah. Yes, so I appreciate the conversation. I think part of the - what I'm struggling with is how we're defining the word framework. So what - I know within the implementation side, for example they had break frameworks into three categories generally, you know, having the process framework, the

determinant framework and the evaluation frameworks.

And so frameworks can be for different purposes. I see what's presented today is more like recommendations for organizing framework or way to kind of organize a lot of the different majors rather than conceptualization around work. I mean, another way like you can organize that as you (unintelligible) cause any sect diagram to kind of show relationships where we could break it into these different whatever categories we wanted.

I actually like having the idea of organizing out more - what (Dave) had suggested is that we start to work with this framework that he proposed to start to organize it, organize the majors to what's missing and then that would help - it was (unintelligible) I think clarified for us what's going to be most useful rather than spending too much energy right now on what's the best one who work from because I think part of it is just organizing the majors in a way that's a little more easy to see how they relate to a life course perspective.

I really appreciate Joia's comments too. It was like a lot of what we've got, you know, and we've talked about this before (unintelligible), there are so many gaps in what we have - what have been - what the majors are currently. So really being conscious of using a way to organize what's currently available to what really should be available. I think having a way to do that will be very helpful.

And whatever ways - I mean, I think we can relate to and we can refer to multiple different frameworks without it being a problem. It's really just a way to organize, I guess, is the way I see it. So I like this one that Liz has but I think we could pool from this and bring it into the other one, I don’t - anyway, I just think that it's more of us getting down to get - having a way to kind of hold us the information together and the way that makes sense and is easy to

follow.

Woman: That was pretty helpful for me because I was confused about how you all (unintelligible) framework is real. It's like you think - I don't really - because I don't - I can't make - have you ever framework with respect (unintelligible) that I think is amazing and I wouldn't want to choose it although they're the same work. But picking one, choosing which one is better is not really the point.

I think it' taking the time to recognize that we will be creating this as they come from a framework. That was my point that they don't just come out of their (unintelligible) and that people historically, every other - most of the (unintelligible) that talks about measures, people just watch the measures and they don't think about under what framework they created them.

So that's how I'm using the word framework like under what period of change, under what - what do you find to do, what is your goals, not just picking some things of what it looks (unintelligible) outcome. So organizing framework. I like that.

Elizabeth Howell: So I hear you guys. I think you guys are absolutely right and again the purpose of this is by no means to sort of choose one of these but to just make sure that we're thinking about all of the different domains that we want to make sure that we're capturing.

And obviously we're going to be (unintelligible) frameworks that we just - there's three - you know, there are other factors as well that might be important that are missed and so this idea just to spark a discussion and that we start sort of thinking about how we want to put these all together in an organizing framework. And on that note, why don't I go to the next slide.

Nicole Williams: We do have two...

Beth Ann Clayton: Can I just comment?

Nicole Williams: ...committee members whose hands are raised...

((Crosstalk))

Beth Ann Clayton: I'm sorry.

Nicole Williams: Ann Clayton, (unintelligible) you and Diana Ramos.

Beth Ann Clayton: Yes, thank you. I'm sorry. It's Beth Ann Clayton. And I just - I like this framework. I just wanted to point out and maybe someone can clarify, under clinician factors, the one thing that I think we should consider is the resources available to the clinicians.

So it may not necessarily be a knowledge that considers experience, but having the resources. When we look at the various studies that have looked at care delivery in predominantly black hospitals versus predominantly white hospitals was well seen but the outcomes were not as favorable in the predominantly black hospitals and it's the white patients delivered in a predominantly black hospital. Their outcome was not as good. Yet if a black patient delivering in a predominantly white hospital, their outcome was better.

And so I think looking into what their resources and the resources doesn't have to be (unintelligible) leadership to those facilities, I'm not sure where that falls in but in mind when I looked at this framework, what pops out it means with clinician factors was what resources the clinicians had available to them

to do the job they needed to do at their respective facility.

Elizabeth Howell: Great. Thank you. Nicole, I can't see the questions. I think you said there's another person with their hand up?

Nicole Williams: Diana Ramos?

Diana Ramos: Yes. You know, I just wanted to comment that I'm not sure how we can incorporate there's oftentimes a continued (immiscible collapse) of factors that impact not just the patient, but the system factors, community. I'm thinking in particular doula support, partner support because we know that that can make a difference.

And in terms of really improving the outcome, I think we're really seeing the opportunity or the overlap is not so clear. So that'd be one recommendation. It's just to make it so that it's not so definitive that these are only the patient factors and only the community but actually there's a lot of crossover and interplay.

Elizabeth Howell: Okay, thanks.

Can we go to Slide 15?

So this is the WHO framework. I think you guys probably have seen this. You can see there's a couple of additional (unintelligible) and important things as well in terms of sort of thinking. You know what, the last line, System Factors, this one is getting up to this level of laws and policies with (unintelligible) an important part of it. They do a nice schematic around life core and try to really focus in on that.

And then you can that they think about the outcomes in terms of a continuum. They think about those functioning and well-being in terms of that outcome. And then they have some limited, you know, conditions with co-morbidity. But again, we're showing this to see what resonates with folks and what - as we think about our organizing framework, what are the things that we want to make sure are included as we've heard about partner and support. We've heard about medical education and how important that is about the way we train our physicians and our nurses. And so this slide is up for discussions as well.

Kay Johnson: This is Kay. So I see that a lot of detail (lost) in this one, particularly around the health system and quality issues that many of us are concerned about and that we spend a lot of time in this committee discussion.

Elizabeth Howell: Yes, and I would agree with you. So I guess the questions is, are there things on here that we want to make sure that we don't miss rather than what it isn't because we're not - I just want to also...

((Crosstalk))

Kay Johnson: I here you.

Elizabeth Howell: We're on the same page. We're not going to use one of these three frameworks. We're trying to come up with what are the domains that when we look at other ones we want to make sure that we're capturing what are the additional things that our group thinks is really important to make sure that we are listening.

Wanda Barfield: All right. This is Wanda. I think one of the things that we haven't considered in some of the framework in terms of morbidity and the preconception period is that there can be a morbidity for women prior to conception that results in

not being able to become pregnant. And how can that be incorporated as well because in the broader sense, that in morbidity, it's just we don't measure it with a data we currently have.

Elizabeth Howell: Great, okay. So we shouldn't be thinking about the - and then that's just to focus on preconception and what are we trying to measure in that period and let me - how are we thinking about it.

Are there questions, concerns? Okay, and then we wanted to also one more framework if you could just sort of - Slide 17.

So this framework, Person-Centered Framework for Reproductive Health Equity has injected some of the things that we've been - some of the things that were missing in the other frameworks in terms of thinking more broadly about person-centered outcome in particular which I think our group had - we touched upon some of these in previous conversations so we just wanted to make sure to get your reaction on those as well.

And then it goes in a little bit more into detail around provision of care which I think we've talked a lot a fair amount of that as well. So wanted to, you know, have us all sort of think about any social support we're seeing in - we talked about some of these in different settings but I think this is something that we would all agree probably need to be set organizing framework when we think about additional outcomes.

Any reactions?

Kay Johnson: This is Kay again. Sorry to have so many thoughts. There's something...

Elizabeth Howell: We appreciate it.

Kay Johnson: There's something in those flowers and titles that I like that we may be able to, you know, think about it in terms of person-centered outcomes and all of that.

I don't love the housekeeping behaviors box. When we did the Institute of Medicine prenatal care study, I worked with (Sarah Brown) on the framework that they have that sort of did these rings of barriers about, you know, financial barriers, the context of care of barriers, personal barriers, and so on. I don't love the way that that middlebox is structured.

Elizabeth Howell: Okay. Great. Thanks for sharing that with us as well.

woman: Is this (unintelligible)?

Woman: Who turned this here? (Unintelligible) because I'm in a bunch of right now but I'll be (unintelligible) kind of address them and look (unintelligible) with them, so (unintelligible).

Elizabeth Howell: This is one - I think Nicole has the answer to that one.

Nicole Williams: We can look that up and search related to the group. I don't have the...

Elizabeth Howell: Okay.

((Crosstalk))

Elizabeth Howell: Okay.

Woman: So I guess the biggest point is that all of these and this point I being resolved. I made a conversation around this but that's default equity and what does that

mean in the context of adding on some of the stuff that we had in her slide so that's not exclusively. To your point, Kay as the (unintelligible) behaviors stuff is not part of that. Frameworks evolve.

Elizabeth Howell: Okay. And so, you know, maybe this has not - with all the - this is a moment in time where I think we - it matters to us how this organizing framework is put together and we've been trying to make sure that we're getting the right cross-cutting themes which we'll get to slide later when we sort of start talking more about that but - and we're talking about the right domains.

Again Kay, that she has sent something around and (unintelligible), but if there's something else that people want to sort of share, and others - and another framework that they think really captures a lot of what we've been talking about and we can add to, I think this is the moment to think about that.

I think this is the - it's foundational to all of the measures and the way we think about morbidity and mortality. So I just wanted to take - (unintelligible) that and remind everyone that if you could...

((Crosstalk))

Elizabeth Howell: If you have...

Woman: Go ahead.

Beth Ann Clayton: Yes, this is Beth. I just want to say that we are trying to, other than cover it, and so we're submitting a conversation and I noticed (unintelligible) committee heard as well and so I don’t know how that works in this kind of context. So, you know, I'll be the simple OBGYN. You all tell me.

Elizabeth Howell: Well there's a bit attribute but I don’t think we can have - yes. So maybe the concept can be overlapping and even if - we should talk about it more offline maybe.

Kimberly Gregory: This is Kim Gregory. I'm not weighing in on any of the framework. I think that they're all sort of very in and of themselves. But one other thing that I think is missing or that I don’t see where it's factored is I don’t know the (unintelligible), I'm making it up right now but that's (unintelligible).

That there is - I think one of the things that happened with integration, so to speak, is that the patients are dispersal over and a lot of the providers are taking care of them because that's where they are but not necessarily because they're interested in them.

And, you know, the same way that we think about people who are interested and talking about global health, in the '60s and '70s and '80s, you know, people went to medical school because they wanted to go back and they wanted to help their community.

And that sense of dedication, a patient that is cared for by providers is that (unintelligible), you got to, right, because you've got somebody who's advocating for you and understand that the resources are limited and that you got to go to a private (unintelligible) to get the access to those three choices. And I don’t know how to capture that, but I think that that's really important and I don’t see it reflected there.

Elizabeth Howell: Yes, I don’t know how you measure them. You know, I think people are - you know what, it's interesting. It's a really good point but it does serve beyond the sort of demographic characteristics of a person or that, you know, it's like, you know.

Kimberly Gregory: So I don't either but I know that - you know, I can tell on a day-to-day the way it's sort of (unintelligible) what I'm calling the (Medicom Mails). It's that the - these providers that are making tons of many because there's this opportunity that not because they're into (unintelligible).

So there might be ways that we can conceptualize it. We would just have to think about it but at this point, I'm putting it on the table.

Debra Bingham: Yes, so, Kim, this is Debra Bingham. There is research around like many (unintelligible) of values so I mean those would be not necessarily have been necessarily for the (tornado) clinicians but it could apply to this work and there is (unintelligible) to show that commitment and confidence in a leader will make a difference in how effective the work is.

So you're right, I mean, you're definitely, you know, those characteristics (unintelligible) there are, there is about (unintelligible) around that. But I'm also - your comment made me also remember research around majoring of (unintelligible) levels and in order to trust like (unintelligible) measurement for caring, C-A-R-I-N-G.

And there's since a lot of research around, not a lot, but there has been some research done to think about the level of trust that clinicians are over under based on (unintelligible) levels and propose quality metrics around this caring, you know, about the care we provide.

So anyway, fascinating, but we could go down that level (unintelligible) people that but I think it's still a really broader point of do we care about each other, relationships-based. There is a quality framework as we're organizing framework that includes that handling, the relationships based out of

(unintelligible) care, that isn't always in a lot of the other framework.

Wanda Barfield: Hi. This is Wanda. I think that your point is great, and I don't know if some of this all relates to the system of clinical education and training because as we get more involved in information technology systems, there are less opportunities for relationship, whether it is that, you know, residents or practicing providers are feeling like they're overwhelmed with, you know, data that they have to enter into a computer. And is that a possibility that disparity is driven further because there is no opportunities with established or experienced relationship?

Elliott Main: This is Elliott. I think there is opportunities to make certain that this is captured in patient-reported experience measures that look at whether the (unintelligible) or family feels that she was treated with empathy, dignity, was listened to and with respect.

That's where I think we're after. You know, with Kim's comments is how the patient is receiving their care, (unintelligible) Medicaid meal, hope presumably they're not going to be filmed that way and that should be reported out in the measure.

So that's an important perspective that I know there's several different metrics and measures being developed on this but I think on the - filling an important gap.

Elizabeth Howell: Great. So I think we went on - I think we covered a lot and we'll look-out for the things that you - the folks who are going to send additional framework for other ideas that they don't want missing from our conversations so forth and we want to ensure that we capture.

And I guess we can go to the next slide.

((Crosstalk))

Woman: Yes, sorry. I had my hand raised but I don’t know if this...

Elizabeth Howell: I couldn't see it on. I'm so sorry. Yes, please go ahead.

Woman: So this is very much directly related to the last set of comments in that we have a whole body of literature on physician and provider experience, physician and provider well-being, specifically on burnout of physicians and what they are erroneously calling resiliency which I won't get on to my soapbox but is very much similar to saying an abused woman who just become more resilient to her abuser, but we won't go into that phase.

Elizabeth Howell: Okay.

Woman: But that becomes (unintelligible) to do with this set of potential metrics to be able to have something to measure. There's a whole set of or body of literature on how to measure those things and that definitely as we all know is very much related to the patient's experience when the patient is cared for by a provider who is under last end, they have a very different experience both medically and socially than if they experienced a provider who is also having good well-being. And so definitely, a part of this that I would like to make we elevate. Thank you.

Elizabeth Howell: Nicole, are there any other hands left?

Okay, all right. I'm not hearing it. So I will turn it back over, I think we're going to now move to Slide 18, and I'll turn it over to (unintelligible).

Woman: Thanks. So, you know, we've just talked a bit about, more than a bit, right, about the various frameworks and what may be missing. And, you know, what elements we have interest in capturing here. I think one thing to note of importance is that, you know, there is an interest in developing two frameworks.

And so, you know, a lot of the, on the one hand, an organizing tool. I think it's part of the charge of this body to really inform the development of the framework for work as we see fit. So the underlying themes or some of the cross-cutting themes that have emerged from our conversation over the past couple of months and earlier today include social determinants of health, person-centered care, racism and discrimination.

Looking at some of that within the confines of the domains or pregnancy-related, pregnancy-associated, and then into some okay those subdomains. And looking at this, I see preconception, prenatal, labor and delivery, postpartum and future reproductive lifecycle. Bu ti think, you know, kind of in that we're living out perhaps another component, right?

So if, you know, women's health, you know, kind of a well-being measured or consideration generally might be a subdomain that is of interest because, you know, there may not be interest in a future pregnancy but there is an interest in (work advantages) and overall health.

So I think what we wanted to do with this time is just think about the - kind of building on conversations as they started earlier thinking about what are the key differences and contributors to morbidity and mortality and kind of breaking down those domains or subdomains a little further so that we can later on think about what measures we currently have and those that are

certainly needed because the gap is already huge.

But - so let me just stop here and ask if, you know, there are any initial thoughts before I move to the next page.

And I can't see hands, so Nicole, let's - unless there's anyone. Okay, so let's move on.

Nicole Williams: We don't have any hands raised, so...

Woman: Okay, so we could - we can share for the next slide.

Nicole Williams: Sorry. Wanda just actually raised her hand.

Woman: Okay.

Wanda Barfield: Yes. I just wanted to comment that I thought this is, you know, really clear and I appreciate...

((Crosstalk))

Wanda Barfield: ...incorporation...

Woman: Okay. Thank you, Dr. Barfield.

Nicole Williams: (Unintelligible).

Woman: Okay, so - it sounds like someone (unintelligible), not too sure. So, you know, again I think here we want to talk about what the critical domains or maternal morbidity measurement should be, you know, what are some of those

elements that should be incorporated.

So preconception which I think I heard earlier maybe Kay, prenatal care, labor and delivery, postpartum, what other components?

Nicole Williams: And this is Nicole. Just to clarify a little bit. The slide we're looking at and the (unintelligible) that we have listed were suggested specifically because we (unintelligible) environmental stand. But I think in the framework that (Dave) presented and also the previous slides show that these to be listed as subdomains and that domains would impact the pregnancy-related and pregnancy-associated. So just for clarification assuming the group agrees or if there are other thoughts around that.

Woman: (Unintelligible).

Kay Johnson: How do you see that right now, Nicole and others? I'm doing a bit of a figure. This is Kay. I'm doing a bit of figure-ground on domains and subdomains and since I don’t know how that actually plays out in your process, it might be important for us to understand a little more. I mean, are you just saying towards these are more appropriate for subdomains or is that a point of discussion?

Nicole Williams: More of a point of discussion.

Kay Johnson: Okay.

Nicole Williams: I know that's how we have them for a feature if you will. And so I'm assuming the group agrees with that but certainly, if there are other thoughts around what domains we should include now is the time to share that.

Kay Johnson: Yes. This is Kay; sorry one more - let me try one more question related to that and that's let's say we have one framework, would morbidity and mortality see the domain, the two domains? And so with one - if let's say really want - divided into one framework about morbidity and one framework about mortality, do those come in the key domains and obviously the subdomains underneath that?

Nicole Williams: That's it. What a great question. So we are charged with developing two frameworks.

Kay Johnson: Okay.

Nicole Williams: Each of those frameworks are identical if that what the group agrees would be the best route, that's something that we can explore but we do need to have two separate frameworks, one for morbidity and one for mortality.

Kay Johnson: Thank you.

Diana Ramos: Hi. This is Diana Ramos. And I just wanted to make a comment; I had my hand raised again. You didn't see it.

But in terms of white cords and really capturing the stress that is intergenerational that you'll then become - you know, (unintelligible) changes. I think it's important to be able to capture it somewhat. I don't know who wants to put that into the preconception piece but I think that's going to be a critical piece to incorporate especially because there are some that shows that pre-term babies event, some of them end up having pre-term babies themselves when they go on to have a child.

And this - the whole - you know, the epigenetic changes that we see in

African-Americans, in particular to (unintelligible) distress and trauma, so I don't know how we can capture that or just want to make sure that we were cognizant that that should be something that we should look at or consider in some ways.

Elliott Main: This is Elliott.

Woman: Okay.

Elliott Main: It's - there are several different ways to slicing this, but it - that are equally important and it's unclear to what you prefer to what you (unintelligible). One is the time course which is represented here which is really important, you know, adding on even earlier to Diana's comment. But the other is the frames that Liz is showing which is basically personal community, support, you know, facilities and systems.

And those are very important domains with where you're going to find actions and those also have time course elements to them. So I think it's - you know, these are vertically or horizontally here in terms of - but all those are important domains.

Woman: Okay. One thing I was supposed (unintelligible). I think it was on mute because I don't remember this comment. Do we have any other hands up at the moment?

Nicole Williams: No, no hands.

Woman: Can I just say something? I didn't raise my hand. Sorry.

Woman: Yes, sure. Go ahead.

Woman: I just wanted to echo what Elliot said because I didn't - this notion of only time course were leaving, if that's the only - if that's - I feel like we're losing a lot if that's - if those are just the domains that we're thinking about. So I'm just (unintelligible).

Woman: So kind of given that are there other ways that we need to capture, the - I mean, this is the case that we need to (unintelligible) some of the items that we heard earlier in terms of resources and, you know, some of those other factors.

Woman: I'm feeling so dense about this. You know, on the one hand I can see a figure, right, that represents our framework that has a lot of the elements somehow represented like some of those that we just looked at. And then of course (unintelligible) that it is in a (unintelligible) set of framework so (unintelligible) - I'm trying to figure out, so if you look at the continuum, this seems right, if you looked at the domains and the subdomains and the subdivision between morbidity and mortality, that all as someone said a moment ago, seem very clear.

And how that translates into a nice figure doing and how other things get incorporated into that figure versus this table is puzzling me. So...

Joia Crear-Perry: So this is Joia. So I like this page that has all of it so maybe it's just because you want to be (unintelligible) less often, it's (unintelligible) to me that you lost your audience. So as they're working for (unintelligible) please.

We'll help your audience right this moment as they think about what are the measurements and people (unintelligible) that address (unintelligible) of the summit (unintelligible) pregnancy versus pregnancy kind of gone across that

way.

Is that helpful? Okay.

Woman: So thank you for that. So we'll add in the one that was mentioned. So it sounds like maybe we don't need to go I don't know, we should put up Slides 20 and see what their reaction is because maybe we might need to skip that and move into the measure discussion, but I'll leave that our (QS) team to decide.

Nicole Williams: Yes, this is Nicole. I think I'd like to understand what other cross-cutting themes and maybe we touched on them because we have quite a bit in the environmental stand but, if there are other cross-cutting themes that you think are appropriate and it sounds like the group is okay with having the first layer, if you will, to our framework, the domains in pregnancy-related and pregnancy-associated and then the sub-domain as shown on this current slide. It sounds like...

((Crosstalk))

Woman: Yes, serving in women's health I think was the exception.

Nicole Williams: Right.

Woman: And whether it's a new role or it goes with preconception or it goes with, you know, reproductive life course, women's health. I'm not sure if it's its own thing or existing with one our the others, but, yes, that was the other exception.

Nicole Williams: Okay.

Eugene Declercq: This is Eugene. Just to be clear on something - I'm sorry.

((Crosstalk))

Eugene Declercq: If we're going to study pregnancy-associated, we're essentially studying women's health, right? And someone's on the (unintelligible) review committee. You know, you look at all the causes of death and any (unintelligible) separate it into pregnancy-associated and pregnancy-related and then most of the focus has been on pregnancy-related because that's closest to the definition.

I mean, it's a time definition different from what we usually call maternal mortality. I strongly agree that we need to look more at pregnancy-associated death but essentially what we're seeing there is we're looking at women's health, right? We're looking at all women's death at that point which I think is a valuable thing to do, a little bit different from how we conceptualized maternal mortality.

So I think we just need to be clear about that distinction. I mean, (Dave) is including it but I don't want us to stumble into that without understanding that we're talking - you know, we're moving from 700 deaths to tens of thousands of deaths once we go to pregnancy-associated.

Joia Crear-Perry: And I would argue - I'm sorry. I didn't raise my hand my (unintelligible) function (unintelligible).

((Crosstalk))

Nicole Williams: Hands up.

Joia Crear-Perry: I do would argue that a lot of things that are put in (unintelligible) that we would (unintelligible) that the community (unintelligible) each committee, everywhere talking (unintelligible) differently. So I will give you an example of (unintelligible). We all talk about it differently, you all put in different categories, none of you have agreed it's a myth.

And so it's important for (Ann) what we could do with very important as (Dave) (unintelligible) out to a year. I mean, not to do the six-weeks of (unintelligible) doesn't make any biological sense. And so for me this is an organizing (unintelligible) help move the larger and global conversation to a thinking about pregnancy-related and associated in 12 months instead of 22 days. Thank you.

Woman: So, Joia, your point is well taken that that's, you know, been for WHO the limitations in measurement because you might argue that the same thing needs to happen for mortality as well.

Joia Crear-Perry: Agree.

Woman: Okay. So I think the comment that (unintelligible) made about women's health I think happen, however, I think sometimes the goals when you're thinking about these components of care a little bit different. Perhaps it's in like future reproductive lifecycle but maybe, you know, the word reproductive isn't the right word given that it took the goal that could be outside of subsequent pregnancy or something like that.

So is that okay?

Nicole Williams: Kate Menard has her hands raised.

Kate Menard: Thanks.

Woman: Okay.

Kate Menard: Just thinking about the pregnancy-related pregnancy-associated piece, this is pretty clear in my mind how the pregnancy-related deaths and the maternal morbidity as we conceive of it now, severe morbidity measures and that sort of thing with (unintelligible) are, you know, (unintelligible).

What do you do about morbidity for this - related to the pregnancy-associated deaths? Is that - you know, we'd be thinking about them in the same way?

Woman: So was that a question for me?

Kate Menard: Yes.

Woman: This is a question (unintelligible), as I look at the table, leaves me wondering what morbidity do we capture...

Kate Menard: What's the focus?

Woman: ...pregnancy issue.

Kate Menard: Uh-huh.

Elizabeth Howell: This is Liz, and I haven't thought about that.

Woman: I guess the (unintelligible) sort of things about the circumstance in terms of, you know, maybe domestic violence, but again I think these factors get really difficult to tease out.

((Crosstalk))

Eugene Declercq: ...pregnancy-associated are often (opioid) cases as well.

((Crosstalk))

Woman: Do you (unintelligible) the studies that were done in Massachusettes that showed, you know, ER visit or domestic violence (unintelligible) for in that, you know, once the pregnancy game leads the obvious include the postpartum period as rates went up.

Eugene Declercq: Yes, that's just a (unintelligible) that they had it. Drugs related death to that. They come off (walker) pregnancy-associated but don't get clapped as pregnancy-related.

LaQuandra Nesbitt: Hi. This is LaQuandra. I joined a little bit late so I was over here trying to raise hands (unintelligible) everybody's doing that.

But, you know, the morbidity thing that - I think one of the things that (unintelligible) the last time is overly kind of (purgatory) (unintelligible) but I think the - one of the thing that I was sort of interest for me was the morbidity and the pregnancy-associated with whether we had no visibility (unintelligible) as it related to cardiovascular events that may be happening in certain high-risk populations like women who maybe had morbid obesity prior to pregnancy or who has their (unintelligible) diabetes - are those types of individuals who may have some long term morbidities related to cardiovascular disease and if those are not being captured with pregnancy-associated deaths.

So if those morbidities are not properly categorized on that then can make the (unintelligible) subsequently be mortality (unintelligible). I think we should probably be thinking more broadly in morbidities than some of the things that have previously didn't mention which also may not be documented.

Woman: Okay. So do we have - are there any other hands up? Thank you, Dr. Nesbitt, for that.

Kay Johnson: This is Kay. I have one question about the word discrimination versus the word bias and maybe we've already been through that 14 times and I know you even bring it up. But...

Woman: So I think that's an indirect question in terms of, you know, how highly documented that in the scan.

Kay Johnson: So I think I would just add in at least (unintelligible) information in the CDC what you're talking - Joia and I were in a committee and I think there's another - I don't have everyone's names as of right now who are helping CDC think about how to stop racism and (unintelligible) help them determine whether it's a contributing factor.

And I think our group, there's a separate in each one, a lot of (unintelligible) around bias versus (unintelligible) and how they thought it was important to be using the word discrimination and that...

((Crosstalk))

Woman: yes, yes. Yes, I mean, discrimination is a word that's used globally and it is actually (unintelligible) and there's no (unintelligible) in bias.

Kay Johnson: I appreciate that. That's helpful to me. I just wanted to be sure we covered that ground. Thank you.

Woman: Yes.

Woman: I'm still a little stuck on one thing, so I just wanted to ask people, you know, (unintelligible) as well. It does seem to me that we're only recognizing the time on it, right? So we're basically saying, okay, mortality, you know, pregnancy-related, pregnancy-associated and we're just going to think about it from the life course discussion and that's the one thing and we're forgetting all the others.

I know we had these cross-cutting things but then we would have to add up - we have much work cross-cutting themes if we were thinking about the rest. I guess what I'm struggling with this but I still like maybe I'm alone on that and other people are...

Elliott Main: No.

Woman: Okay.

Elliott Main This is Elliott. I have my hands up but I feel strongly that way is that the cross-cutting themes are equal if not more important. It is more than the three illustrated here that can be (unintelligible) from the prior slides. And that's why I'm pushing for more of a great approach where you have - you look at races - you look at the cross-cutting themes in each of the time periods, you know, and that makes a lot of sense to me.

Kay Johnson: I favor that as well. This is Kay.

Woman: Yes, I know we'll bring in some of the other comments about facility, environment, resources of those.

Elliott Main: Quality of care.

Kay Johnson: Quality, yes.

Woman: And so with that, from your perspective again to like we add additional items to that cross-cutting theme, that will take us out of the seemingly time-bound categorization that we have currently.

Nicole Williams: Yes, I mean it is only one - time is only one element. So let's just sit back and recognize that but visually it looks (unintelligible). It doesn't show that (unintelligible).

Woman: Right.

Nicole Williams: Yes, we'll fix that. Yes.

Woman: Our - okay, I think we touched on it being - for the frameworks so if we want to talk about existing measures, then the measure kind of (unintelligible).

Nicole Williams: Yes, that would be great.

Woman: Okay.

Nicole Williams: And we do have (unintelligible) 1:40 and this conversation will be a lot more limited and - but we will have a later date on the next webinar to (unintelligible).

Woman: Okay. So - but I think at the same time, I think we've also started to have this conversation already. You know, there are a number of comments about gap. The purposes of some of the measures that currently exists, let's move to the next slide, which may not fully address the items in the domains that we just spoke about in the previous slides.

The preconception measures that we have are related to contraceptive care, so most moderately effective methods, this one is marked. The well-woman visit from versus data. And I don't know that - you all going to let me know if it's useful to go into the detail about the measures - these measure concepts or who would be more useful I think to move into other concepts.

So I'm going to (unintelligible).

Nicole Williams: I think we can - maybe in the interest of time is look at the existing measures.

Woman: Yes, that's good.

Nicole Williams: Across themes and domains and...

Woman: Right, yes, yes. That sounds good.

So we have this prenatal postpartum care timeliness measure which is really the - was account measure and had some challenges with respect to enrollment within and we're (unintelligible) diabetes and pregnancy - have a glycemic agent which is also no longer endorsed along with frequency of ongoing prenatal care. Again, another accounts measure and the prenatal anti-D immune globulin measures.

Prenatal HIV, early prenatal care which part of NVSS, the preventive dental

visits, again this is (unintelligible) and then smoking during pregnancy. This relates to some of the prenatal domains.

All right, next one. Thank you.

Labor and delivery. So we have low-risk C-section, severe maternal morbidity, as analyzed through HCUP, the early elective delivery measure on CMS hospital compare. The NQF Rh immunoglobulin measure, no longer endorsed. (Unintelligible) birth and episiotomy.

Other term - the labor and delivery category are (unintelligible) all three of these are no longer endorsed, NQF endorsed so appropriate VTE prophylaxis and women undergoing C-section, antibiotic, prophylaxis (unintelligible) C-section, elective delivery and then the intrapartum antibiotic for Group B strep.

So - okay, I don't know, there's a movement in the site. So I think what - whatever you want me to do here. And so I think we want to talk about, you know, given some of these existing measures where the general framework that we just kind of talked about, where are some of the opportunities for measure, what are some concepts that are important and although I don't think we looked at the labor in postpartum measures actually.

Could you move to those maybe? Okay, thanks.

So there is the prenatal and postpartum care that's no longer endorsed. However, there are new measures. I think they are currently in test phase right now for postpartum care, contraceptive postpartum and the maternity and care postpartum follow-up and care coordination. And this is (unintelligible).

All right, so, you know, I think we can just look (unintelligible) Slide 37 and then talk about some of the measure concepts so that we can - yes, Slide 37. Okay.

So these are a few that have emerged in terms of concepts for measurements that cross over some domains. So I think we can talk about these. So professionals with gloves, using - you know, certain gloving techniques, transfusion.

You know, I know there was a lot of workaround, you know, trying to identify methodology account and use the data to assess units of bloody measurement. Incidence of severe maternal morbidity and all of these others here on the screen.

So I wanted to invite others on the committee to identify the areas that would identify additional concepts for measures given the ones that we just reviewed that are A, no longer NQF endorsed in a lot of cases and B, may - and (unintelligible) don't really address the issues that we've identified in the domains earlier.

So what may be some preconception measures or some other measures in the morbidity domain that we should include or concept measures that we should include?

Woman: Is Dr. Williams with Kaizer? I kind of raised my hand...

((Crosstalk))

Woman: Thank you.

Woman: In the (unintelligible) previously why have the prophylaxis antibiotic and VTE prophylaxis been removed? Those are major causes of maternal morbidity.

Woman: This is my hands (unintelligible).

Woman: So I don't know if someone is trying to respond to that but why are those no longer NQF endorsed given that (unintelligible) maternal morbidity?

Woman: So interesting. I don't know that I've been in a meeting settings with this. So...

Nicole Williams: Yes, we - so I don't have a clear answer for you. We would have to go back and look at more specifically when the measure was up for review, what happened during that time period.

Woman: But honestly, listen, I raised my hand for this. So it didn't work, so I'm just talking again. So (unintelligible) the other side when I no longer - because many of the things that are no longer endorsed are things that we still need. And so for me, the utility of this process also includes how did this even get managed?

Like we've spent some time taking some measures to what end because we still need most of the ones that were previously (unintelligible) about postpartum visits (unintelligible). So how these ones become no longer endorsed?

Woman: So I think they're...

Nicole Williams: Yes.

((Crosstalk))

Woman: Oh go ahead.

Nicole Williams: I was just going to say briefly, it's a long process. We have a very extensive criteria. We also rely obviously on the measure stewards who are stewarding these measures to update testing and specifications and things like that.

So there could be a myriad of reasons why it's no longer endorsed. Part of it could be because it didn't pass our guiding criteria and it could also be due to the measure steward. So again we can go back and - at the details but what I would encourage the committee is if you see that the measures that listed that were no longer endorsed.

What I would suggest is to highlight those as important to continue or important measures as part of this work.

Woman: So I can offer a couple of comments about a few of the measures but not any of the prophylactic measures. So the postpartum measure, while very important I think there was a lot of discussion about the need to have earlier postpartum visits and that is target goal of like six weeks or 12 weeks, but to ensure that women are being seen earlier to address some of these very concerns that are coming out of this discussion around, you know, morbidity and mortality.

So I think that is part of it and the measure is being updated to reflect that, to reflect earlier visits in addition to like a, you know, late visit. And I think some of the others really didn't - they were very much focused on count and not on the content of the visit. So the frequency and early prenatal care were not necessarily focused on the content and component.

Woman: Thank you.

Woman: You're welcome.

Woman: Is there - is the HEDIS measure and postpartum visits changed formally yet?

Woman: It's in process.

Woman: It's in process?

Woman: Yes, it's in process, yes, as far as the draft specifications, but it's not like in HEDIS, you know, formally yet.

Beth Ann Clayton: It's Beth Ann Clayton. Are we looking at we want to look and discuss new measurements or only the existing ones that are there at this moment in this discussion?

Woman: We are opening the conversation to measure concepts and/or any additional m measures that the committee may not be fully aware of that could fit into, you know, one of the - address one of the domains or subdomains.

Beth Ann Clayton: So I'm not sure of the method of how to capture this but one thing when I looked through this that kind of stuck out to me and I went back to our environmental scan and I appreciate - I'm apologizing for being late to point this out.

But one thing that stuck with me is the lack of addressing pain control. And pain control in labor and delivery we know that if there's not adequate pain control tat can interfere sometimes with the ability to have a vaginal delivery and (unintelligible) higher caesarian section rate.

And then when you look at the adequacy of pain control in a post-caesarian patient and the morbidity that can come from inadequate pain control and acute pain control, we can certainly see higher incidences of postpartum depression or (DPT) incidence (unintelligible) and increase in our opioid-dependent use and they don't know where in any of our discussions we've been talking about management of pain control.

Both in labor and delivery and the intrapartum (those) and then the postpartum phase as well. And looking at that pain control, is it inadequate in pain control or is it lack of availability for pain control? And the measure is slated to that and how that's slated into our morbidity.

Certainly, the pain control doesn't necessarily plan to mortality unless that leads to the higher incidence and the extent of the postpartum depression, but it certainly does lead to morbidity.

Woman: Thank you for that. Do we have other comments? I can...

Charlene Collier: This is Charlene. Just to I add - just chiming in, I wanted to go back with the pain (unintelligible) sad earlier in the conversation about the idea sort of those that are - those risk measures that are available to us immediately or, you know, attainable versus aspirational.

Does the committee think that that would be helpful, I don't want to use the framework again, but I can't get it out of my head. but it's sort of help - outline to follow in this process because certainly a lot of the, you know, existing measures are things that are easy to capture through various reporting systems. But I think a lot of our conversations have, you know, centered on concepts that we all think are extraordinarily important and maybe a little bit harder to

collect data on.

I'd be curious to what people think we should do balancing for the practicality versus, you know, in a dreamworld what would be available to us.

Woman: Yes, I think there should be a bit of balance of both. You know, realistic measure, data collection I think is very important, but then also, you know, a couple of our committee members at the outset of this talked about how we've moved in terms of data sources and information.

And so, you know, we might offer a couple of tier, you know, two-tiers of measures but I open the floor to others as well.

Wanda Barfield: Hi, this is Wanda. Yes, I think that is a really important theme here. There are some things that are aspirational that may not be available at this time but there are some measures that are important that could be incorporated and the opportunity to think about certain prospect measures is at some of these areas that people are thinking about.

So for - and there are also other data sources. For example, within a facility, where is the availability of transfer of services for a hospital that has, you know, a predominant, you know, Internet or component with multiple languages spoken. Could that be a quality measure?

Time to admission and then, you know, time to certain services in an intensive care unit. There's a - you know, there has been some of these process measures that have been looked at Stanford. I know that it's - you know, it will take time but this - think this group has the opportunity to think about it.

And then one simple component, particularly within - with respect to hospital

data how come we don't have information on race ethnicity in terms of self-reported information in the hospital records?

Nicole Williams: This is Nicole.

Elliott Main: Go ahead.

Nicole Williams: Yes, I'm sorry. We're out of time. So I apologize, Elliot, for cutting you off. I wanted to ask if there are any public comments. If anyone from our public audience who has been listening had any brief comments?

I will take that as no. So again apologize for having to kind of cut us off in the middle of your discussion but know that we will have an opportunity to discuss the measures in much more detail, more time dedicated to completing that.

I wanted just to also quickly bring to this group's attention, our - some of our next steps. As I mentioned, our environmental stand and in draft form right now. We're preparing to submit a second draft of that stand to CMS and preparing to go out for public comments the end of July.

So we'll be reaching out to the group once more to allow for you all to provide any additional comments or feedback on that before it goes out to public comment. Our next meeting as a group will actually be in September. So by then our comment period on the stand with have closed and will be talking through some of the comments we received then and also planning to use a little bit of that time to revisit the measurement framework.

And as you can see on the side we do have two other meetings after September to also help to internalize this important work.

So thank you so much for your time. You all know how to reach us if you have any additional comments, resources that you want to share for anything else that you'd like to communicate to the team as a whole.

I also want to thank our co-chairs, Dr. Howell and Lekisha Daniel-Robinson for leading us in our discussion today.

Okay, thank you, everyone. Have a good week.

Woman: Thank you.

Woman: Take care. Thank you.

Woman: Thank you. Bye-bye.

Elliot Main: Bye, everyone.

END