



Jan 9, 2012

Dear members of the NQF Steering Committee,

I am writing to strongly urge the committee to recommend **NQF Measure 0479 for re-endorsement** (Birth dose of the hepatitis B vaccine and hepatitis B immune globulin (HBIG) for newborns of hepatitis B surface antigen (HBsAg) positive mothers). This is an important quality performance measure that would address the gaps in perinatal hepatitis B prevention hospital policies and practices **by ensuring newborns at highest risk of becoming chronically infected are appropriately protected with HBIG in addition to hepatitis B vaccine according to ACIP guidelines**. The re-endorsement of this measure is also timely and will be an important tool to help achieve one of the priority goals of the DHHS "Action Plan for the Prevention, Care and Treatment of Viral Hepatitis" released in May, 2011 to eliminate mother-to-child transmission of hepatitis B (DHHS, 2011).

Chronic hepatitis B is a leading cause of liver cancer and preventable death. **Adherence to NQF measure 0479 would save lives** by preventing up to **1,000** newborns each year from becoming developing chronic hepatitis B infection and **250** of them from dying from its complications including liver cancer (Ward, 2008; WHO, 2008). Since over 50% persons living with chronic hepatitis B in the U.S. are Asian Americans, this measure is also important in helping to eliminate a major health disparity in the country (CDC, 2009).

Strict adherence to preventive guidelines for newborns of HIV positive mothers has virtually eliminated perinatal HIV transmission. Newborns of HBsAg positive mothers have up to a 90% risk of developing chronic hepatitis B infection. **Strict adherence to NQF measure 0479 by administration of both HBIG and hepatitis B vaccine within 12- 24 hours of birth would eliminate chronic hepatitis B infection in newborns to mothers who are HBsAg positive**. CDC estimates that **17,000 newborns are born to HBsAg positive mothers each year**, 80% of them foreign born and over 50% Asians (Din et al, 2011). However, gaps in hospital policies and practices (to ensure timely identification of HBsAg positive mothers and administration of HBIG and hepatitis B vaccination within 12-24 hours of birth) are likely to blame for the 800-1200 newborns annually who become chronically infected with hepatitis B since 2001 (Ward, 2008).

In the past few years, the Asian Liver Center partnered with the California Department of Public Health and county health departments in efforts to improve the prevention of perinatal hepatitis B transmission in the state. So, we are very encouraged that the data submitted to the steering committee by California showed that over 90% of infants born to mothers identified as

HBsAg positive prenatally received hepatitis B vaccination and HBIG in the first 24 hours of birth. However, despite the encouraging data from California, it is unlikely to be representative of the practices by hospitals across the country.

In fact, a recently published CDC study of 190 hospitals in 50 states, District of Columbia and Puerto Rico (apart from California and Texas because few hospitals in these states participated) demonstrated a need for improvement in hospital policies and practices (Willis et al, 2010). **In this study, major gaps in hospital practices were identified among infants born to HBsAg positive mothers.** Only 62% of the high risk newborns received the hepatitis B vaccine and HBIG within 12 hours of birth as recommended by ACIP. Another alarming finding is **20% of newborns to HBsAg positive mothers did not receive HBIG, and 14% did not receive the hepatitis B vaccine before discharge** (Willis et al, 2010).

Measure 0479 would be an important quality measure to address these gaps in hospital practices. Measure 0479 is also the only quality measure that specifically address the importance of timely protection of the group of high risk newborns to prevent them from developing chronic infection. It should not be confused with Measure 0475 that is intended to improve universal hepatitis B immunization coverage of all newborns prior to hospital discharge.

**Based on the above evidence, I urge the committee to recommend NQF Measure 0479 for re-endorsement, and furthermore promote its implementation nationwide.**

Sincerely,

A handwritten signature in black ink, appearing to be 'S. So', written in a cursive style.

Samuel So, MD, FACS  
Lui Hac Minh Professor  
Professor of Surgery  
Director, Asian Liver Center  
Stanford University School of Medicine

**References:**

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January 19, 2012

Reva Winkler, MD  
Suzanne Theberge, MPH  
National Quality Forum  
1030 15th St, NW, Suite 800  
Washington, DC 200050

Dear Dr. Winkler and Ms. Theberge:

The Academy of Nutrition and Dietetics (“the Academy”), formerly the American Dietetic Association, wishes to express its appreciation to the National Quality Forum (NQF) for its work developing consensus standards applicable to perinatal and reproductive health. With over 72,000 members, the Academy is the largest association of food and nutrition professionals in the United States and is committed to working with CMS to improve Americans’ health through food and nutrition from gestation until the end of life. The Academy specifically expresses its support for quality measure number 0480 (“Exclusive Breastfeeding during Birth Hospitalization”), and respectfully suggests NQF include additional quality measures.

First, the Academy agrees with the Committee on Obstetric Practice of the American College of Obstetricians and Gynecologists that “[a]ll pregnant woman should be screened for [Gestational Diabetes Mellitus (GDM)], whether by patient history, clinical risk factors, or a 50-g, 1-hour loading test to determine blood glucose levels.”<sup>1</sup> In addition, all women diagnosed with GDM after one or more plasma glucose values exceed established cutoffs should receive nutrition counseling by a registered dietitian. The Academy requests that NQF develop quality measures related to GDM screening and nutrition counseling.

Second, the Academy notes that the effect of maternal nutritional status prior to pregnancy on reproduction and pregnancy outcomes is of great public health importance and has been extensively studied over time. A woman’s pre-pregnancy weight has been used as a marker of nutritional status. Being underweight, defined as a body mass index (BMI; calculated as weight (kg)/m<sup>2</sup>) less than 18.5, may reflect chronic nutritional deficiency. A high BMI (>25) reflects an imbalance between energy intake and expenditure (and thus

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<sup>1</sup> Screening and Diagnosis of Gestational Diabetes. Committee Opinion. No. 504. American College of Obstetricians and Gynecologist. *Obstet Gynecol* 2011;118:751-3.

varying degrees of adiposity) and is associated with higher risk for GDM, preeclampsia, cesarean delivery, and infectious complications. In addition, “gestational weight gain is considered an independent risk factor from pre-pregnancy obesity.”<sup>2</sup> The National Institutes of Health and the International Obesity Task Force have defined overweight (or preobese) as a BMI of 25 to 29.9 and obese as a BMI of 30 or more.<sup>3</sup> During pregnancy all overweight and obese women should be informed about current IOM gestational weight gain target goals, be advised to not lose weight during pregnancy, and counseled about eating healthful foods during pregnancy as described in the ADA position “Nutrition and Lifestyle for a Healthy Pregnancy Outcome”<sup>4</sup> and in ChooseMyPlate.gov’s “Health & Nutrition Information for Pregnant & Breastfeeding Women” (<http://www.choosemyplate.gov/pregnancy-breastfeeding.html>).<sup>5</sup> Accordingly, the Academy requests that NQF establish quality measures for weight gain during pregnancy.

We appreciate the effort made by NQF on this important initiative and the opportunities it creates to make substantive changes in the nation’s health. Please contact either Jeanne Blankenship at 202-775-8277 ext. 6004 or by email at [jblankenship@eatright.org](mailto:jblankenship@eatright.org) or Pepin Tuma at 202-775-8277 ext. 6001 or by email at [ptuma@eatright.org](mailto:ptuma@eatright.org) with any questions or requests for additional information.

Sincerely,



Jeanne Blankenship, MS RD  
Vice President, Policy Initiatives and Advocacy  
Academy of Nutrition and Dietetics



Pepin Andrew Tuma, Esq.  
Director, Regulatory Affairs  
Academy of Nutrition and Dietetics

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<sup>2</sup> California Pregnancy-Associated Mortality Review, page 32, accessed 19 January 2012 at <http://www.cdph.ca.gov/data/statistics/Documents/MO-CA-PAMR-MaternalDeathReview-2002-03.pdf>.

<sup>3</sup> World Health Organization. Physical status: The use and interpretation of anthropometry. WHO Technical Report Series 854. Geneva, Switzerland: World Health Organization; 1995:1-452.

<sup>4</sup> American Dietetic Association. Position of the American Dietetic Association: Nutrition and lifestyle for a healthy pregnancy outcome. J Am Diet Assoc. 2008;108:553-561.

<sup>5</sup> MyPyramid for Pregnancy. MyPyramid Web site. <http://www.choosemyplate.gov/pregnancy-breastfeeding.html>. Accessed 19 January 2012.