NATIONAL QUALITY FORUM

Meeting Summary

Perinatal and Women's Health Standing Committee Web Meeting

The National Quality Forum (NQF) convened a public web meeting for the Perinatal and Women's Health Standing Committee on March 15, 2019.

Welcome, Introductions, and Review of Web Meeting Objectives

Suzanne Theberge, NQF senior project manager, welcomed participants to the web meeting. Carol Sakala, PhD, MSPH, Committee Co-Chair, also provided welcoming remarks. The Standing Committee does not have measures to review in the fall 2018 cycle, but was convened for a topical webinar on perinatal measures under development and the results of the evaluation of the Strong Start for Mothers and Newborns Initiative. Ms. Theberge provided opening remarks, conducted a Committee roll call, and briefly reviewed the four presentations planned for the webinar. Two new members, Jill Arnold and Martha Carter, DHSc, MBA, APRN, CNM, have joined the Standing Committee, and they introduced themselves.

Results of the Strong Start for Mothers and Newborns Evaluation

Emily Johnston, PhD, a research associate from The Urban Institute, presented the results of the Strong Start for Mothers and Newborns Initiative Evaluation. This initiative had a goal to improve outcomes for low-income women and infants, with a focus on reducing preterm birth rates, as well as reducing the rate of low birthweight and the cost of care.

Dr. Johnson explained the difference between the typical care received for prenatal women with Medicaid and the care received as part of the initiative. Typical care includes deliveries in private practices, Federally Qualified Health Centers (FQHCs), and hospital outpatient department clinics. The care is usually medical in nature, can be overly interventionist, and is not sufficiently focused on patient education or offering provider continuity. The Strong Start Initiative supported three evidence-based enhanced prenatal care models: the use of birth centers (the midwifery model of care, enhanced with peer counseling), group prenatal care (clinical care provided in a group setting, supplemented by education and facilitated discussion), and maternity care homes (standard clinical care, enhanced with care coordination and referrals). The five-year evaluation used a mixed methods approach with qualitative case studies, participant-level process evaluation, and impact analysis. Strong Start served a high-risk population of 46,000 women enrolled in Medicaid or the Children's Health Insurance Program (CHIP), with many women having poor prior birth outcomes. In addition, participants had high levels of need: many had multiple medical risk factors or mental health issues, low levels of employment or education, were overweight or obese, and/or had high rates of food insecurity. One of the key aspects of the Strong Start Initiative was that participants spent more time with providers, allowing the providers to identify and address medical, psychosocial, and education needs while building patient-provider trust.

Participants also reported structural barriers to accessing care, even under the enhanced Strong Start models. These barriers included transportation (issues with Medicaid-covered transportation), childcare, time constrains (especially for the group prenatal care), and communication (e.g., frequent changes of address or phone number).

The evaluation found that the Strong Start Initiative did not have enough resources to address the identified psychosocial needs in the communities—including, but not limited to mental health services, referrals for housing and domestic violence services, and Medicaid-supported transportation. This limited the ability of the program to improve outcomes.

Dr. Johnston noted that data sources for this initiative included an evaluation project linked to birth certificates, Medicaid eligibility, and Medicaid claims and encounter data, along with an analytical file including Medicaid covered births for those enrolled in the initiative and comparison groups. The analytic approach for the impact analysis involved the comparison group and propensity score reweighting. The comparison group comprised women with Medicaid-covered births in the same counties as the Strong Start participants, but who received typical care. Using the approach, Dr. Johnston created propensity score-based weights for the group based on demographic characteristics, Medicaid eligibility, and risk factors.

Dr. Johnston reported the following results: (1) The initiative did not associate any improvements in outcomes or reduction in cost with the maternity care homes model, as there was a struggle to address the social, physical, and mental problems often faced by this high-risk population; (2) the group prenatal care model demonstrated lower costs of prenatal care and increased rates of weekend deliveries (indicating fewer interventions); however, women had difficulties attending visits with set schedules due to work, transportation, and child care barriers; and (3) the birth centers model was the most successful, with more positive birth outcomes and lower costs than typical care. Dr. Johnston noted that a critical component for improving birth outcomes in this latter cohort could be the longer visits with providers and the emphasis on patient education and psychosocial support. The final evaluation report and each annual report can be found the CMMI Strong Start website.

Questions and Discussion

Dr. Sakala opened the discussion for the Committee's comments and questions. Committee members supported the project and noted high interest in seeing the results implemented in future projects.

One Committee member asked what was done specifically to address social determinants of health. Dr. Johnston explained that women in the comparison groups were women in the same county who were also within the Medicaid population; however, she conceded that other social determinants of health that could be impacting outcomes were not captured. Committee members also highlighted the importance of wrap around services. In response to a question about policy recommendations, Dr. Johnston said the Urban Initiative had not discussed specific policy responses, but suggested that state-level policy innovations would be a potential path forward at this time.

A Committee member noted that she was part of this initiative and participated as a provider. She explained that women had the option to choose between hospital and birth center births; choices were made due to a variety of factors, including medical risk factors, but the delivery location did not impact the type of prenatal care offered. She added that once risk status is controlled for, the difference in outcomes occurred at a system level.

Development of an Adverse Outcome Index Composite Measure

Janet Muri, MBA, President of the National Perinatal Information Center, and Susan Mann, MD from the Beth Israel Deaconess Medical Center and Harvard University, presented on the Adverse Outcome Index Composite Measure. The Adverse Outcome Index (AOI) was created for resource management and improvement outcomes in birth. The index is made up of three composite measures: the adverse outcome index (number of patients with one or more identified adverse outcomes over the total number of deliveries), weighted adverse outcome score, and the severity index.

In 2011, Ms. Muri and Dr. Mann submitted this composite measure to NQF for endorsement consideration. Although the 2011 Perinatal Committee was interested in the measure, it did not recommend it at the time. Committee members made suggestions to refine the measure's components, including extending the time period for neonatal death attributable to the delivery process, risk adjusting for unplanned neonatal intensive care unit admission of term infants to account for different care practices between hospitals, and further consideration of the APGAR score, since Committee members found it too subjective. The 2011 Committee supported several components of the measure, including maternal blood transfusion, third- and fourth-degree laceration, and unanticipated operative procedure. Having considered these comments, Ms. Muri and Dr. Mann revised the specific component measures. Changes include the removal of third-degree lacerations, updating the measure to ICD-10 codes, and several other minor modifications. The developer plans to resubmit the AOI composite for review soon.

Questions and Discussion

Dr. Sakala thanked the developer for its presentation on the AOI composite. The Committee inquired what proportion of the identified cases are preventable actions that could be addressed with education. The developer explained that many facilities receive results quarterly, which allow them to quickly see and respond to variances, as well as to review all cases in the numerator to see what they might be missing. Facilities have seen improvements of as much as 17-20 percent in the measure over a year's time, once training has been implemented. The presenters and the Committee further discussed the challenges of risk adjustment in the perinatal population and the need for public reporting of this measure, due to patient interest in these outcomes.

Challenges in Perinatal and Women's Health Measure Development

Lindsey Roth, MPP, and Sepheen Byron, MHS, of the National Committee for Quality Assurance (NCQA), presented on their experiences developing perinatal measures. NCQA developed and

manages HEDIS, a widely used set of measures, and it is working on including new HEDIS measures that address prenatal and postpartum care. For example, HEDIS added a new prenatal immunization status measure for 2019. This measure assesses the proportion of pregnancies in which women received the Tdap and influenza vaccines during their pregnancy. In addition, there are two new measures proposed for HEDIS: prenatal depression screening and postpartum depression screening. These proposed measures focus on the proportion of pregnancies in which patients were screened for clinical depression during their pregnancy and in the postpartum period, and if screened positive, whether they received follow-up care within 30 days of the screen.

Ms. Byron discussed NCQA's development process. During measure development, NCQA evaluates measures on desirable attributes, including evidence, relevance, scientific soundness, and feasibility. Its measure development process involves multistakeholder input, evidence and guideline review, feasibility testing, public comment, and an independent advisory panel approval process. Ms. Byron noted that NQF's measure submission process now includes the Scientific Methods Panel Review (SMP) for complex measures; if a measure does not pass SMP review, then the submission is halted, and the developer needs to revise and resubmit. The prenatal immunization measure did not pass the SMP this fall due to having a sample size too small to address some of the questions the Panel had around reliability and validity, since the testing data were based on a pilot during the first year of use. Ms. Byron noted that the increased requirements from NQF lead to challenges, particularly due to increased costs for testing, and NCQA is still considering how to balance piloted implementations with submitting for endorsement. Currently, given the level of field data available, NCQA will not submit the perinatal measures for the fall 2019 cycle. However, it hopes to submit in 2020.

Questions and Discussion

The Committee commended NCQA on the presentation and especially noted the importance of recognizing depression during prenatal and postpartum care. The Committee asked the speakers to provide additional information about HEDIS and its use in so many different electronic systems, raising interoperability problems. NCQA agreed that electronic data systems are still relatively new and under development, but noted that its system builds on the foundation of claims data. Having a standardized, flexible model can funnel data to identify gaps in care and provide a complete picture of health. The Committee requested that the speakers also consider creating a similar measure related to prenatal and postpartum anxiety. NCQA stated an interest in doing so and hopes to in the future. One major challenge, however, is that there are no guidelines yet about primary treatment for anxiety (as there are for depression), and NCQA does not want to create a screening measure if there is no guideline.

Transition to eCQMs and Development of Maternal Morbidity Measures

Susan Yendro, MSN, RN, and Lisa Anderson, MSN, RN-BC, from The Joint Commission (TJC), presented on their work in perinatal care and the process of transitioning to eCQMs. Ms. Yendro began by reviewing the role of TJC, which evaluates and accredits healthcare organizations in

the United States and worldwide. It helps to support improvement efforts by assessing standards during on-site surveys, using performance measures, and sharing leading practices through webinars, surveys, and publications. Ms. Yendro then explained that specific to perinatal health, TJC requires that, to be accredited, any organization reporting more than 300 births annually must collect and report on six perinatal measures (PC-01 Elective Delivery, PC-02 Cesarean Birth, PC-03 Antenatal Steroids, PC-04 Health Care-Associated Bloodstream Infections in Newborns, PC-05 Exclusive Breast Milk Feeding, and PC-06 Unexpected Complications in Term Newborns). For certification, the organization must report all six measures, regardless of the number of deliveries. Ms. Yendro also noted that of the perinatal measures, the elective delivery and exclusive breast milk feeding measures also are currently available as eCQMs, and the cesarean birth and unexpected complications in term newborn measures are being developed as eCQMs.

Another lever to help improve care is to publicly report on performance of measures. Recently, TJC announced that it will begin publicly reporting c-section rates for hospitals with persistently high rates. Public reporting will begin in July 2020, using three criteria to determine a hospital's PC-02 rating. Ms. Anderson also discussed some of TJC's potential levers to continue to increase perinatal safety. TJC has a few measures (on topics like maternal hypertension and hemorrhage) that could be added to either the accreditation or certification sets, and it is considering developing new measures on maternal morbidity. She noted one challenge is that certification measures are not publicly reported, which is a barrier for NQF endorsement; the lengthy process for submission and endorsement is another barrier.

Ms. Anderson provided an overview of The Joint Commission measure development process, beginning by explaining the differences between chart-based and eCQM measures. The development of eCQMs requires more discussion with EHR users and vendors to have a better handle on the feasibility and face validity on the data elements. She noted that to receive NQF endorsement, eCQMs must be piloted on two sites with two different electronic health records (EHRs), which means TJC needs to allow extra time to recruit facilities for testing and for them to configure their EHRs. TJC found that large academic medical centers are most likely to have the resources needed for testing, although diversity of the testing site types is then an issue. Nevertheless, TJC noted that once a site has tested one measure, it is more willing to participate in future testing. Additionally, TJC is now working with EHR vendors during the measure development process which also is facilitating testing. Ms. Anderson noted that it takes more than two years to develop an eCQM, whereas a chart-based measure usually takes 18-24 months.

TJC created an eCQM task force and a technical advisory panel consisting of terminologists and EHR vendors to talk through specific challenges in the development of eCQMs. Other challenges to developing and implementing eCQMs include mapping for accurate data; significant unplanned expenses for IT, clinical staff, and education; and the need to develop discrete documentation requirements that do not compromise care. In addition, changing the EHR systems and the vendors' ability to produce the Quality Reporting Document Architecture

(QRDA) document are also important limitations to note. Transition to eCQMs has been challenging and time intensive.

Questions and Discussion

Dr. Sakala thanked the speakers for their presentations. Janet Muri asked how the electronic health data are gathered in addition to the EMR, such as using the testing site's administrative data. The presenters confirmed that all data are captured from EHRs and EMRs.

Public Comment

Ms. Theberge opened the web meeting to allow for public comment. No public comments were received.

For a final Committee question, one member asked how The Joint Commission planned on making the rates public. TJC responded that the rates will be publicized on its website via the Quality Check program, with the cesarean section measure rates being available mid-2020.

Next Steps

Navya Kumar, NQF project analyst, summarized the next steps for the Committee. Specifically, since the measure submitted for spring 2019 did not pass NQF's minimum criteria for scientific acceptability, the Committee will have a strategic web meeting for the spring cycle. Ms. Theberge concluded the call by thanking everyone for participating.