NATIONAL QUALITY FORUM

Perinatal & Women's Health

Committee Strategic Web Meeting

Suzanne Theberge
Robyn Y. Nishimi
Navya Kumar

November 8, 2018

Welcome

Agenda

- Introductions and Meeting Objectives
- Patient Reported Labor and Delivery Measures
- MADM and MORi Tools for Measuring Women's Respectful Care
- Listening to Mothers - California Survey Results
- NQF Member and Public Comment
- Next Steps
- Adjourn

Project Team

- Suzanne Theberge, MPH, Senior Project Manager
- Robyn Y. Nishimi, PhD, Senior Consultant
- Navya Kumar, MPH, Project Analyst

Perinatal & Women's Health Standing Committee

- **Kimberly Gregory, MD, MPH** (Co-Chair)
- **Carol Sakala, PhD, MSPH** (Co-Chair)
- J. Matthew Austin, PhD
- Jennifer Bailit, MD, MPH
- Amy Bell, DNP, RNC-OB, NEA-BC, CPHQ
- Tracy Flanagan, MD
- Ashley Hirai, PhD
- Mambarambath Jaleel, MD
- Diana Jolles, CNM, MS, PhD (c)
- Deborah Kilday, MSN, RN
- Sarah McNeil, MD
- Jennifer Moore, PhD, RN
- Kristi Nelson, MBA, BSN
- Juliet M Nevins, MD, MPA
- Sheila Owens-Collins, MD, MPH, MBA
- Cynthia Pellegrini
- Diana E. Ramos, MD, MPH, FACOG
- Naomi Schapiro, RN, PhD, CPNP
- Karen Shea, RN, MSN
- Marisa "Mimi" Spalding, JD, MPH
- Sindhu Srinivas, MD, MSCE
- Rajan Wadhawan, MD, MMM, CPE, FAAP
- Carolyn Westhoff, MD, MSc

Patient Reported Labor and Delivery Measures

Kimberly Gregory, MD, MPH

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Predictors of Hospital Satisfaction in Childbirth

The Maternal Quality Indicator Work Group &
The Childbirth PRO Partnership
November 8, 2018

March 9, 2018

M Q I

CBEX
Childbirth Experience Survey

CEDARS-SINAI MEDICAL CENTER

Disclosures

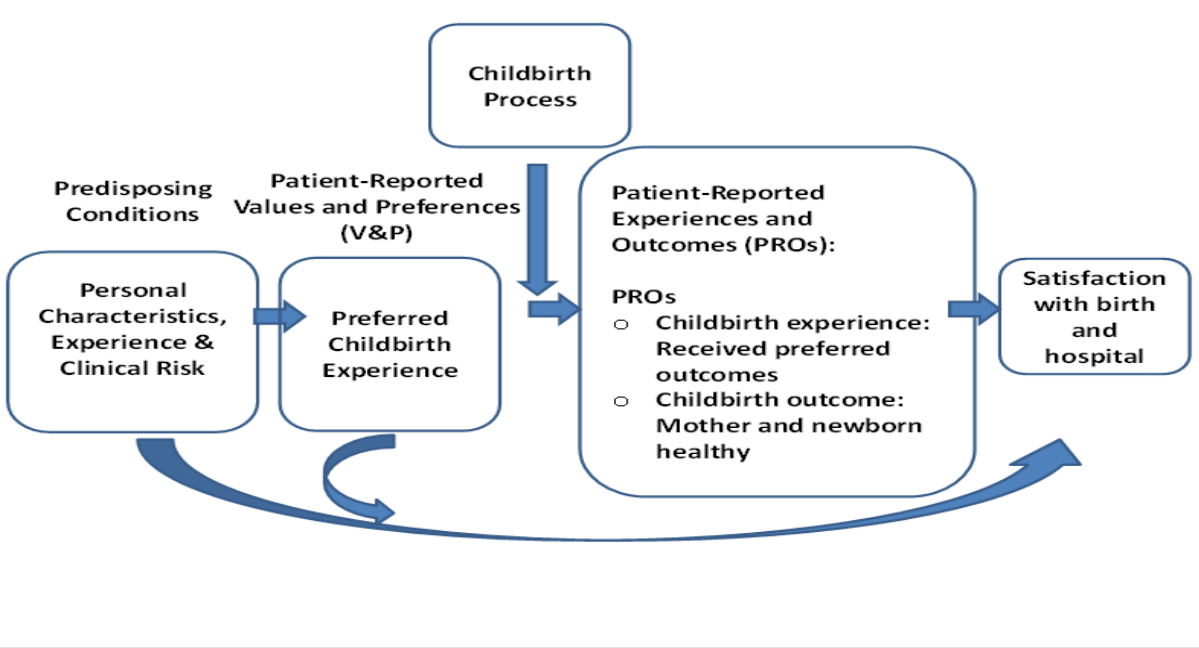
- Funding provided by PCORI
  - ***Expanding PROMIS® item bank development to the pregnant population;***
  - *PCORI Award ID: ME-1402-10249*
  - *HSRProj ID: 20152288*

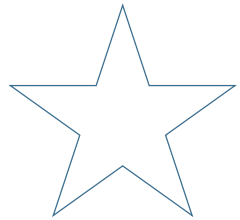
- Supplemental funding provided by The Cohen Family Foundation

- Drs. Lisa Korst and Moshe Fridman own Maternal Metrics, Inc.

-

Goal: Develop a conceptual framework and preliminary item bank for Childbirth PROs

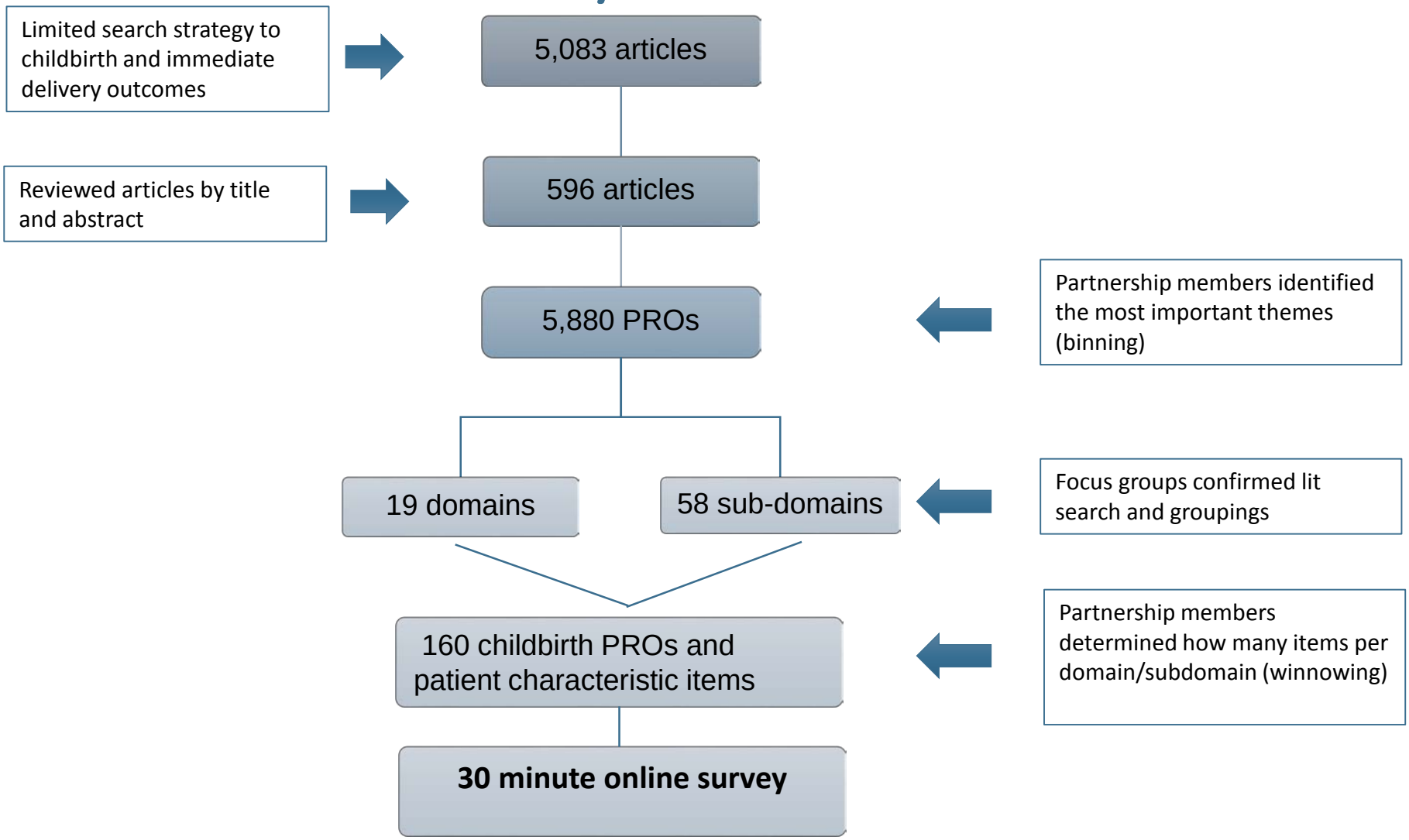




Overarching hypotheses:

- Predisposing conditions generate values and preferences (V&P) for the services desired.
- After giving birth, women assess whether these V&P were fulfilled. Predisposing conditions, fulfillment of V&P's are associated with satisfaction with their birth and hospital experiences

PROMIS Methods to identify PROs and create survey



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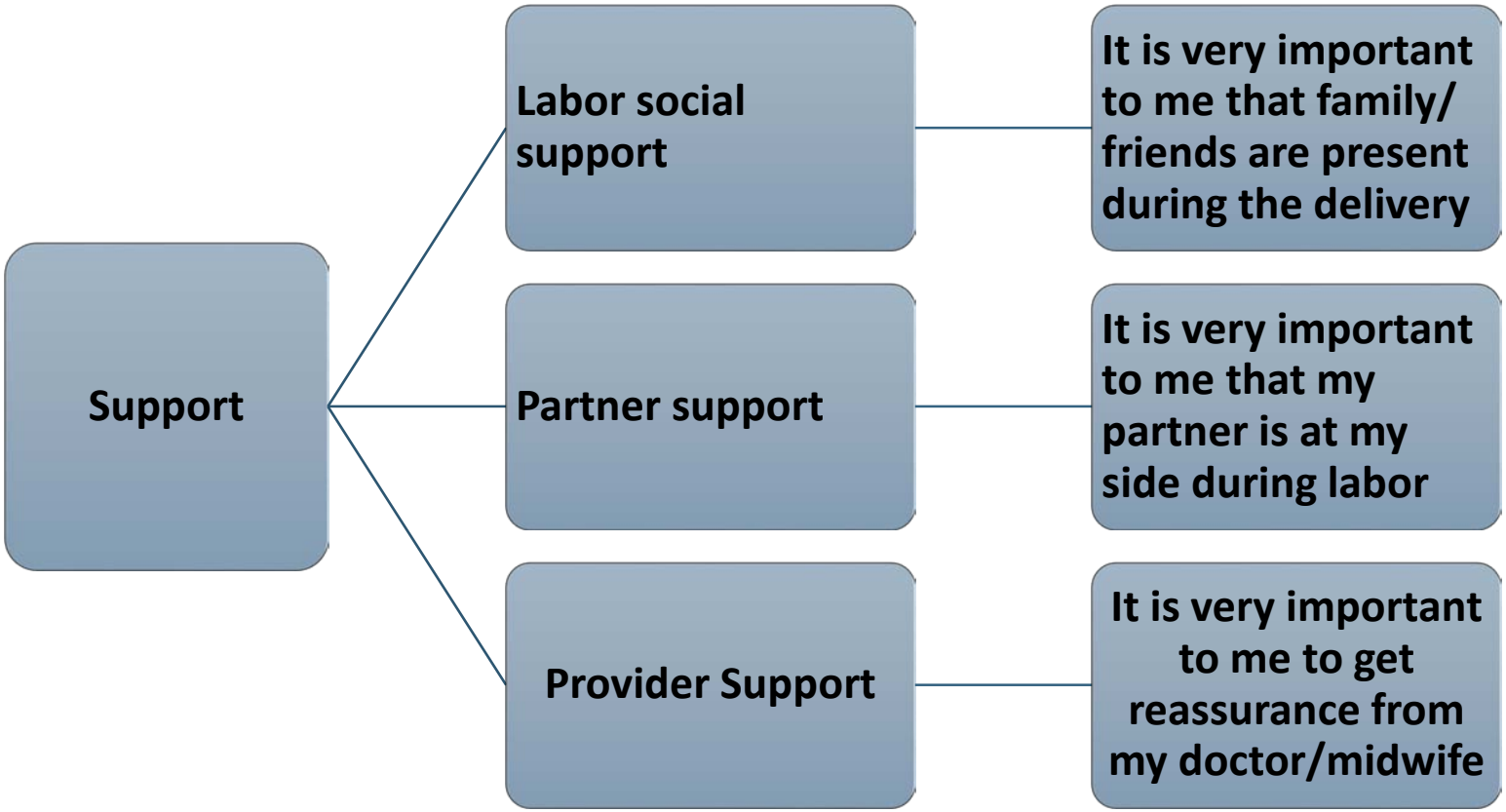

Support
Labor social support
Partner support
Provider Support
It is very important to me that family/ friends are present during the delivery
It is very important to me that my partner is at my side during labor
It is very important to me to get reassurance from my doctor/midwife

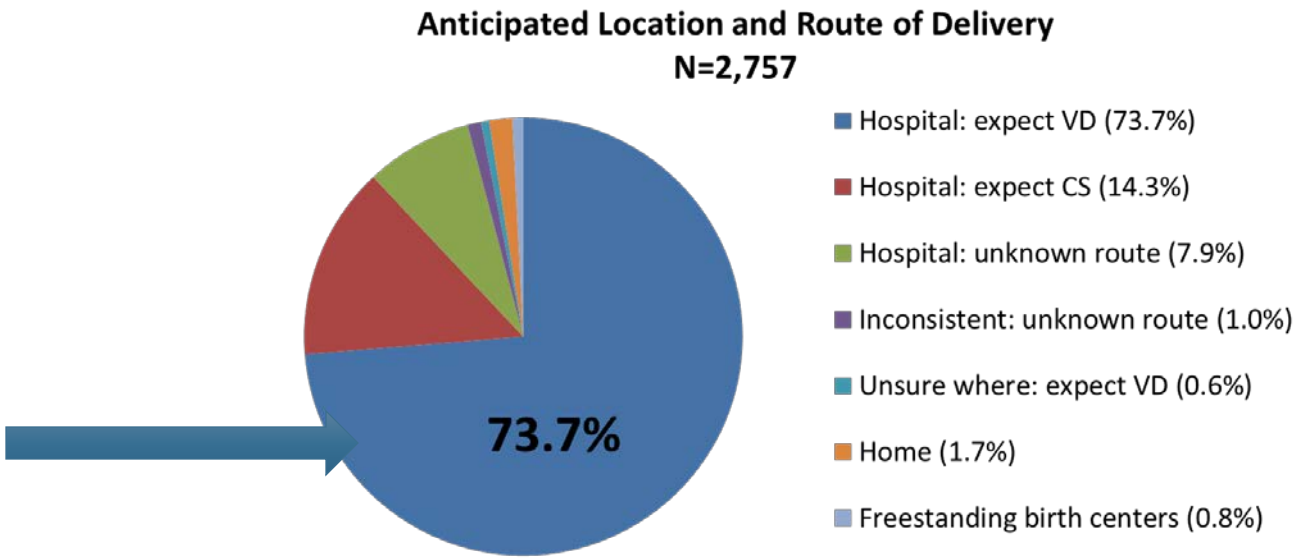
Developed a two part survey Administered nationally

- **Phase 1 (antepartum data):**
  - *What do women want?*
    - » Want to understand: "who wants what"
      - *Who: Predisposing conditions: Demographics, clinical status, relevant personality traits, beliefs and experiences, etc.*
      - *What: PROs*

- **Phase 2 (antepartum + postpartum data):**
  - *Determine if women got what they wanted*
  - *Determine "gaps" in what women wanted and what they got*
  - *Determine which PROs predicted hospital and birth satisfaction*

National Survey to Pregnant Women

- The Nielsen Company administered the survey using its online panels
- Women 18+ years, 20+ weeks of gestation, US resident
- English & Spanish
- 2757 responses in 2 weeks
- Nielsen provided weights for a “nationally representative sample”



Examples of V&P used in Childbirth Experience Survey (CBEX)

Hypothesized Universal PRO's
- Pain control, safety, courtesy, communication

Labor Management
- Want eat/drink in labor
- Want massage, shower, walking, tub/ball/stool in labor
- Want to avoid interventions: induction, IV, pitocin, CS, forceps/vacuum, EFM, epis

Providers
- Want female, want to know in advance: MD/MW, Peds

Labor/Birth Position
- Want choice of position, assistance with position

Control/Decision-making
- Want ability to refuse tx
- Want to talk family first
- Want to let provider decide
- Involve in decisions re pain

Labor Staff Support
- Doctor/midwife, nurse reassurance/comfort
- Respect cultural/spiritual beliefs

Labor Pain Management
- Acupuncture, breathe, epidural, massage, mental strategies, nitrous oxide, narcotics, shower/tub, TENS, walk

Anticipated Delivery Route and Location

Labor Social Support
- People in room

Privacy Respect
- Want choice of who is in room, private room
- Space/food for partner
- Providers talk postpartum re birth, feelings

Postpartum Care
- Stay > 48 hours
- Want tubal sterilization

Newborn Care
- Skin to skin after birth
- Baby stays with mom
- Feeding: practical support, type, encouragement
- Information re baby care

Lots of data reduction…examples of summary results

- 39 PROs; 19 domains
- PROs vary by patient characteristics and V&Ps
- Two types of PROs
- 1. Universal PROs
  - *(items that everybody would most likely want)*
  - *Example: safety, courtesy, respect*
- 2. Specific PROs
  - *(items likely to vary by patient characteristics*
  - *Example: wanting childcare information may vary depending on whether this is your first or second child*

Example—PROs varied by patient characteristics

Example: Race*Respect spiritual/cultural needs

Patient characteristic	Percent with characteristic who wanted PRO	P value
Race		<0.0001
Black (n=359)	77.1%	
Hispanic (n=349)	70.0%	
Asian (n=69)	61.5%	
White (n=1108)	63.3%	
Other* (n=86)	69.3%	
***includes mixed race**		

PROs: Who Wants What by Parity

- **Nulliparas**
  - *More likely to want:*
    - To avoid intervention
    - To receive information regarding baby care, feeding
    - To receive practical support regarding feeding
    - To breastfeed
    - To have a female provider available
    - To talk with the family first regarding decisions in labor and delivery
    - Multiple pain management options: breathing techniques, massage, mental strategies, nitrous oxide, shower/tub, TENS, walking

Additional Patient Characteristics

- **Characteristics that were important but providers do not normally address in advance**
  - *Confidence in the birth process (important for 25 PROs)*
  - *Belief that they would cope well with pain*
  - *Belief that giving birth put them in a "helpless" position*
  - *Belief that it was better not to know about the processes of childbirth*
  - *Worry about giving birth*
  - *Negative memories about a previous birth*
  - *History of abuse, discrimination*
  - *Self-rating of mental health as poor or fair*

- Perceived clinical risk not highly important in the models

Developed models for each PRO for women anticipating vaginal birth

- All models included age, education, parity, prior cesarean, pregnancy and medical complications, race/ethnicity, gestational age at survey, region, multiple gestation
- Included patient characteristics that were statistically significant in the crosstabs, such as discrimination, abuse, social support, provider preference
- Purpose of the models was to isolate the most important associated characteristics and to quantify their relative importance
- One model for each PRO (n=39)

Example: Model for "Want Skin to Skin" at birth

Patient characteristic	Adjusted Odds Ratio (95% CI)	Interpretation
Birth plan	1.38 (1.04-1.83)	More likely
Confidence high	1.96 (1.47-2.61)	More likely
Confident filling out medical forms (literacy)	1.80 (1.31-2.47)	More likely
Believe will cope well with pain	1.86 (1.35-2.58)	More likely
Plan to have a support person	2.30 (1.11-4.80)	More likely

- 72% of respondents anticipating labor said they "want skin to skin"
- Example of interpretation:
    - Women who planned to have a support person were more than 2.3 more likely than women who did not plan to have a support person to want the baby placed "skin to skin"

Phase 2: Postpartum Survey

- Received supplemental funding from PCORI and The Cohen Family Foundation to develop and administer the postpartum survey
  - *You said you wanted X service, did you get it?*
- Added questions that could not be asked antepartum
  - *e.g., HCAHPS questions, pain questions*
- Did women get what they wanted (GAP) ?
- How satisfied were women with the birth or hospital?

OUTCOME

What number would you use to rate this hospital during your stay ?

- *0 = Worst hospital possible to 10 = Best hospital possible*
- *Split at 9+ versus < 9 (median =9)*

Postpartum Results

- 800 postpartum responses
- 500 respondents who anticipated a vaginal birth and labored in a hospital
  - *58 CS (11.6%)*

- Start with bivariate analyses
  - *Predictors: Predisposing conditions, V&P, "Gap variables, clinical complications"*
  - *Outcome: Hospital satisfaction*

Postpartum Results

- Focused on whether women "got what they wanted"
- We are calling this "Gap Data"
- There are four possible outcomes ("Gap Data") for each PRO
  1. *Didn't want, didn't get*
  2. *Didn't want, got anyway*
  3. *Wanted, didn't get*
  4. *Wanted, got*

- We hypothesized that it is important when there is a **difference** between what was preferred/expected antepartum and what actually happened during delivery

Example: Wanted But Didn't Get The Service

Example:

Potential Universal PRO "Reassurance from provider"	Percent Satisfied with hospital	P value
Didn't want, didn't get	52.3%	0.0022
Didn't want, got anyway	48.2%	
Wanted, didn't get*	29.6%	
Wanted, got	63.4%	

- Pain treatment: narcotics
- Information re where newborn should sleep
- *Women who wanted, but didn't get the service were the **least** satisfied

For these PROs, it helps to know in advance if a patient wants these options

Example: Didn't Want But Got The Service Anyway

Example:

GAP for "Partner in Room"	Percent Satisfied with hospital	P value
Didn't want, didn't get	0%	0.0704
Didn't want, got anyway*	28.2%	
Wanted, didn't get	67.1%	
Wanted, got	61.4%	

- Breast feeding encouragement
- Pain treatment [acupuncture]
- *Women who specified they didn't want the service, but got it anyway, were the **least** satisfied

For these PROs, it helps to know in advance if a patient does not want these options

Developed logistic regression models to predict hospital satisfaction

- What were the strongest predictors?
  - *Predictors: Predisposing conditions, V&P, Gap variables, clinical complications*
  - *Outcome: Hospital satisfaction*

- Adjusted models for age, race, education, multiple gestation, parity/prior CS, US region, perceived risk, overall health, overall mental health

Patient characteristics associated with hospital satisfaction (measured antepartum)

*Red bold text=less satisfied

- **Maternal mental health reported as poor/fair***
  - *Overall health reported as poor/fair and complicated pregnancy were not associated with hospital satisfaction*
- High confidence
- High confidence in filling out medical forms (literacy)
- **History of discrimination***
- Had immediate help (social support)
- **Had negative memories from previous childbirth***
- **Most days reported as stressful***
- **Worried about birth***
- Wanted shower/tub for pain treatment

Patient characteristics associated with hospital satisfaction (measured postpartum)
*Red bold text=less satisfied

- Examples (abbreviated list)
- Coped well with pain OR pain relief adequate
- **Lost control***
- Had doula in the room
- Had choice for who was in the room for procedures
- Had spiritual/cultural needs respected
- Was involved in decisions regarding labor pain management
- Was told of labor progress
- **Felt pressure by the providers, family or friends to have a CS***
- Had adequate space/food for support person
- Had newborn placed skin to skin

PROs where "Gaps" mattered and were associated with hospital satisfaction

*Red bold=less satisfied

- Wanted/got massage
- Wanted/got nurse comfort
- Wanted/got tubal sterilization (especially satisfied)

- **Wanted/didn't get narcotics***

- **Did not want partner in the room/got it***
- **Did not want breastfeeding/got too much* breastfeeding encouragement from the provider***

Final Model for Hospital Satisfaction (score 9 or 10 out of 10)

Patient characteristic	Adjusted Odds Ratio (95% CI)	Interpretation
Coped well with labor pain	1.64 (1.05-2.57)	More likely
Had continuous electronic fetal monitoring	2.30 (1.33-3.98)	More likely
Had adequate space/food for support person	2.45 (1.32-4.52)	More likely
Had debriefing re what happened during birth	1.78 (1.14-2.78)	More likely
Had practical support for newborn feeding	3.32 (1.79-6.16)	More likely
Was told about labor progress	2.14 (1.09-4.18)	More likely
GAP: wanted/got massage	1.78 (1.00-3.17)	More likely
Wanted partner in the room	5.50 (1.16-26.06)	More likely

- Adjustors
  - Age, education, race, region, parity, multiple gestation, perceived health problem, overall health poor/fair: not significant (remained in model)
  - Overall mental health reported as poor/fair: OR 0.45 (0.21-0.94) Less likely

Lessons Learned

- Irrespective of what women say they want or do not want antepartum, there are certain service expectations (i.e., universal PROs) that are associated with increased patient satisfaction
  - *For example: safety, skin to skin, control, and adequate space/food for support person*
- Based on patient characteristics, there are specific preferences that matter and can be known in advance that could improve patients satisfaction with their birth and hospital experience,
  - *There are also services that patients may be expecting that the hospital cannot provide -> opportunity for expectation management and education*
    - Example: VBAC

Current project: PCORI Dissemination & Implementation grant

- CBEX has been shortened; now have a mobile version and the web version
- The goal is to collect data on approximately 3,000 women across 10 diverse hospitals in California
- Go Live: October 30, 2018

- Primary outcome measure of success is to implement in each hospital and reach recruitment goal of 3000 completed surveys

Current project: PCORI Dissemination & Implementation grant

- Additional measures of success include:
  - *Staff engagement in the recruitment process*
  - *Number of women who register and/or complete the antepartum survey*
  - *Number of women who register and/or complete the postpartum survey*
  - *Feedback from hospitals regarding anticipated changes in care based on recommendations generated from hospital specific reports*
    - Did we achieve meaningful comparisons across hospitals

Next steps: Begin to define improvement strategies

- Provide universal PROs to all women
- Identify vulnerable patients based on antepartum survey and develop training or educational programs for staff to help women get what they want
- Ask about preferences directly; integrate into EMR
- Develop referral options for patients for whom the hospital cannot meet requests

Next steps: Academic task

- Continue along the National Quality Forum/PROMIS pathway for performance measure development of childbirth PROS
  - **Completed Step 1 of 5 Steps in the PROMIS Pathway**
    - Complete childbirth-specific set of PRO domains and preliminary item bank
  - **Currently working on Steps 6&7 of the NQF Pathway**: evaluating PRO measure in the target population, comparing aggregate data across hospitals

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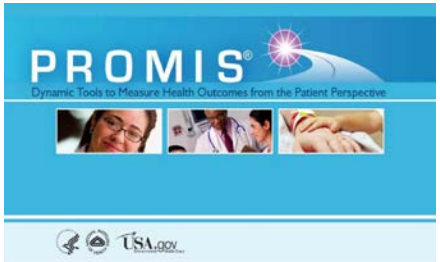
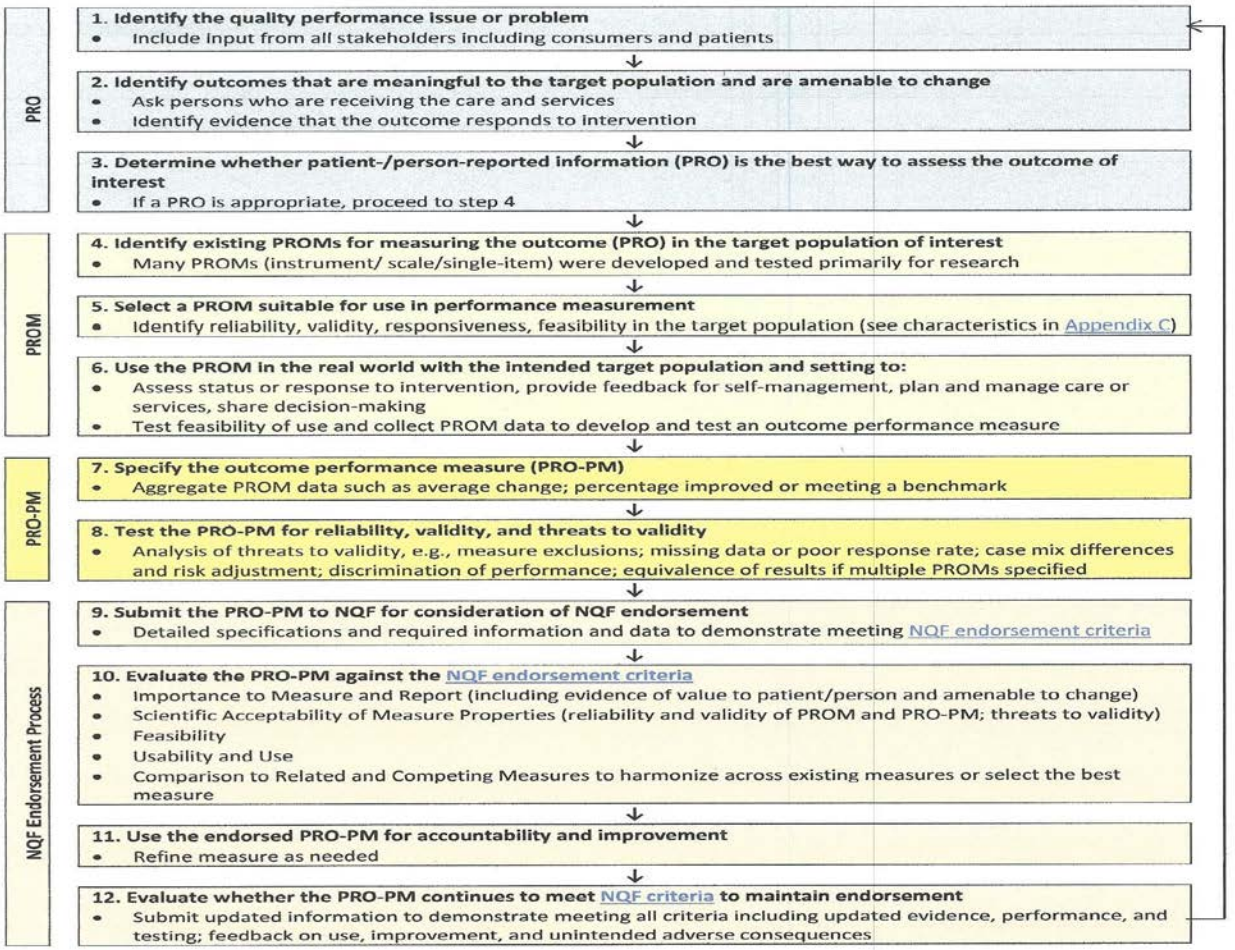


NQF Pathway

PCORI Promis Methods project

PCORI D&I project

Figure 2. Pathway from PRO to NQF-endorsed PRO-PM



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Thank you!

Academic Research Team
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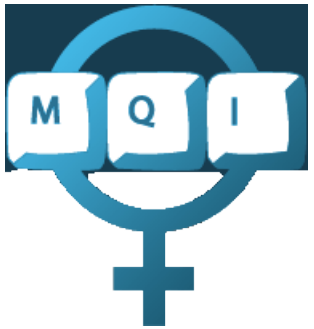
Lisa Korst MD, PHD Co-PI
Moshe Fridman PHD, Team Statistician
Samia Saeb MPH, Project Coordinator
Arlene Fink PHD, Survey Consultant
Jeanette McColloch, Childbirth Advocate
& with ongoing gratitude to the past/present/and future members of
The Childbirth PRO Partnership



MADM and MORi Tools for Measuring Women's Respectful Care

Saraswathi Vedam, RM RACNM MSN, Sci D (hc)

Who defines quality and safety?

Measuring Respectful Maternity Care in North America

On behalf of:

CHANGING CHILDBIRTH IN BC STEERING COUNCIL

CONSUMER, ETHICS, REGULATION, AND RESEARCH TASK FORCES: HBS 2014

GIVING VOICE TO MOTHERS STEERING COUNCIL

NQF Webinar November 8, 2018

No conflicts to declare

Funding Sources:

- Transforming Birth Fund, New Hampshire Charitable Foundation
- Michael Smith Health Professional Investigator Award
- Vancouver Foundation
- Groundswell Fund

Person-Centered Outcomes Research
The Participatory Process

Stakeholders engaged in:

- Formulating research questions;
- Defining essential characteristics of study participants,
- Identifying and selecting outcomes that the population of interest notices and cares about (e.g., survival, function, symptoms, health-related quality of life).
- Choosing methods of data collection, leading recruitment, monitoring study conduct and progress;
- Partners in analysis, interpretation, key messages
- Designing/suggesting plans for dissemination and implementation activities
- Ongoing training, education, capacity building

PCORI Institute/CBPR

Changing Childbirth in BC

COMMUNITY BASED PARTICIPATORY ACTION PROJECT

3400 Pregnancies, Diverse Populations, Scale Development

The Community in BC

Steering group of women of childbearing age from different cultural and socio-economic backgrounds

Four working groups:

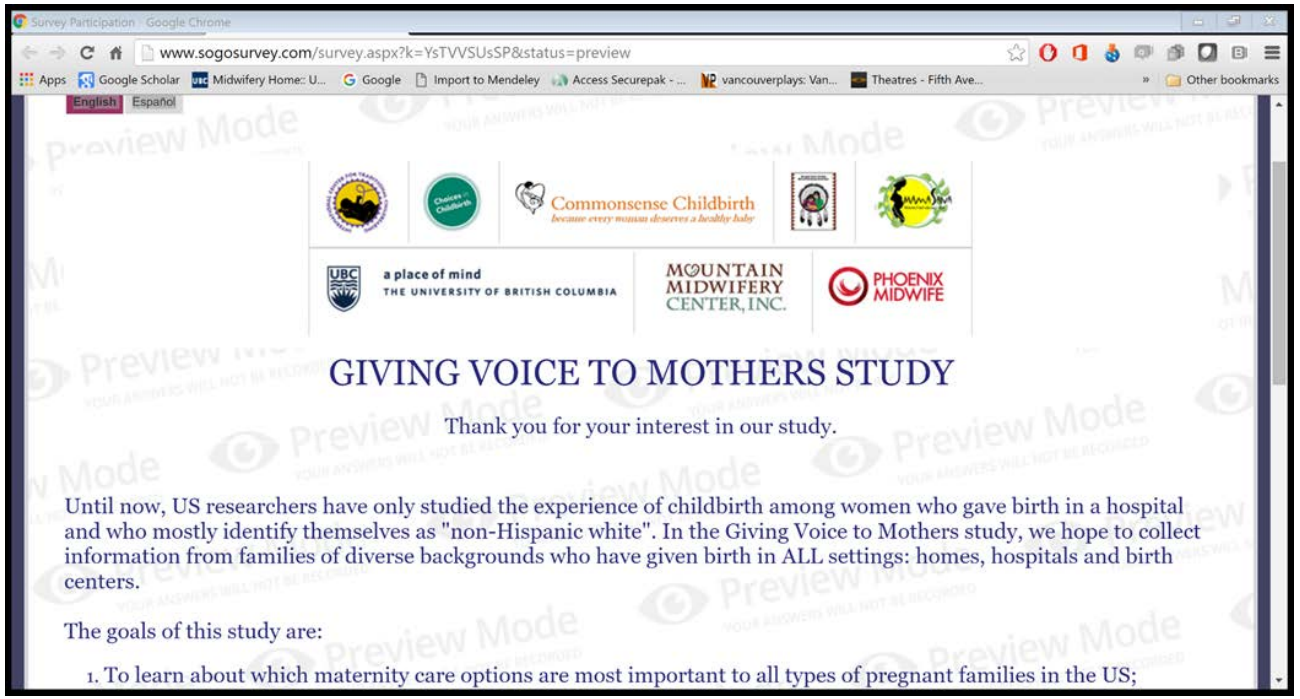
- Current/potential maternity clients
- Women who have been incarcerated
- Immigrant and refugee women
- Women who have experienced homelessness, poverty and/or other barriers

Key Domains chosen by community- Canada

- Access to care
- Preferences for care
- Experiences with maternity care
  - Decision-making
  - Place of Birth
- Knowledge of Midwifery

The Giving Voice to Mothers – US Team

Authenticity in representation, Geographic and demographic diversity, Credibility and Access to participants



Key Domains for communities of colors - United States

- Access to care
- Preferences for care
- Experiences with maternity care
  - Decision-making
  - Respect, Autonomy
  - Racism, Mistreatment, Non-Consented Care
- Predictors of Resilience

Content Validation & Adaptation - US

- Convened Community Partners
- Literature Review for new topics
- Reviewed previous validated survey items
- Steering Committee and clients: draft new questions
- 57 Community members rated each question for relevance, clarity, and importance
- Ongoing community consultations
- Reviewed all drafts and distribution plan with Team

Shared Decision Making vs. Women-Led Decision Making?

Assessment

The 9-item Shared Decision Making Questionnaire (SDM-Q-9). Development and psychometric properties in a primary care sample

Levente Kriston [a], Isabelle Scholl [a], Lars Hölzel [b], Daniela Simon [b], Andreas Loh [c], Martin Härter [a,b,*]

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ABSTRACT

Objective: To develop and psychometrically test a brief patient-report instrument for measuring Shared Decision Making (SDM) in clinical encounters.
Methods: We revised an existing instrument (Shared Decision Making Questionnaire; SDM-Q), including the generation of new items and changing the response format. A 9-item version (SDM-Q-9) was developed and tested in a German primary care sample of 2351 patients via face validity ratings, investigation of acceptance, as well as factor and reliability analysis. Findings were cross-validated in a randomly selected subsample.
Results: The SDM-Q-9 showed face validity and high acceptance. Factor analysis revealed a clearly one-dimensional nature of the underlying construct. Both item difficulties and discrimination indices proved to be appropriate. Internal consistency yielded a Cronbach's α of 0.938 in the test sample.
Conclusion: The SDM-Q-9 is a reliable and well accepted instrument. Generalizability of the findings is limited by the elderly sample living in rural areas of Germany. While the current results are promising, further testing of criterion validity and administration in other populations is necessary.
Practice implications: The SDM-Q-9 can be used in studies investigating the effectiveness of interventions aimed at the implementation of SDM and as a quality indicator in health services assessments.

The 9-item Shared Decision Making Questionnaire (SDM-Q-9)

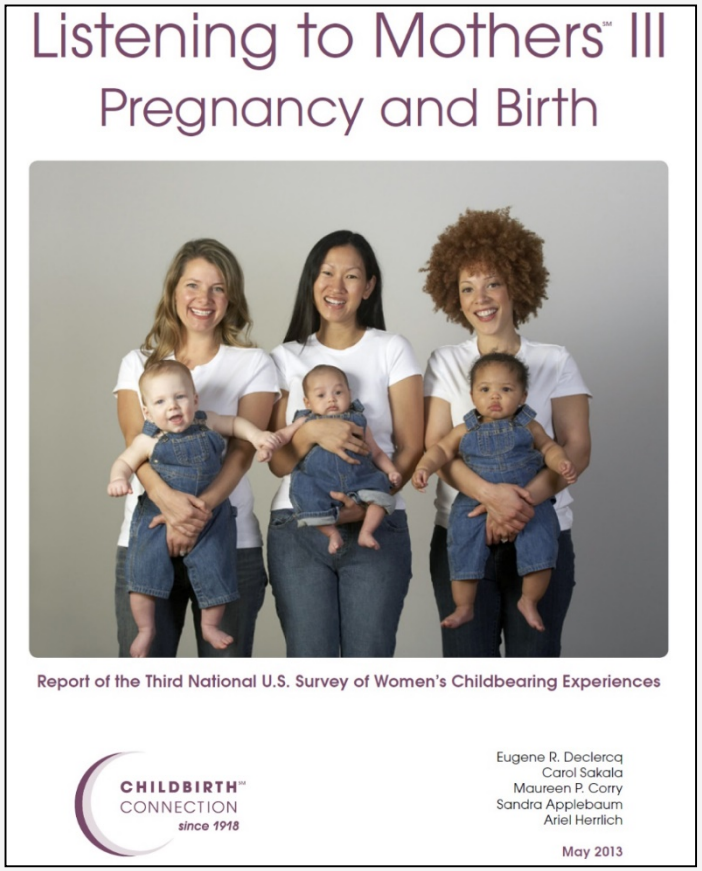
[Example] **Please indicate which health complaint/problem/illness the consultation was about:**

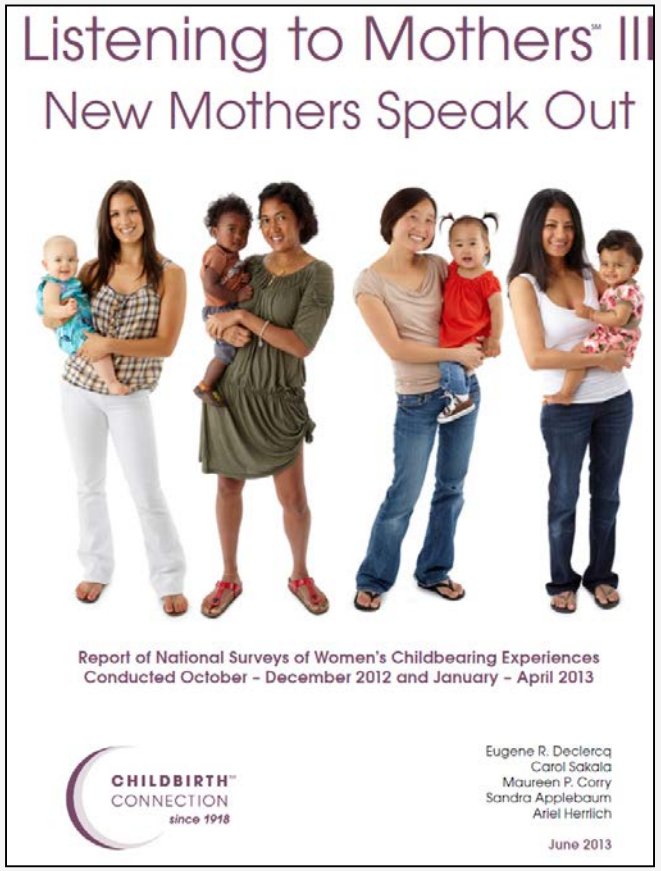
[Example] **Please indicate which decision was made:**

Nine statements related to the decision-making in your consultation are listed below. For each statement please indicate how much you agree or disagree.

		completely disagree	strongly disagree	somewhat disagree	somewhat agree	strongly agree	completely agree
1.	**My doctor made clear that a decision needs to be made.**	☐	☐	☐	☐	☐	☐
2.	**My doctor wanted to know exactly how I want to be involved in making the decision.**	☐	☐	☐	☐	☐	☐
3.	**My doctor told me that there are different options for treating my medical condition.**	☐	☐	☐	☐	☐	☐
4.	**My doctor precisely explained the advantages and disadvantages of the treatment options.**	☐	☐	☐	☐	☐	☐
5.	**My doctor helped me understand all the information.**	☐	☐	☐	☐	☐	☐
6.	**My doctor asked me which treatment option I prefer.**	☐	☐	☐	☐	☐	☐
7.	**My doctor and I thoroughly weighed the different treatment options.**	☐	☐	☐	☐	☐	☐
8.	**My doctor and I selected a treatment option together.**	☐	☐	☐	☐	☐	☐
9.	**My doctor and I reached an agreement on how to proceed.**	☐	☐	☐	☐	☐	☐

Listening to Mothers





GIVING VOICE TO MOTHERS

What do YOU think is most important for your pregnancy care?

PLEASE CONSIDER SHARING YOUR STORY

www.voicesofmothers.org

Questions? Please contact Barbara at
604.875.2000 ext: 5879
or barbara.karlen@ubc.ca

DANDO VOZ A LAS MADRES

¿Qué considera usted lo más importante para SU cuidado materno?

COMPARTA SU HISTORIA CON NOSOTROS

www.voicesofmothers.org

¿Preguntas? Por favor, póngase
en contacto con Barbara al:
604.875.2000 ext: 5879
escriba a: barbara.karlen@ubc.ca

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Article

The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth

Saraswathi Vedam[a,*], Kathrin Stoll[b], Nicholas Rubashkin[c,d], Kelsey Martin[a], Zoe Miller-Vedam[e], Hermine Hayes-Klein[e], Ganga Jolicoeur[f], the CCinBC Steering Council[1]

PLOS ONE

RESEARCH ARTICLE

The Mother's Autonomy in Decision Making (MADM) scale: Patient-led development and psychometric testing of a new instrument to evaluate experience of maternity care

Saraswathi Vedam[1]*, Kathrin Stoll[1,2], Kelsey Martin[1], Nicholas Rubashkin[3], Sarah Partridge[4], Dana Thordarson[1], Ganga Jolicoeur[5], the Changing Childbirth in BC Steering Council[¶]

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¶ A complete list of Steering Council members can be found in the Acknowledgments.
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OPEN ACCESS

Social Science & Medicine

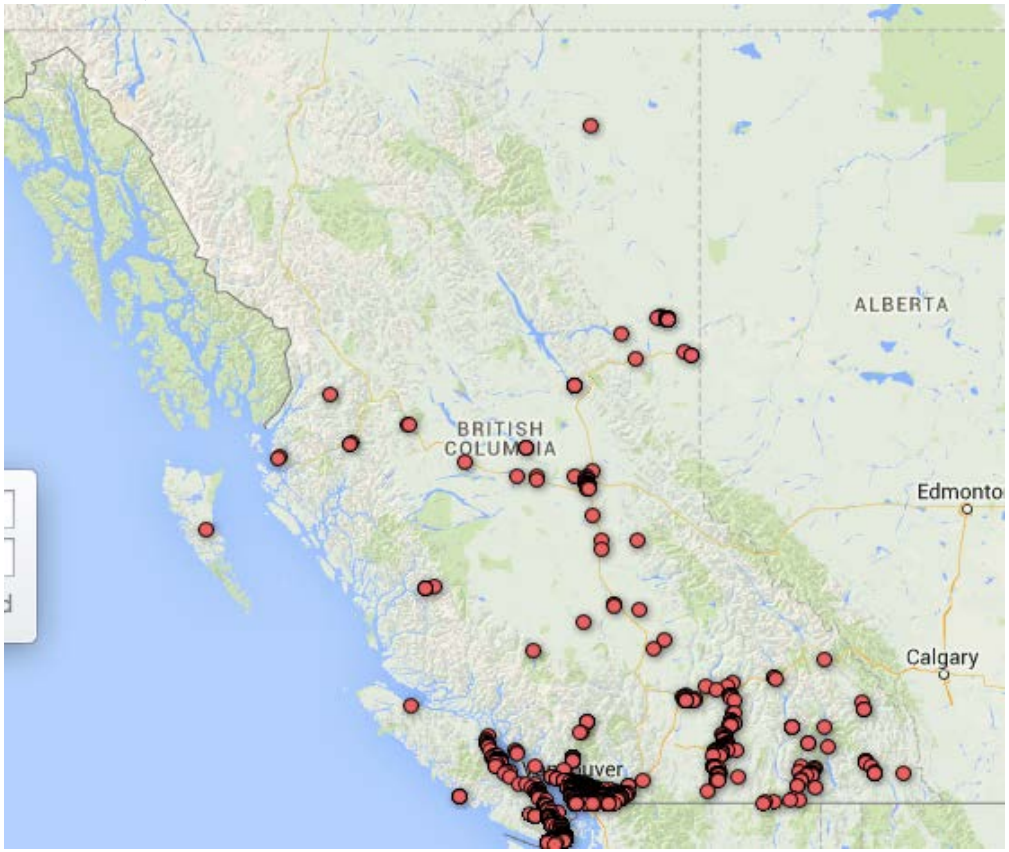
Volume 189, September 2017, Pages 86-95

Informal cash payments for birth in Hungary: Are women paying to secure a known provider, respect, or quality of care?

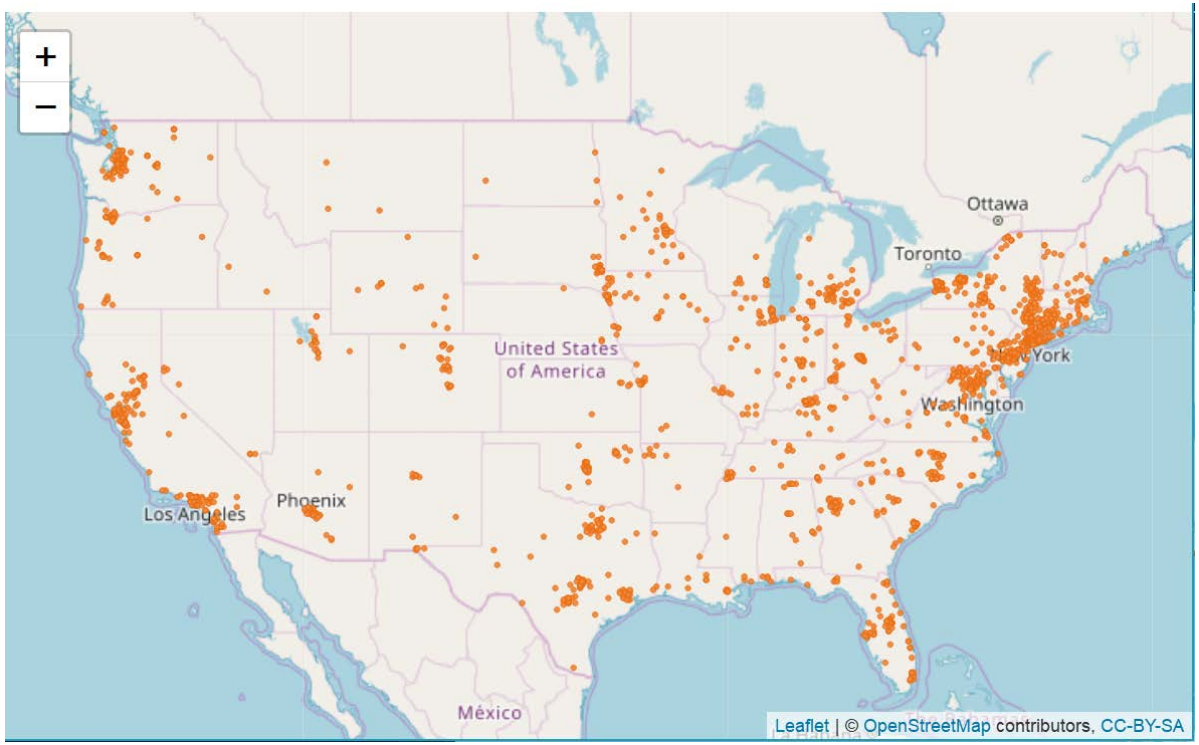
Petra Baji [a, b], Nicholas Rubashkin [c, d, e], Imre Szebik [e], Kathrin Stoll [f], Saraswathi Vedam [f, g]

Results

Survey Respondent Map

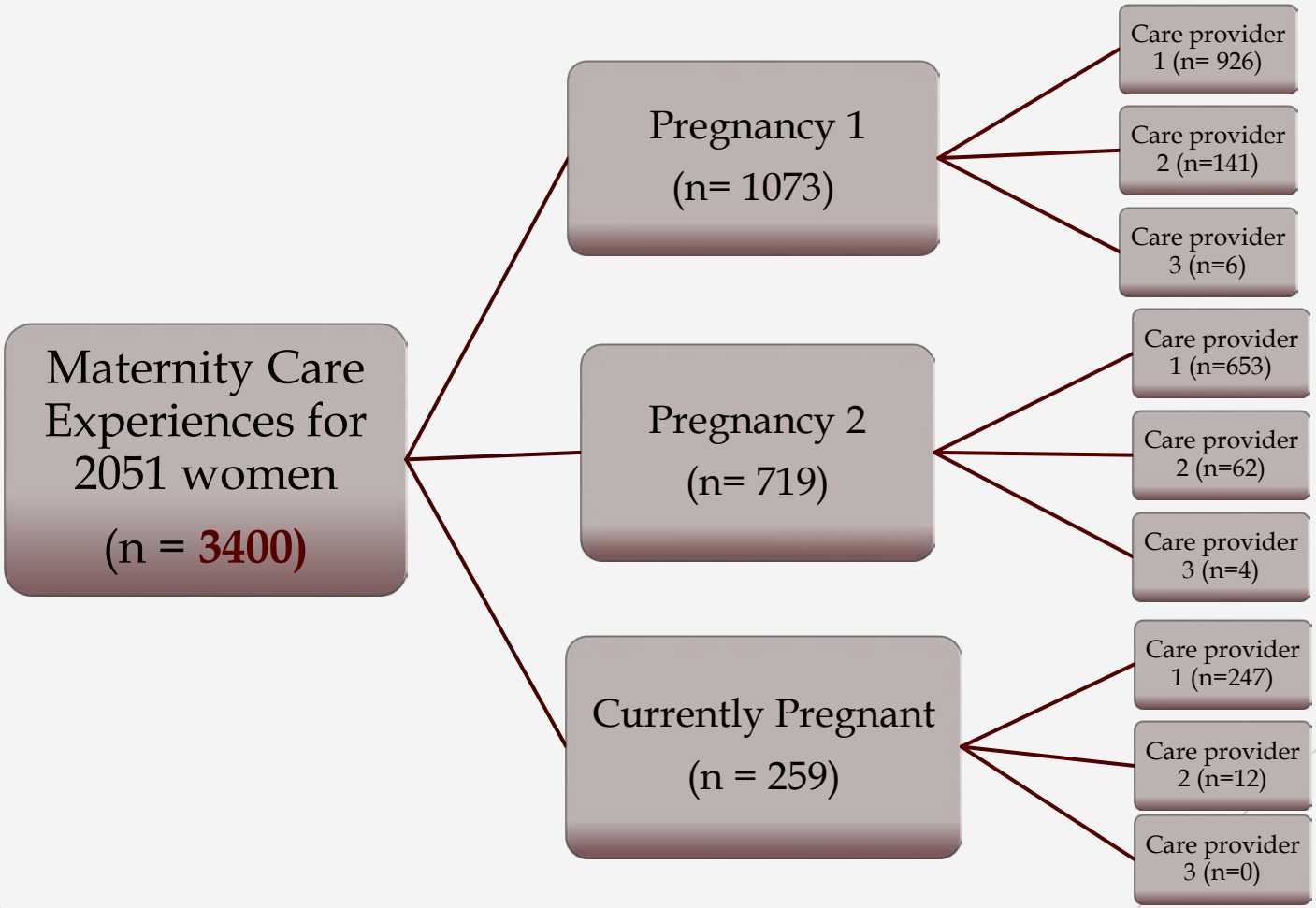


Respondents, based on zip codes at time of last pregnancy

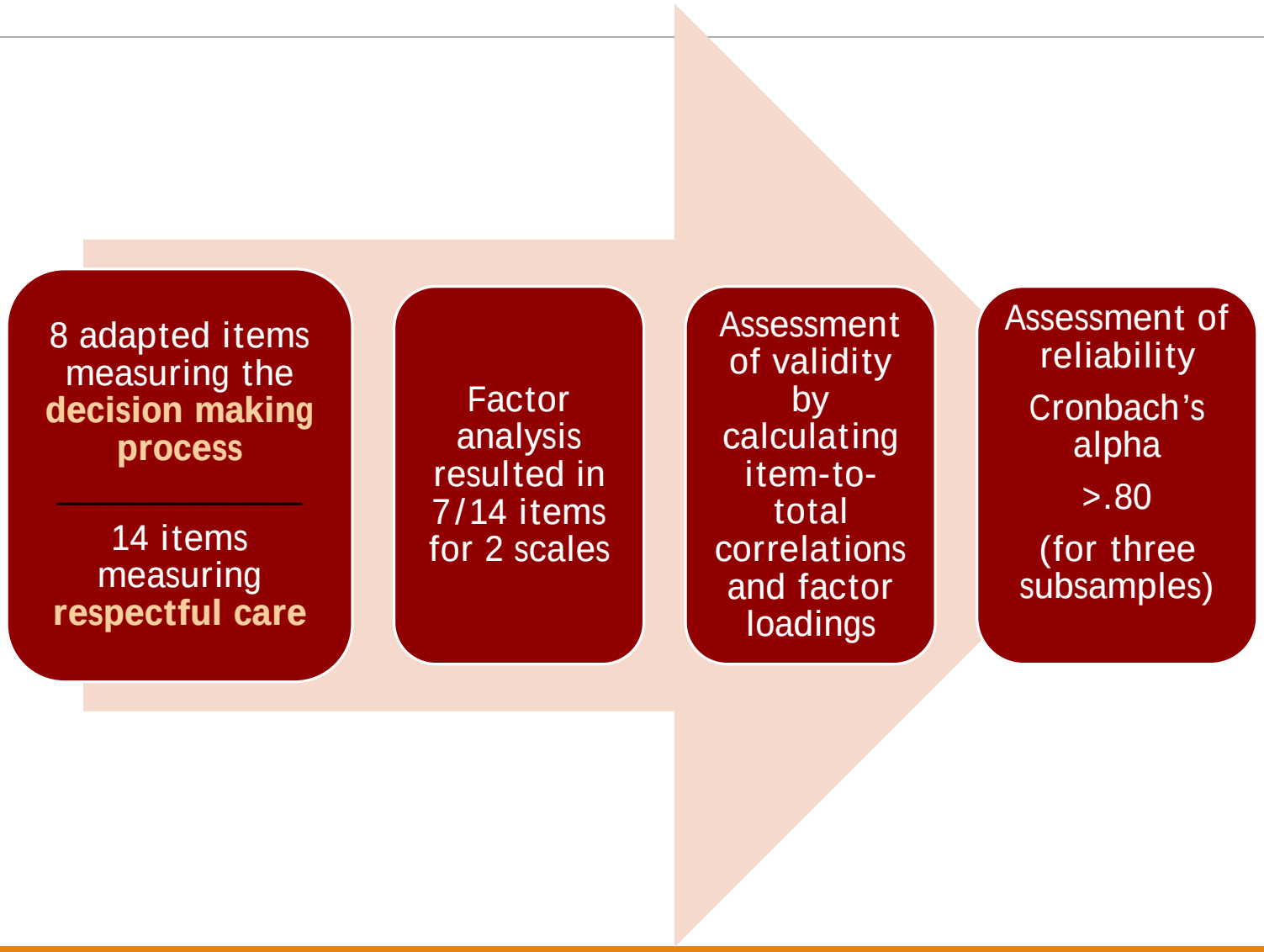


Mixed Effects Analysis:

- Control for possible effect of one woman reporting on a number of different pregnancies and care providers
- Determine relative importance of drivers



Scale development and psychometric evaluation



KEY Level of Autonomy (by quartiles)	
Total Score	***Indication of Respect***
7 - 15	Very Low Patient Autonomy
16 - 24	Low Patient Autonomy
25 - 33	Moderate Patient Autonomy
34 - 42	High Patient Autonomy

Vedam et al, PLOS ONE 2017

MOTHERS AUTONOMY IN DECISION MAKING: THE MADM SCALE

Please tell us about your discussions with your doctor or midwife about your options for care (for example: prenatal testing, starting your labour, medications, where to give birth, newborn care, whether to have a cesarean, etc.)

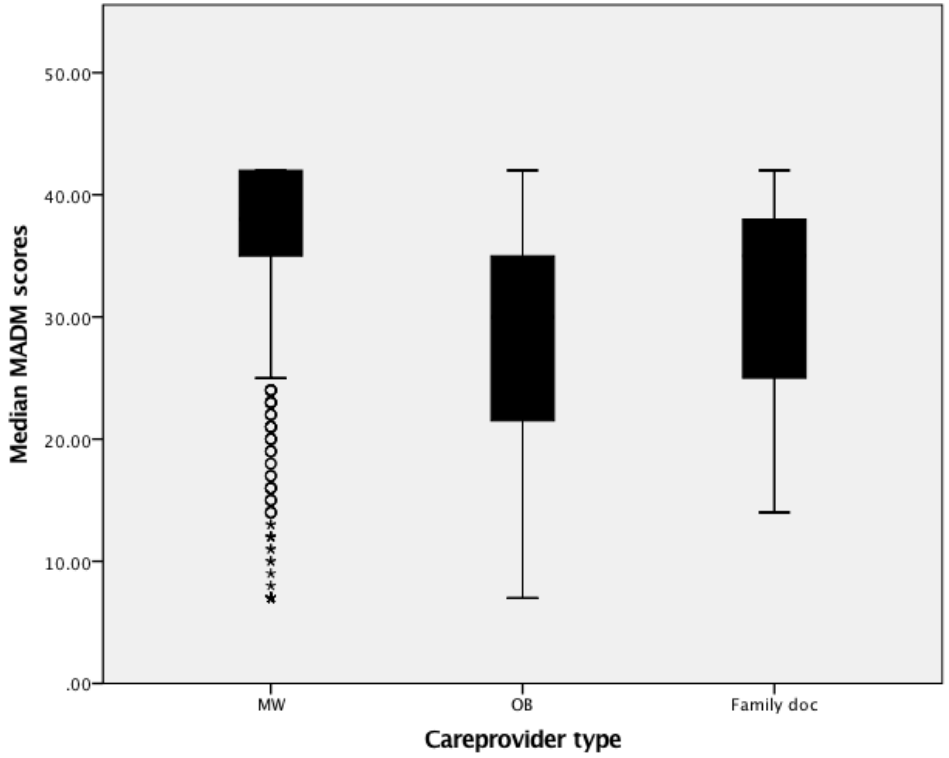
My answers describe my conversations or experiences with a:

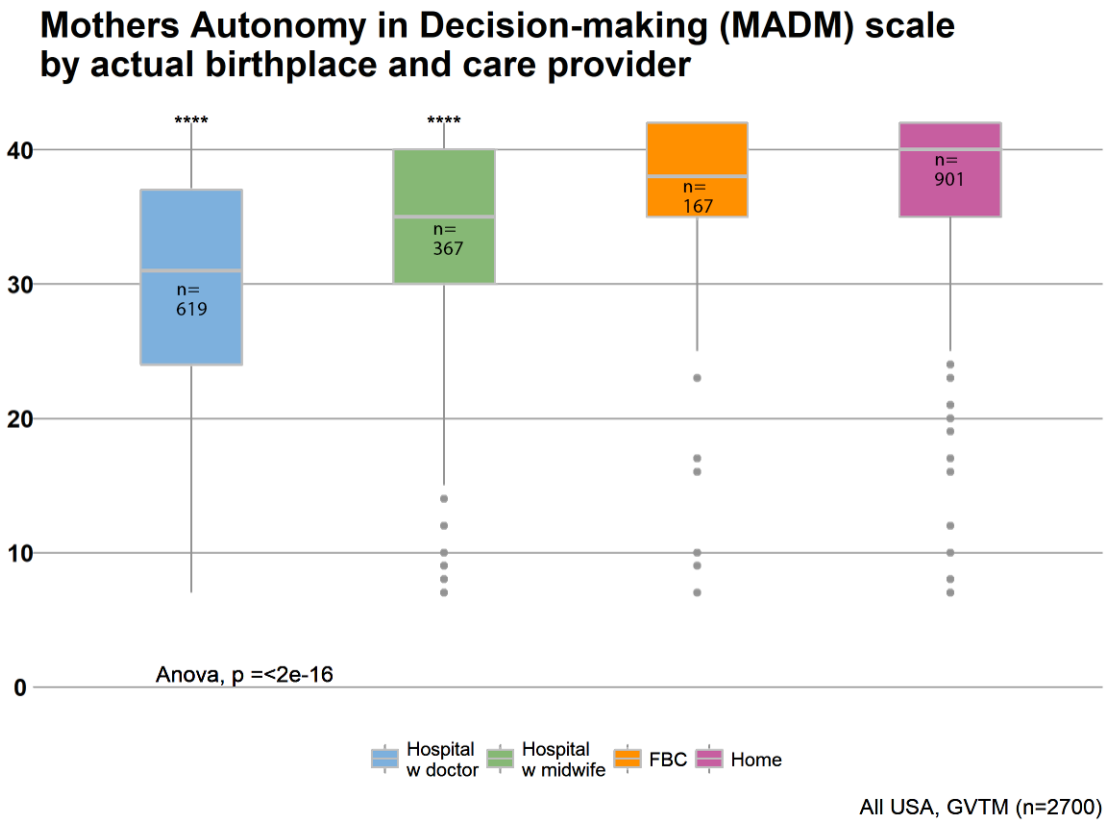
- ☐ Family doctor
- ☐ Obstetrician/OB-GYN doctor
- ☐ Midwife
- ☐ Not applicable, did not have a doctor or midwife

Please describe your experiences with decision making during your pregnancy, labour and/or birth. (select one option for each)

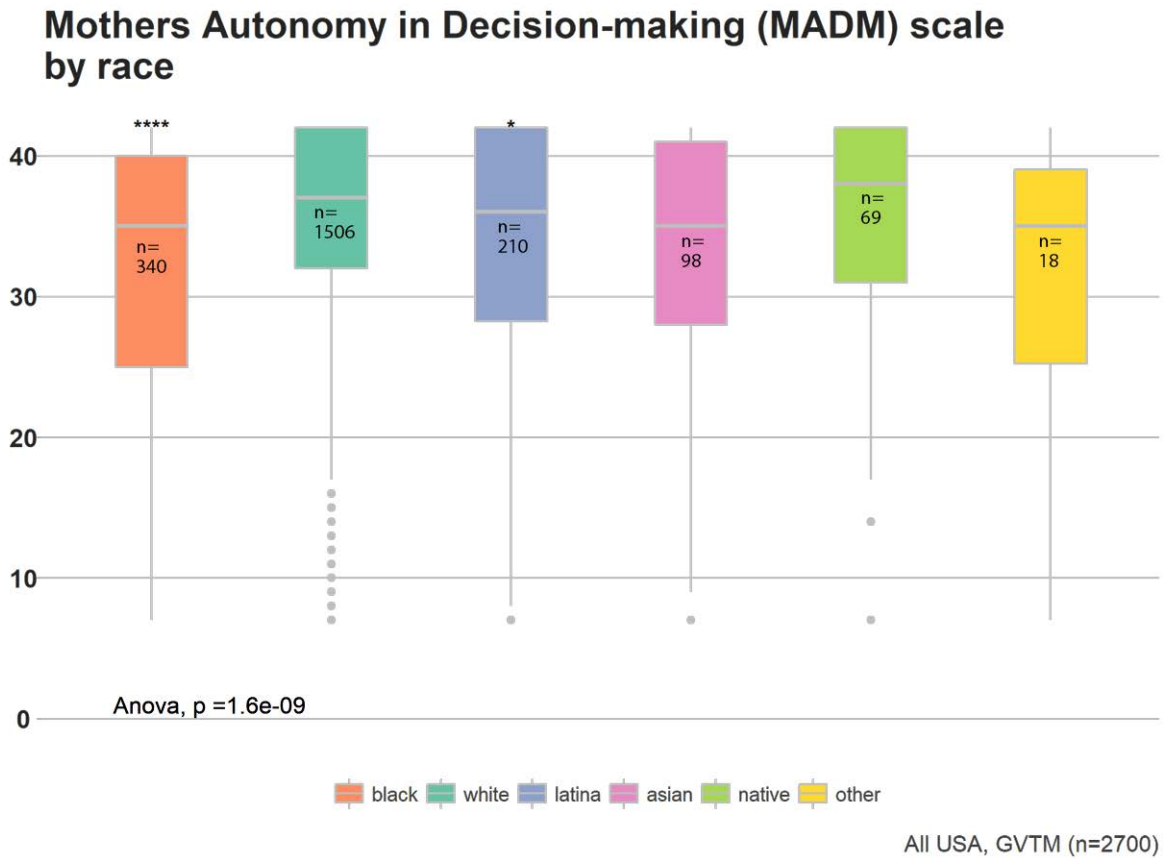
	Completely Disagree	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Completely Agree
My doctor or midwife asked me how involved in decision making I wanted to be.	1	2	3	4	5	6
My doctor or midwife told me that there are different options for my maternity care.	1	2	3	4	5	6
My doctor or midwife explained the advantages/ disadvantages of the maternity care options.	1	2	3	4	5	6
My doctor or midwife helped me understand all the information.	1	2	3	4	5	6
I was given enough time to thoroughly consider the different care options.	1	2	3	4	5	6
I was able to choose what I considered to be the best care options.	1	2	3	4	5	6
My doctor or midwife respected my choices.	1	2	3	4	5	6
	SUM OF ALL CIRCLED ITEMS = TOTAL SCORE:					

Autonomy (MADM) scores, by provider type

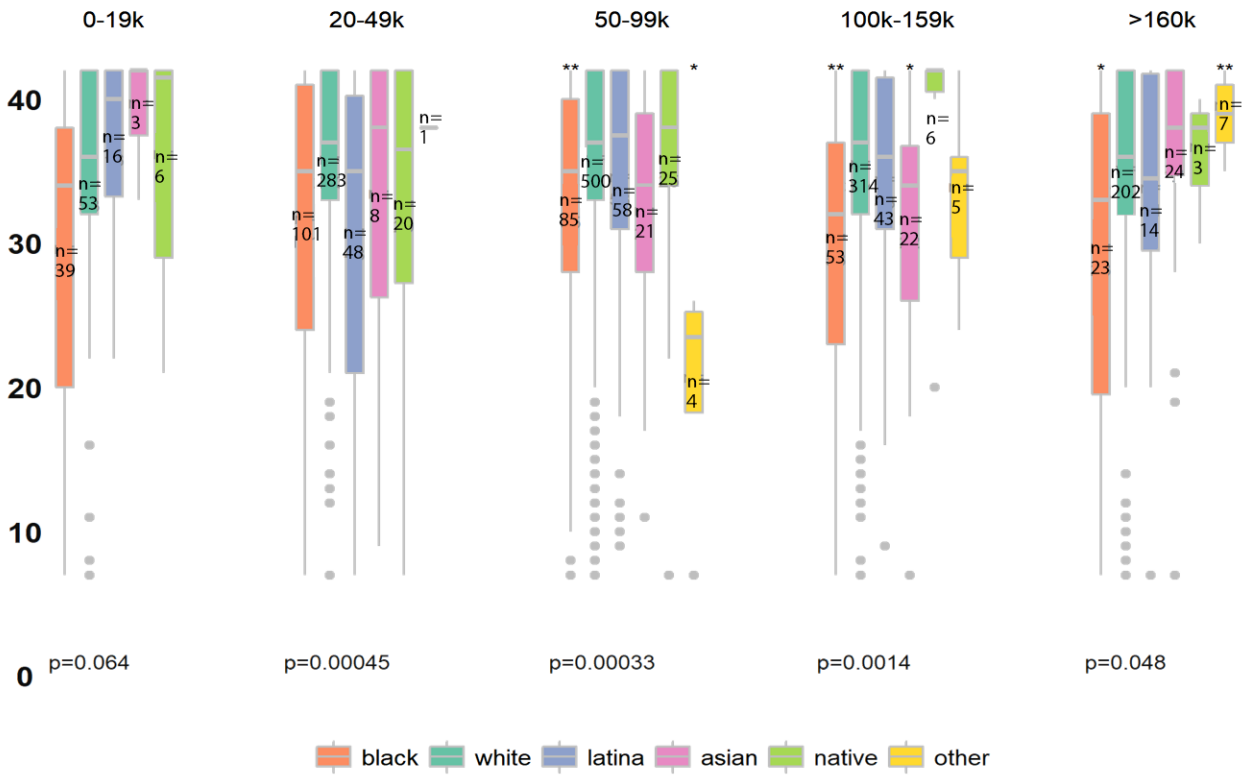




- ns: p > 0.05
- *: p <= 0.05
- **: p <= 0.01
- ***: p <= 0.001
- ****: p <= 0.0001

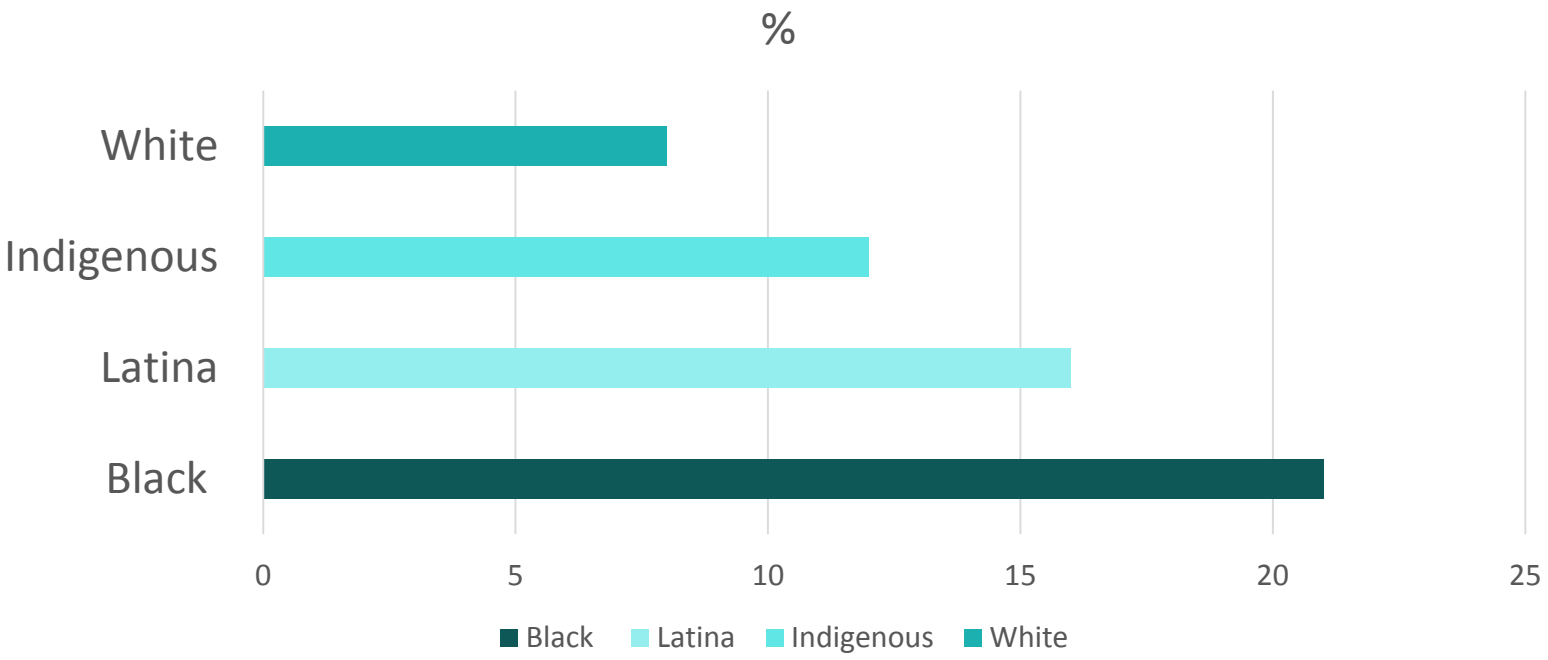

Mothers Autonomy in Decision-making (MADM) scale by race
****
*
40
30
20
10
0
n= 340
n= 1506
n= 210
n= 98
n= 69
n= 18
Anova, p =1.6e-09
black
white
latina
asian
native
other
All USA, GVTM (n=2700)

Mothers Autonomy in Decision-making (MADM) scale by income and race



All USA, GVTM (n=2700)

Lowest MADM Scores (1-10th percentile)



The Mothers On Respect (MOR) index

Vedam et al., SSM Population Health 2017

A: Overall while making decisions about my pregnancy or birth care: (select or circle one answer for each statement)

	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
I felt comfortable asking questions	1	2	3	4	5	6
I felt comfortable declining care that was offered	1	2	3	4	5	6
I felt comfortable accepting the options for care that my doctor or midwife recommended	1	2	3	4	5	6
I felt pushed into accepting the options my doctor or midwife suggested	6	5	4	3	2	1
I chose the care options that I received	1	2	3	4	5	6
My personal preferences were respected	1	2	3	4	5	6
My cultural preferences were respected	1	2	3	4	5	6
	SECTION A TOTAL SCORE:					

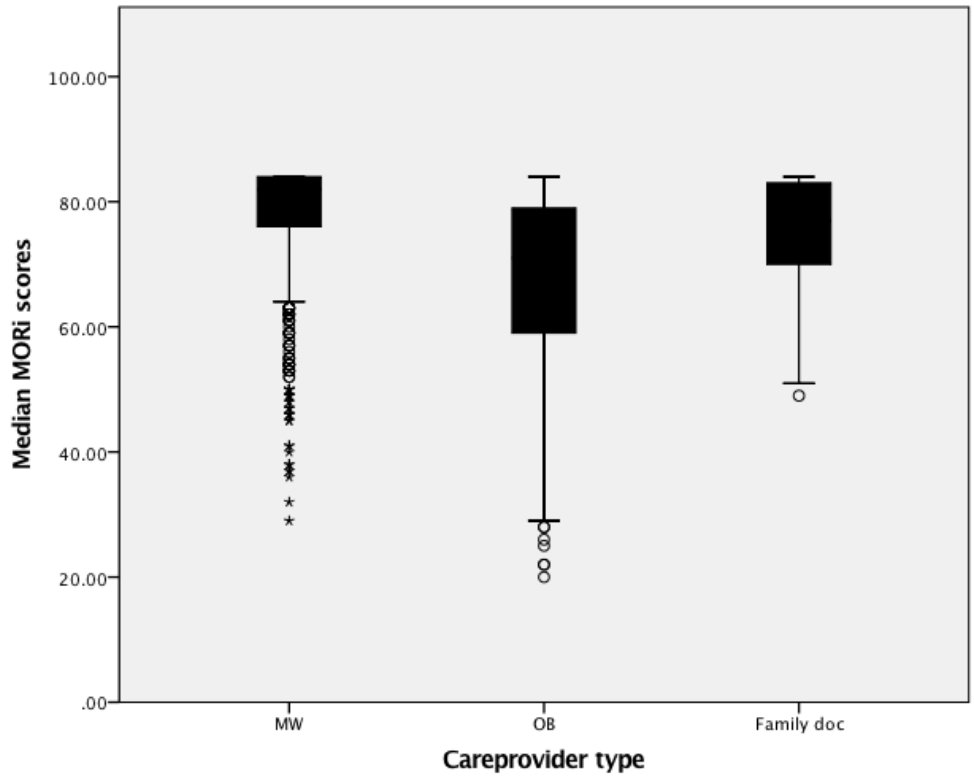
B: During my pregnancy I felt that I was treated poorly by my doctor or midwife because of: (select or circle one answer for each statement)

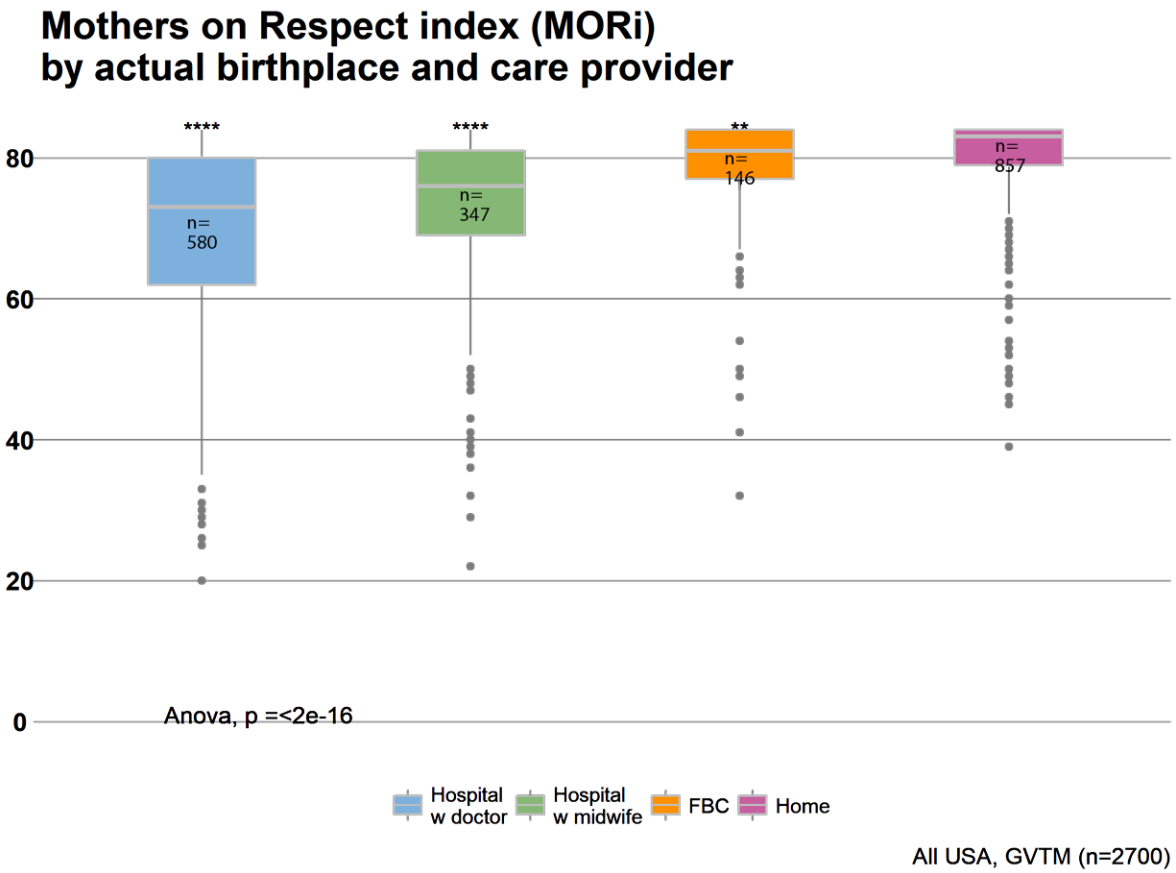
	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
My race, ethnicity, cultural background or language*	6	5	4	3	2	1
My sexual orientation and / or gender identity*	6	5	4	3	2	1
My type of health insurance or lack of insurance*	6	5	4	3	2	1
A difference of opinion with my caregivers about the right care for myself or my baby*	6	5	4	3	2	1
ADD ALL SCORES IN SECTION B:	SECTION B TOTAL SCORE:					

C: During my pregnancy I held back from asking questions or discussing my concerns because: (select or circle one answer for each statement)

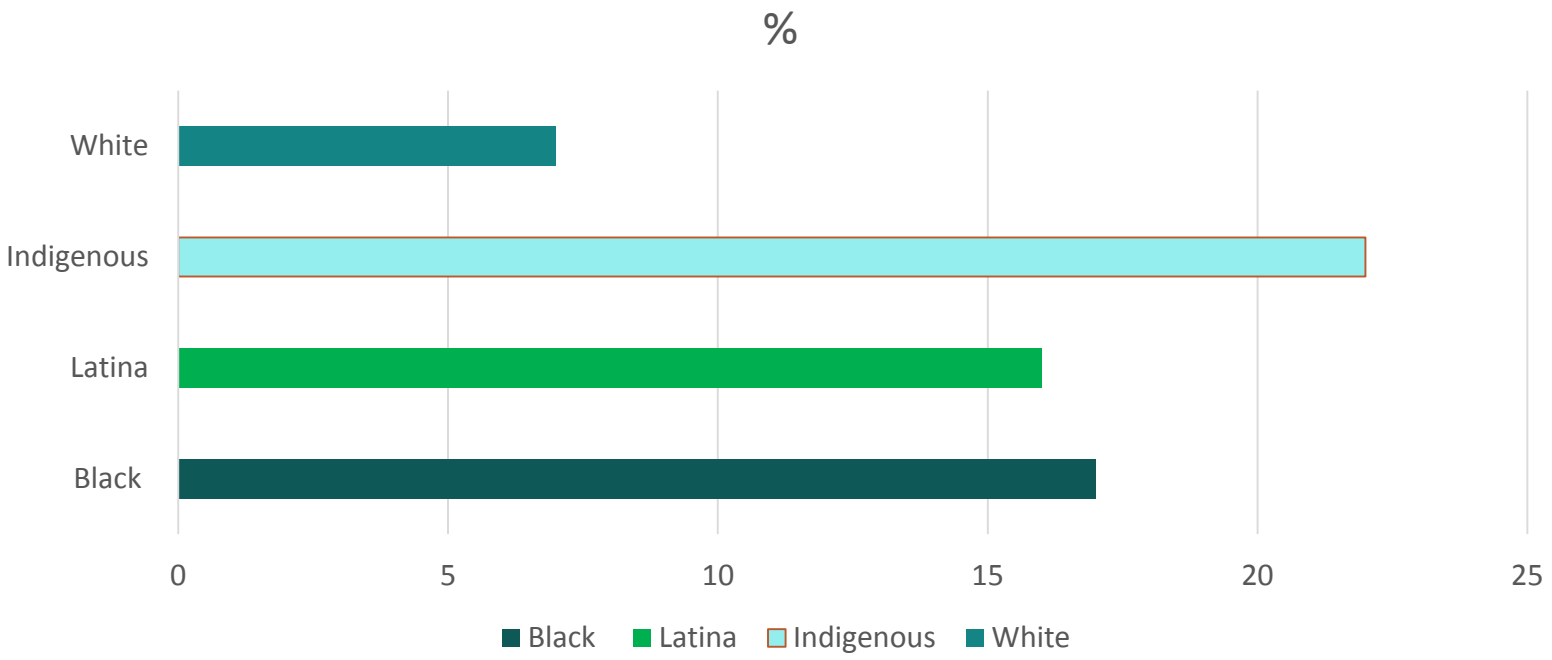
	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
My doctor or midwife seemed rushed*	6	5	4	3	2	1
I wanted maternity care that differed from what my doctor or midwife recommended*	6	5	4	3	2	1
I thought my doctor or midwife might think I was being difficult*	6	5	4	3	2	1
ADD ALL SCORES IN SECTION C:	SECTION C TOTAL SCORE:					

Respect (MORi) scores, by provider type




Mothers on Respect index (MORi)
by actual birthplace and care provider
****
****
**
n=
580
n=
347
n=
146
n=
857
80
60
40
20
0
Anova, p =<2e-16
Hospital
w doctor
Hospital
w midwife
FBC
Home
All USA, GVTM (n=2700)

Lowest Respect (MORi) Scores (1-10th percentile)



Measuring Mistreatment by Providers

Your private or personal information was shared without your consent
Your physical privacy was violated, for example being uncovered or having people in the delivery room without your consent
A healthcare provider shouted at or scolded you
Healthcare providers withheld treatment or forced you to accept treatment that you did not want
Healthcare providers threatened you in any other way
Healthcare providers ignored you, refused your request for help or failed to respond to requests for help in a reasonable amount of time.
You experienced physical abuse, such as aggressive physical contact, inappropriate sexual conduct a refusal to provide anesthesia for an episiotomy etc.
None of the above

Innovative, patient-centered items to capture social determinants of health

1.Composite index of low SES:

- family income **below federal poverty** threshold (based on before tax family income and household size),
- heat **or electricity was turned off** (during her pregnancy or the year preceding it),
- received **a housing subsidy**,
- received **assistanc**e from Indian Health Services, or a state health plan,
- received Temporary Assistance for Needy Families (TANF), **food stamps, WIC food vouchers**, etc
- **inability to buy enough food** or inability to pay monthly bills .

2. Elevated pregnancy risk status:

- a pre-pregnancy BMI of 40 or higher, carrying multiples, HTN, GDM, breech, problems with baby's growth/health, preterm labour, but not preterm birth

3. History of social risks:

- reported substance use, hx of incarceration (herself or partner), homeless, Child & Family Services and/or IPV.

Mistreatment by Sociodemographics

	Full sample (n=2138)	Low SES (n=735)[1]	Elevated pregnancy risks (n=440)[2]	Elevated social risks (n=176)[3]	Newborn health problems (n=149)[4]
Any mistreatment	**17%**	**22%**	**28%**	**30%**	**27%**
Private/personal information shared without consent	1%	2%	2%	3%	4%
Privacy was violated	6%	6%	8%	**13%**	9%
Health care providers shouted or scolded	**9%**	**12%**	**26%**	**15%**	**13%**
Health care providers threatened to withhold treatment or forced unwanted treatment	5%	7%	8%	**10%**	6%
Threatened by health care providers in any other way	2%	3%	3%	3%	1%
Health care providers ignored, refused request for help, or failed to respond to requests for help in a reasonable amount of time	8%	**11%**	**12%**	**13%**	**15%**
Physical abuse	1%	3%	2%	3%	2%

Mistreatment indicators, stratified by mode of birth

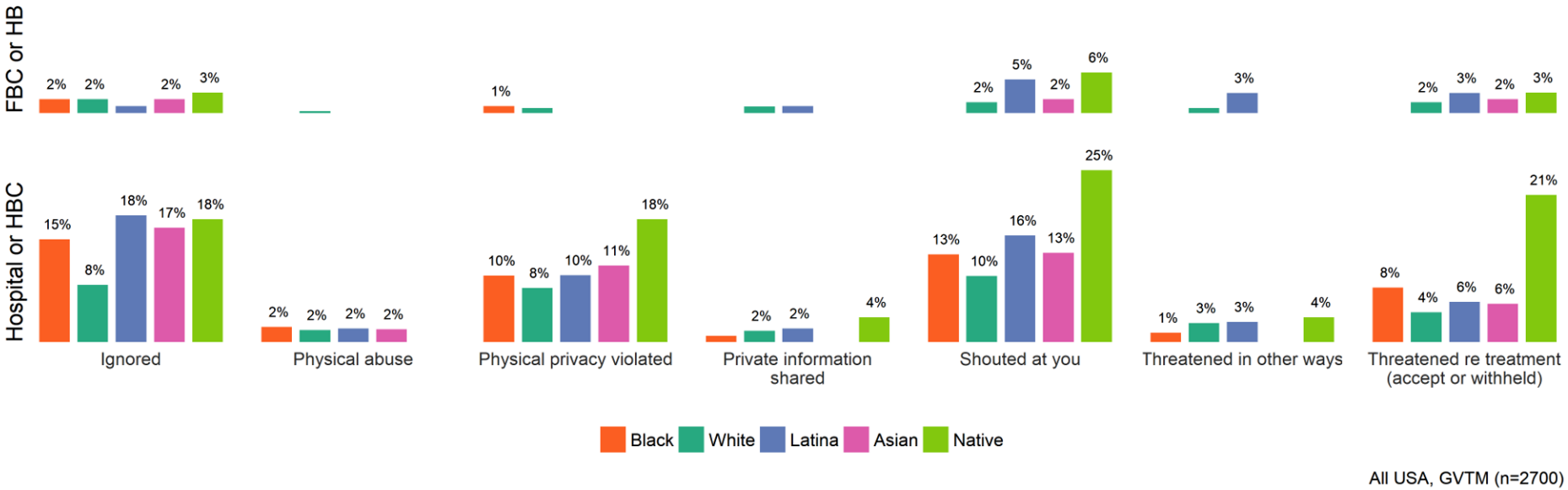
	Planned CS n=85	Unplanned CS n=209	Vaginal birth n=1802	Instrumental birth n=33	VBAC n=152
Your private or personal information was shared without your consent	0 (0)	3 (1.4)	22 (1.2)	1 (3.0)	0 (0)
Your physical privacy was violated	4 (4.7)	22 **(10.5)**	86 (4.8)	**5 (15.2)**	9 (5.9)
Health care providers shouted at or scolded you	8 (9.4)	44 **(21.1)**	121 (6.7)	9 **(27.3)**	14 (9.2)
Health care providers threatened to withhold treatment or to force you to accept treatment you did not want	1 (1.2)	23 (**11.0**)	71 (3.9)	2 (6.1)	10 (6.6)
Health care providers threatened you in any other way	0 (0)	12 (5.7)	31 (1.7)	1 (3.0)	2 (1.3)
Health care providers ignored you, refused your request for help, or failed to respond to requests for help	9 (10.6)	39 **(18.7)**	112 (6.2)	6 (**18.2**)	9 (5.9)
You experienced physical abuse (aggressive physical contact, inappropriate sexual conduct, refusal to provide anesthesia for an episiotomy, etc.)	0 (0)	7 (3.3)	19 (1.1)	1 (3.0)	1 (0.7)
None of the above	68 (80.0)	121 (57.9)	1433 (79.5)	20 (60.6)	116 (76.3)

Mistreatment Indicators Stratified by disagreement between Woman and Care Provider

	Declined care n =1063	Pressured into interventions n= 689	Difference in opinion n =104
Any mistreatment	**19%**	**38%**	**79%**
Private/personal information shared without consent	2%	2%	7%
Privacy was violated	7%	14%	**27%**
Health care providers shouted or scolded	10%	**20%**	**45%**
Health care providers threatened to withhold treatment or forced unwanted treatment	**7%**	**11%**	**39%**
Threatened by health care providers in any other way	3%	5%	21%
Health care providers ignored, refused request for help, or failed to respond to requests for help in a reasonable amount of time	**8%**	**17%**	**42%**
Physical abuse	1%	4%	8%

Mistreatment by race and actual place of birth

Did you experience, during pregnancy or birth? (proportion of women in group who reported)
Completed, planned Hospital or Hospital Birth Center v. Freestanding birth center or Home birth



All USA, GVTM (n=2700)

PLOS | MEDICINE

RESEARCH ARTICLE

The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review

Meghan A. Bohren[1,2]*, Joshua P. Vogel[2], Erin C. Hunter[3], Olha Lutsiv[4], Suprita K. Makh[5], João Paulo Souza[6], Carolina Aguiar[1], Fernando Saraiva Coneglian[6], Alex Luíz Araújo Diniz[6], Özge Tunçalp[2], Dena Javadi[3], Olufemi T. Oladapo[2], Rajat Khosla[2], Michelle J. Hindin[1,2], A. Metin Gülmezoglu[2]

Table 1. Typology of the mistreatment of women during childbirth.

Third-Order Themes	Second-Order Themes	First-Order Themes
Physical abuse	Use of force	Women beaten, slapped, kicked, or pinched during delivery
	Physical restraint	Women physically restrained to the bed or gagged during delivery
Sexual abuse	Sexual abuse	Sexual abuse or rape
Verbal abuse	Harsh language	Harsh or rude language
		Judgmental or accusatory comments
	Threats and blaming	Threats of withholding treatment or poor outcomes
		Blaming for poor outcomes
Stigma and discrimination	Discrimination based on sociodemographic characteristics	Discrimination based on ethnicity/race/religion
		Discrimination based on age
		Discrimination based on socioeconomic status
	Discrimination based on medical conditions	Discrimination based on HIV status
Failure to meet professional standards of care	Lack of informed consent and confidentiality	Lack of informed consent process
		Breaches of confidentiality
	Physical examinations and procedures	Painful vaginal exams
		Refusal to provide pain relief
		Performance of unconsented surgical operations
	Neglect and abandonment	Neglect, abandonment, or long delays
		Skilled attendant absent at time of delivery
Poor rapport between women and providers	Ineffective communication	Poor communication
		Dismissal of women's concerns
		Language and interpretation issues
		Poor staff attitudes
	Lack of supportive care	Lack of supportive care from health workers
		Denial or lack of birth companions
	Loss of autonomy	Women treated as passive participants during childbirth
		Denial of food, fluids, or mobility
		Lack of respect for women's preferred birth positions
		Denial of safe traditional practices
		Objectification of women
		Detainment in facilities
Health system conditions and constraints	Lack of resources	Physical condition of facilities
		Staffing constraints
		Staffing shortages
		Supply constraints
		Lack of privacy
	Lack of policies	Lack of redress
	Facility culture	Bribery and extortion
		Unclear fee structures
		Unreasonable requests of women by health workers

Mistreatment and risk of mortality

- The significant number of respondents that reported "being ignored" or that "providers failed to respond to their requests for help" is a disturbing finding in a high resource setting.
- The California Pregnancy-Associated Mortality Review (CA-PAMR):
  - **Healthcare provider factors** - most common contributor to maternal deaths,
  - 81% of maternal deaths in that time period.

The most common provider factor was delayed response to clinical warning signs, followed by ineffective care.

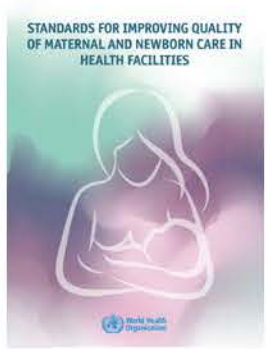
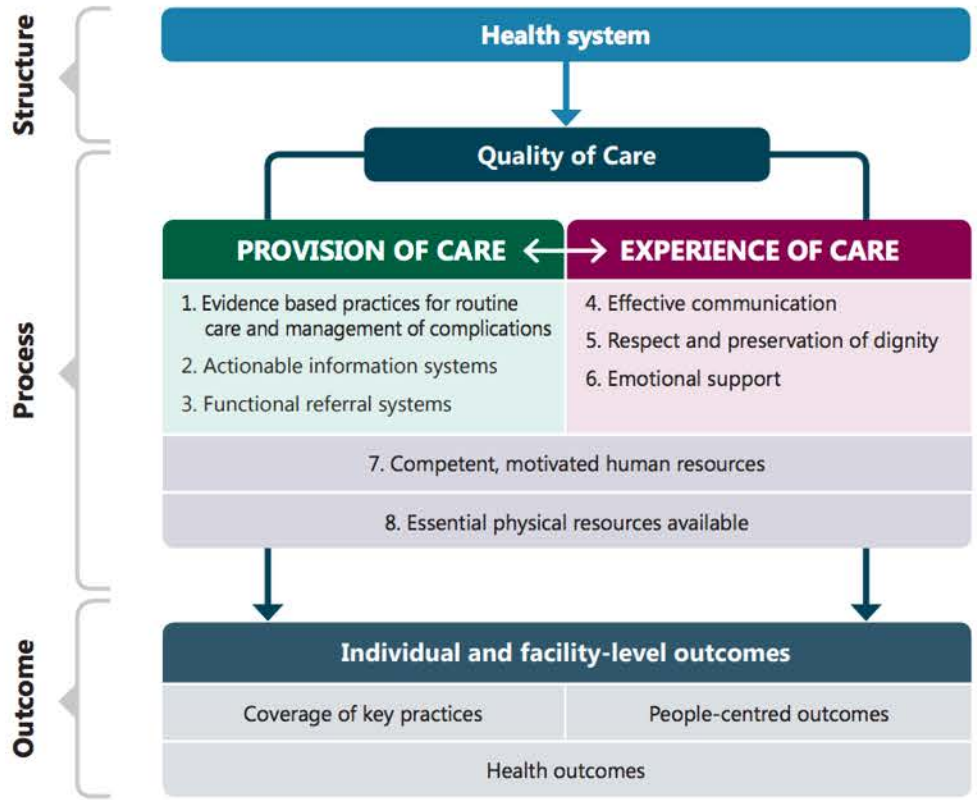


Fig. 1. WHO framework for the quality of maternal and newborn health care



Standards of care and quality statements

Standard 1: Every woman and newborn receives routine, evidence-based care and management of complications during labour, childbirth and the early postnatal period, according to WHO guidelines.

Quality statements

1.1a: Women are assessed routinely on admission and during labour and childbirth and are given timely, appropriate care.

Standard 2: The health information system enables use of data to ensure early, appropriate action to improve the care of every woman and newborn.

Quality statements

2.2: Every health facility has a mechanism for data collection, analysis and feedback as part of its activities for monitoring and improving performance around the time of childbirth.

Standard 3: Every woman and newborn with condition(s) that cannot be dealt with effectively with the available resources is appropriately referred.

Quality statements

3.3: For every woman and newborn referred within or between health facilities, there is appropriate information exchange and feedback to relevant health care staff.

Standard 4: Communication with women and their families is effective and responds to their needs and preferences.

Quality statements

4.1: All women and their families receive information about the care and have effective interactions with staff.

4.2: All women and their families experience coordinated care, with clear, accurate information exchange between relevant health and social care professionals.

Standard 5: Women and newborns receive care with respect and preservation of their dignity.

Quality statements

5.1: All women and newborns have privacy around the time of labour and childbirth, and their confidentiality is respected

5.2: No woman or newborn is subjected to mistreatment, such as physical, sexual or verbal abuse, discrimination, neglect, detainment, extortion or denial of services.

5.3: All women have informed choices in the services they receive, and the reasons for interventions or outcomes are clearly explained.

Standard 6: Every woman and her family are provided with emotional support that is sensitive to their needs and strengthens the woman's capability.

Quality statements

6.1: Every woman is offered the option to experience labour and childbirth with the companion of her choice.

6.2: Every woman receives support to strengthens her capability during childbirth.

Standard 7: For every woman and newborn, competent, motivated staff are consistently available to provide routine care and manage complications.

Quality statements

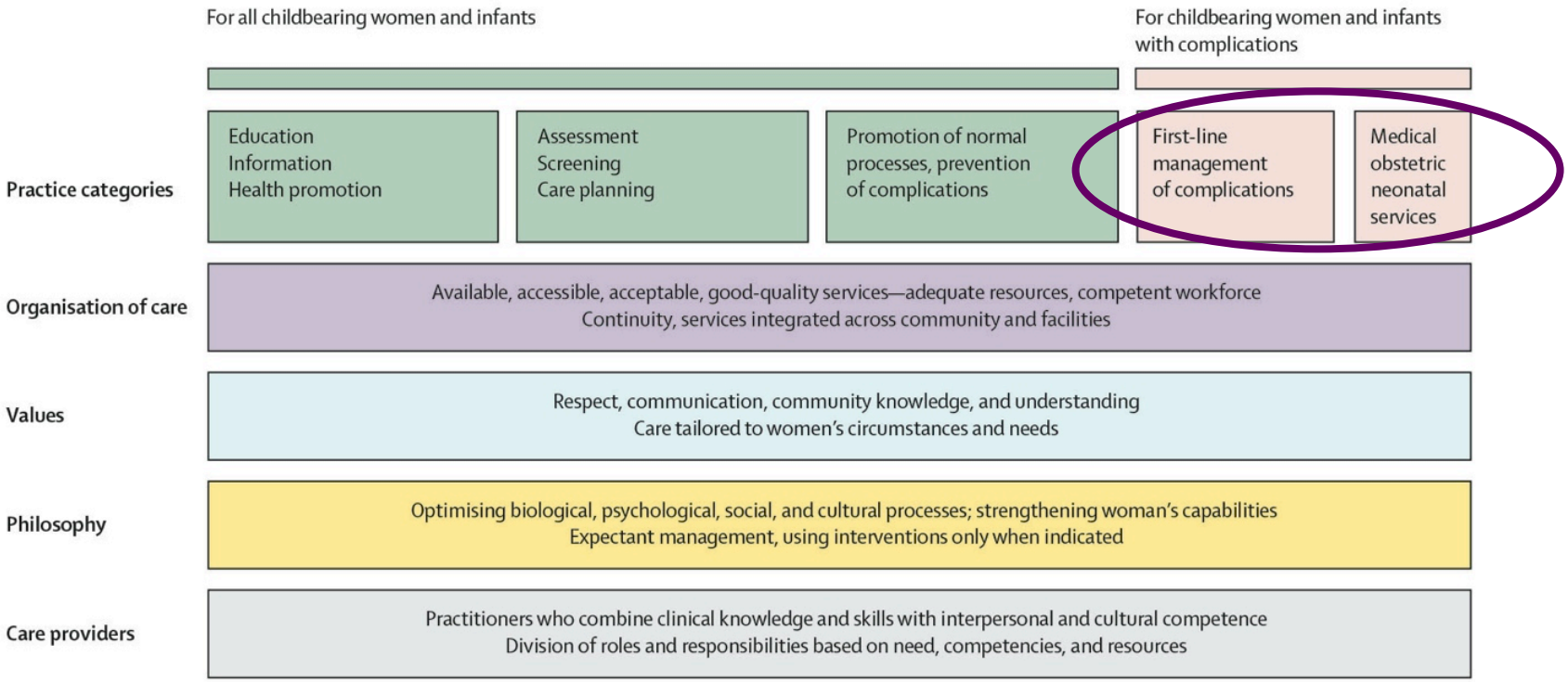
7.3: Every health facility has managerial and clinical leadership that is collectively responsible for developing and implementing appropriate policies and fosters an environment that supports facility staff in continuous quality improvement.

Standard 8: The health facility has an appropriate physical environment, with adequate water, sanitation and energy supplies, medicines, supplies and equipment for routine maternal and newborn care and management of complications.

Quality statements

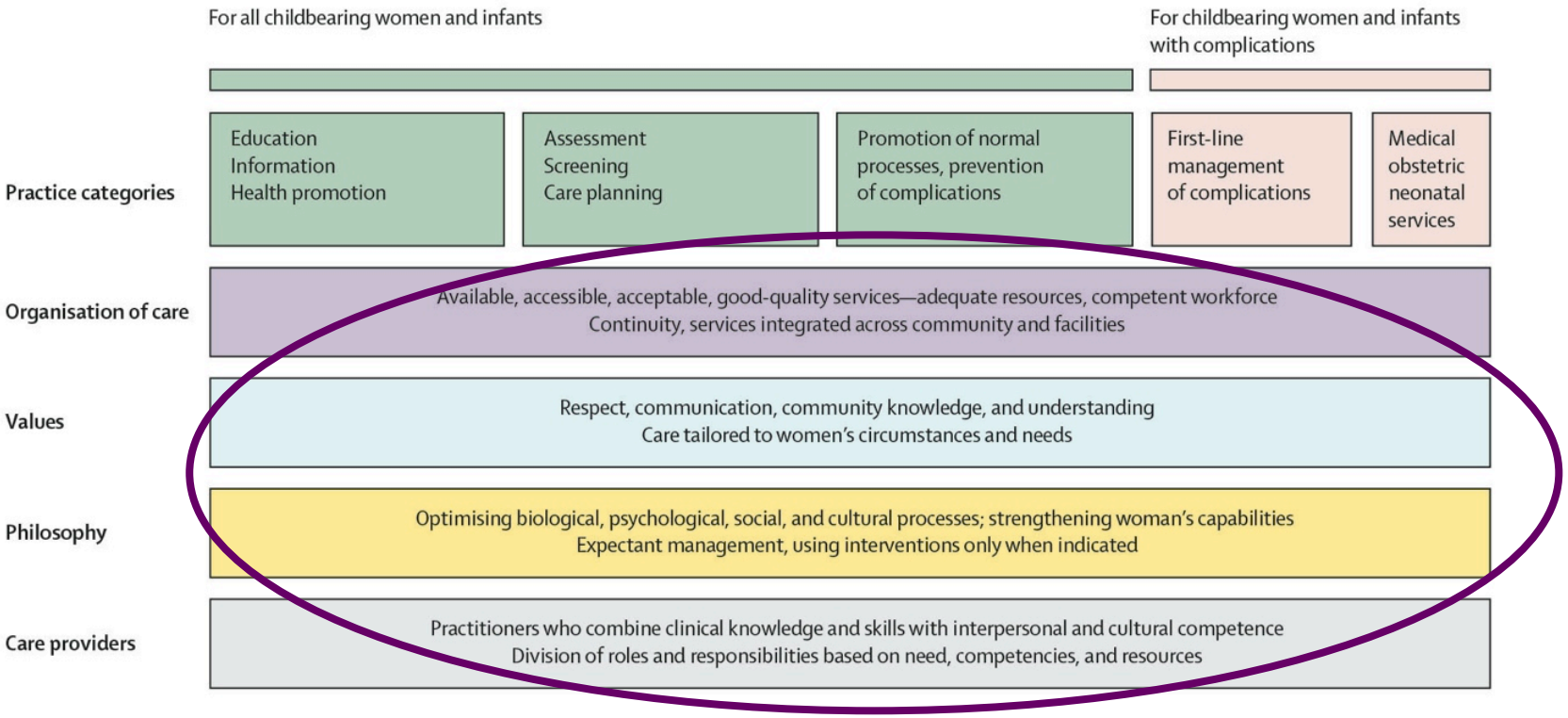
8.2: Areas for labour, childbirth and postnatal care are designed, organized and maintained so that every woman and newborn can be cared for according to their needs in private, to facilitate the continuity of care.

Asking Different Questions:
What is Quality in Maternal & Newborn Care?



Kennedy et al., Birth 2018

Asking Different Questions:
What is Quality in Maternal & Newborn Care?



Kennedy et al., Birth 2018

The Birth Place Lab

www.birthplacelab.org

Multi-disciplinary and community-based participatory research on high quality maternity health care across birth settings.

Respectful Maternity Care

Research and tools designed to help understand how service users experience care.

Birth Place and Provider

Research on the links between provider, place of birth, and health outcomes, and tools to support collaboration.

Person-Centered Decision Making

Online course for health care providers and tools to support dialogue and decisions.

Listening to Mothers – California Survey Results

Carol Sakala, PhD, MSPH

NATIONAL QUALITY FORUM

Listening to Mothers in California and *Blueprint for Advancing High-Value Maternity Care*

Highlights from new National Partnership for Women & Families resources

Carol Sakala, PhD, MSPH

Perinatal and Women's Health Care Standing Committee Off-Cycle Webinar

November 8, 2018

National Partnership for Women & Families

- The National Partnership is a nonprofit, nonpartisan advocacy group dedicated to promoting access to quality health care, reproductive health and rights, fairness in the workplace and policies that help women and men meet the dual demands of work and family.

- More information is available at

  http://www.NationalPartnership.org
  http://www.ChildbirthConnection.org

Goals for Today

- Build awareness of resources from two new National Partnership for Women & Families projects
- Present highlights relevant to woman- and family-centered care and Committee interests
- Encourage members to further explore these resources

1. *Listening to Mothers in California* Survey

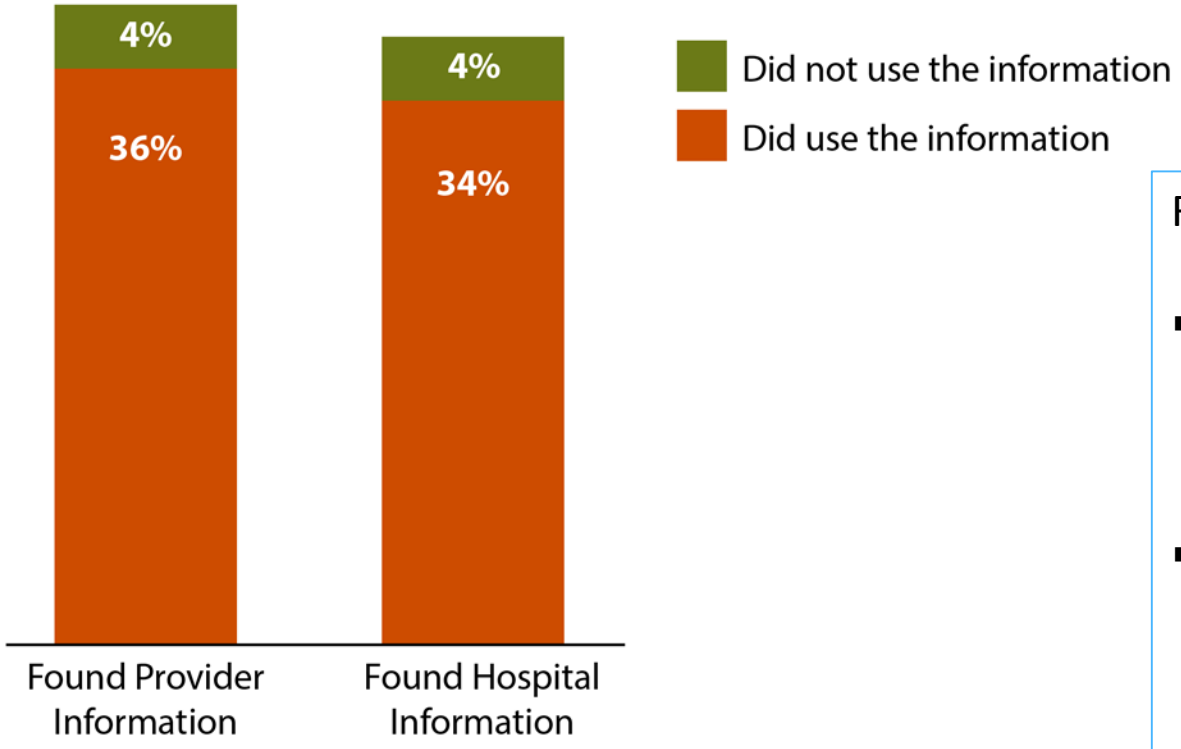
- Built on national *Listening to Mothers* surveys, 2002-
- 2,539 women completed surveys in 2017
  - *Population-based sample drawn from 2016 birth certificate files*
  - *Available in Spanish and English*
  - *Outreach by mail, text, phone and email*
  - *Participate on any device or with trained telephone interviewer*
  - *Medi-Cal data linkage, abstraction; birth certificate file weighting*
- Oversampled Black women, women with midwifery-attended births, women with VBAC
- Project materials available at both
  - *http://www.NationalPartnership.org/LTMCA*
  - *https://www.chcf.org/collection/listening-to-mothers-in-california/*
- Funders: California Health Care Foundation and Yellow Chair Foundation

National Relevance of Survey Results

- Valuable for California stakeholders to have current, population-based results overall and for subgroups with questionnaire adapted for that context
- California's maternal demographics differ in important ways from national profile
- However, results generally very consistent with what we have learned from national *Listening to Mothers* surveys
- California has 12% of nation's births (1 in 8)
- California is a leader in maternity care quality improvement (e.g., reversal of rising maternal mortality)

Many Women Used Quality Information to Choose Provider and Hospital

BASE: WOMEN WHO FOUND COMPARATIVE QUALITY INFORMATION (n = 1,309)



Related results

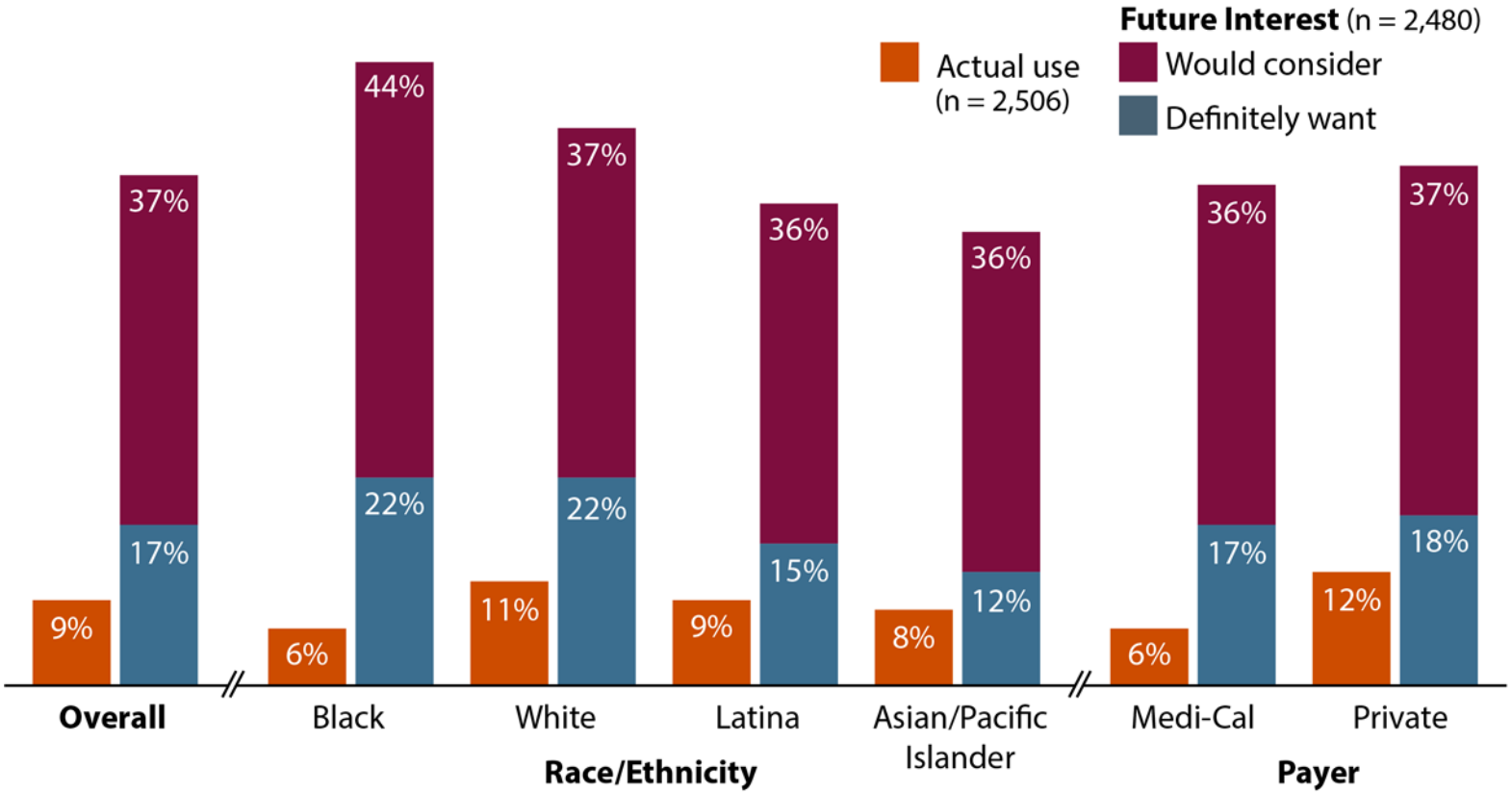
- 32% sought information about hospital cesarean rates
- Just 1 in 3 were aware of variation in quality across obstetricians and across hospital

Notes: “Not sure” and “did not find any information” not shown. Not all eligible respondents answered each item.
Source: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018, http://www.chcf.org (PDF).

Most Women Interested in Using Midwife for a Future Birth

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION

If you have a future pregnancy, how open would you be to having a midwife as your maternity care provider (with doctor care, if needed)?



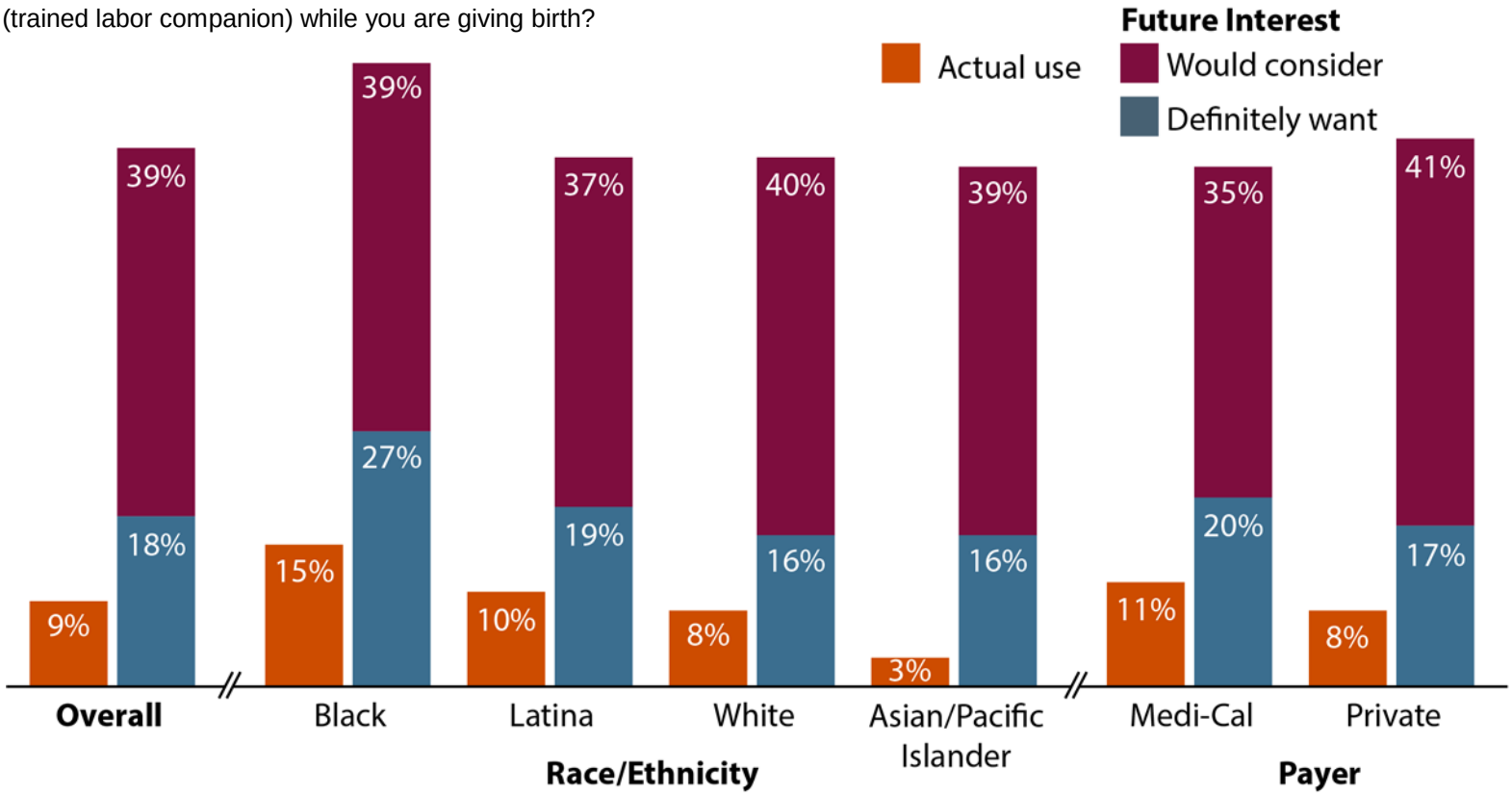
Notes: Data shown for use of midwife as birth provider. Midwives were the main prenatal care providers for 7% of survey participants (not shown). Not shown: "Would definitely not want this" and "not sure." Not all eligible respondents answered each item. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Differences within groups were not significant.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse.

Most Women Interested in Using Doula for a Future Birth

BASE: WOMEN WHO SPEAK PRIMARILY ENGLISH AT HOME (N = 1,433)

If you have a future pregnancy, how open would you be to having the support of a doula (trained labor companion) while you are giving birth?



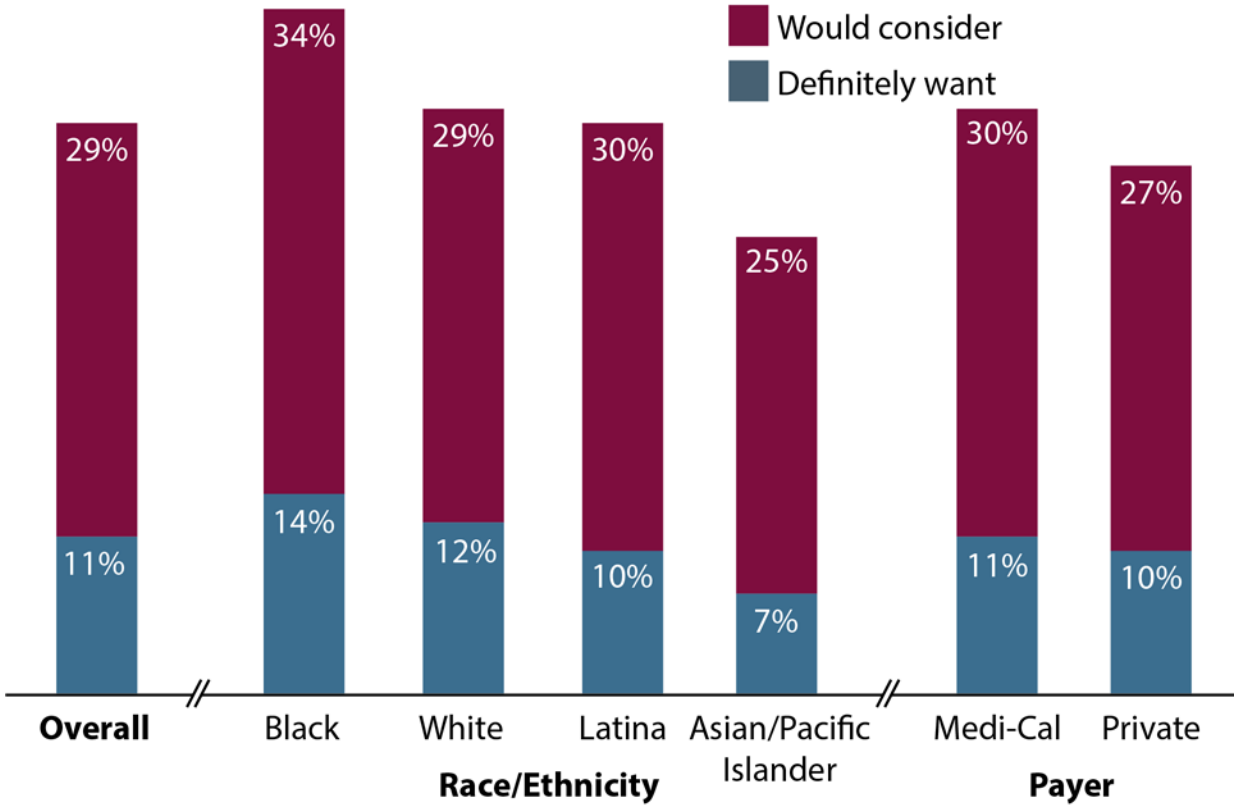
Notes: A labor doula is a nonclinician health worker who offer continuous physical, emotional, and informational support to women around the time of birth. Due to evidence of overcounting the doula role among some non-English speakers, we limited our analyses of doula support to women who primarily speak English at home. "Would definitely not want this" and "not sure" not shown. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item. $p < .01$ for differences by race/ethnicity and by payer.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018;California Department of Health Care Services MIS/DSS Data Warehouse

Many Women Would Want or Consider Birth Center for a Future Birth

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (N = 2,482)

If you have a future pregnancy, how open would you be to giving birth in a birth center that is separate from a hospital (with hospital care, if needed)?



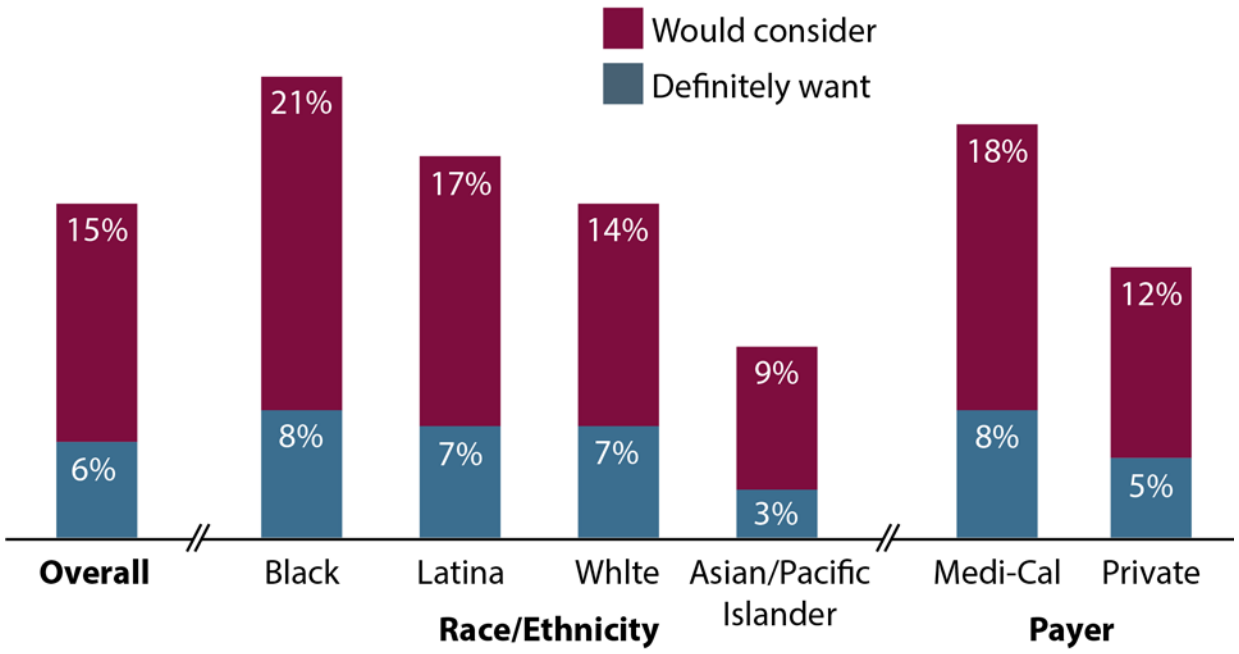
Final CA 2016 birth certificate file:

- 0.3% of births in birth center

Notes: "Would definitely not want this" and "not sure" not shown. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim. Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item. $p < .01$ for differences by race/ethnicity and by payer.
Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse; Natality public-use data 2007–16 in CDC WONDER database, Centers for Disease Control and Prevention, February 2018, accessed March 6, 2018, http://wonder.cdc.gov.

Fewer Women Would Want or Consider Home Birth for a Future Birth

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (N = 2,482)
If you have a future pregnancy, how open would you be to giving birth at home (with hospital care, if needed)?



Final CA 2016 birth certificate file:

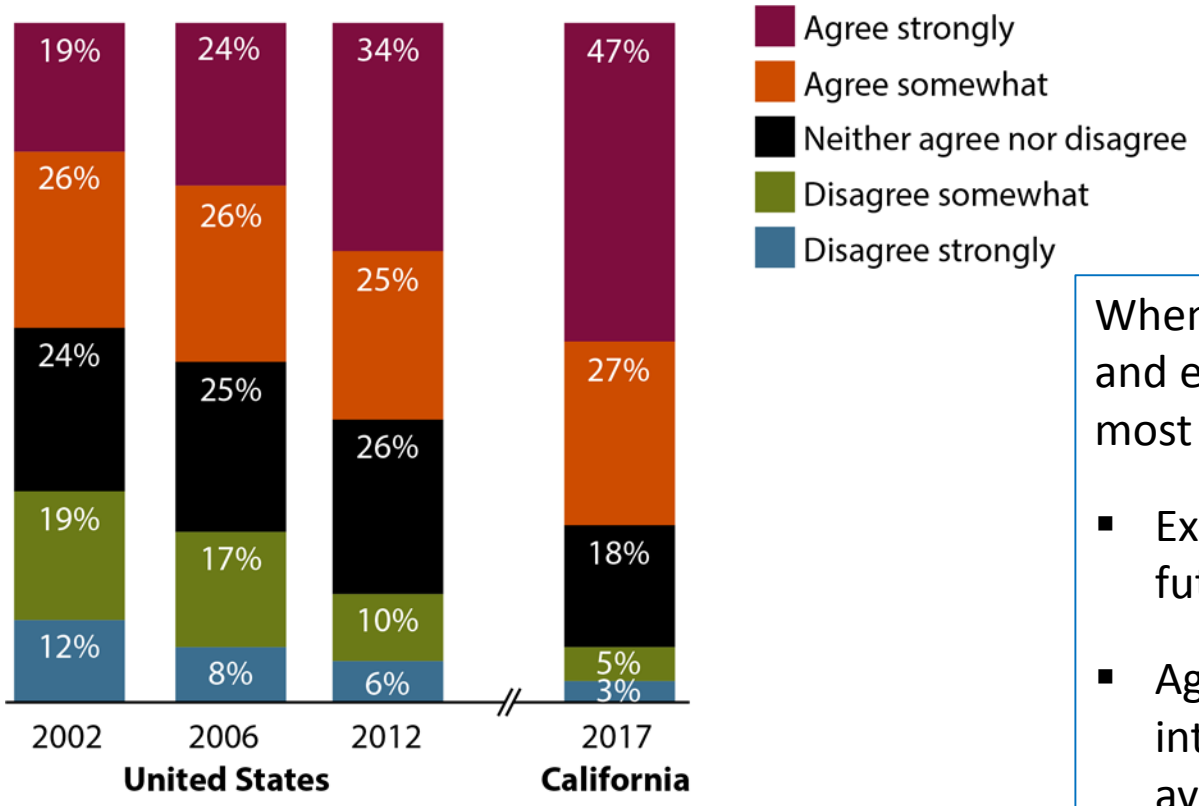
- 0.7% of births at home

Notes: "Would definitely not want this" and "not sure" not shown. Medi-Cal respondents were identified based upon a Medi-Cal record of a paid 2016 childbirth claim.
Privately insured respondents self-identified in the survey. Not all eligible respondents answered each item. $p < .01$ for differences by race/ethnicity and by payer.
Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; California Department of Health Care Services MIS/DSS Data Warehouse; Natality public-use data 2007–16 in CDC WONDER database, Centers for Disease Control and Prevention, February 2018, accessed March 6, 2018, http://wonder.cdc.gov.

Women Do Not Want Unnecessary Interference with Childbirth

BASE: ALL WOMEN WHO ANSWERED THIS QUESTION (n = 2,451)

Childbirth is a process that should not be interfered with unless medically necessary.



When broken down by race and ethnicity, Black women most frequently

- Expressed interest in all 4 future forms of care
- Agreed that childbirth interference should be avoided when possible

Notes: Not all eligible respondents answered each item. Segments may not add to 100% due to rounding.

Sources: Listening to Mothers in California (statewide survey of 2,539 women who gave birth in California hospitals in 2016), National Partnership for Women & Families, 2018; Listening to Mothers III: Pregnancy and Birth, June 2013; Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences, October 2006; Listening to Mothers: Report of the First National U.S. Survey of Women's Childbearing Experiences, Maternity Center Association, October 2002, http://www.nationalpartnership.org.

Women Experienced High Rates of Intervention

- 40% experienced attempted labor induction
  - *Conservatively, 37% of those lacked an evidence-based indication*
- 3% had intermittent auscultation and no EFM
- 75% experienced epidural analgesia
- 46% experienced synthetic oxytocin to induce and/or speed up labor
- 31% had a cesarean birth
- 85% with a past cesarean had a repeat cesarean
- 5% met the ACOG reVITALize definition of “physiologic childbirth”

Most Women Reported Respectful Care, But Thinking of the Hospital Stay ….

- 11% of Black women (versus 1% of white women) reported being treated unfairly due to their race or ethnicity
- 13% who primarily spoke an Asian language at home and 10% who spoke Spanish (versus 2% who spoke English) reported being treated unfairly due to their language
- 9% of women with Medi-Cal coverage (versus 1% with private insurance) reported being treated unfairly due to their insurance

Experienced pressure from a health professional to have
- Induced labor: 14%
- Epidural: 12% who labored
- Cesarean: 11% overall (24% with previous cesarean)

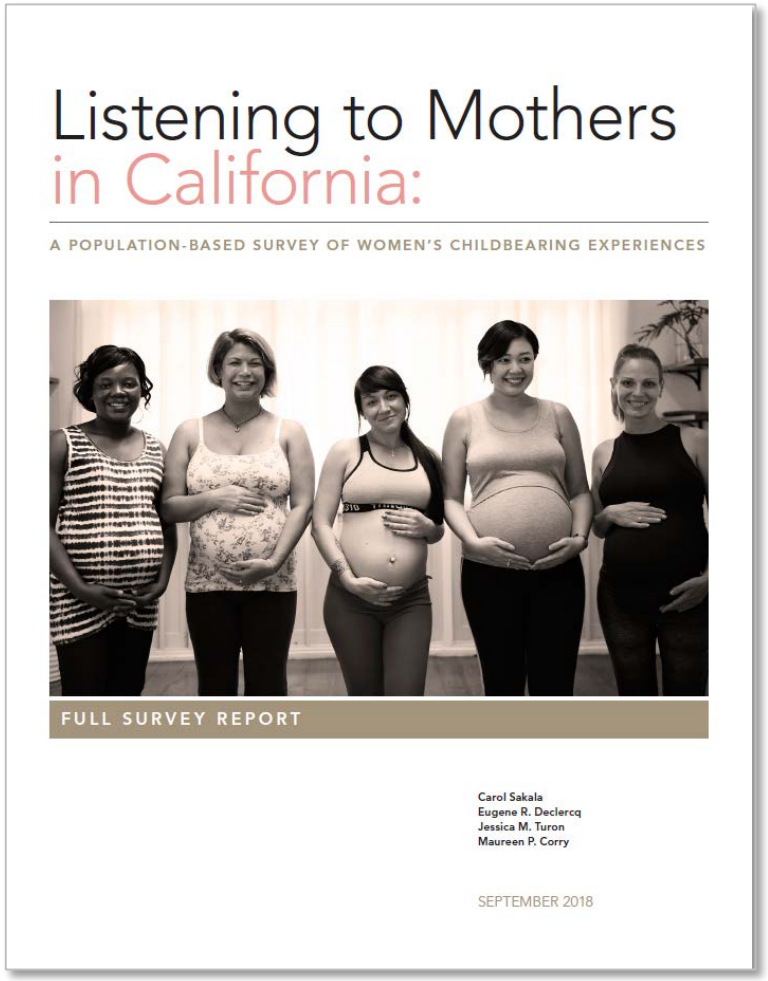
Selected Postpartum Results

- 9% had no postpartum visit
- 17%-18% of Medi-Cal beneficiaries reported never having sources of practical and emotional support since giving birth
- 48% working at a paid job had stayed home with their baby as long as they liked
- 42% who breastfed at 1 week and were not breastfeeding at the time of the survey had fed breast milk as long as they liked
- 28% participating 6 or more months after birth met the consensus recommendation for exclusive breast milk feeding to six months

Selected Maternal Mental Health Results Using PHQ-4 (PHQ-2 and GAD-2)

- Prenatal psychological distress with PHQ-4: 28% mild, 10% moderate, 4% severe
- Postpartum psychological distress with PHQ-4: 19% mild, 5% moderate, 2% severe
- Positive screens were more frequent for anxiety than for depression, both during pregnancy and after birth
- Just 1 in 5 who screened positive for these conditions in pregnancy and 1 in 3 who screened positive after birth received mental health counseling or treatment

Extensive *Listening to Mothers in California* Resources at http://www.NationalPartnership.org/LTMCA



In addition to full survey report:

- Data snapshot: curated highlights
- 3 issue briefs
- 3 fact sheets
- 4 brief videos
- Infographic
- Methodology overview
- Questionnaire
- About the survey fact sheet
- Digital version of full report
- Launch webinar recording

2. *Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing*

- Consensus document from 17 national clinical leaders; QI, payment reform and performance measurement experts; consumer advocates; clinical and policy researchers
- Balance focus on high-risk and complications with limiting over- and underuse and providing access to benefits of healthy perinatal physiologic processes
- Beneficiaries include those who will
  - *Reduce need for rescue through upstream prevention*
  - *Reduce disparities through attentive, respectful, preventive care*
  - *Remain healthy by avoiding unneeded interventions and complications*
  - *Benefit from healthy perinatal physiologic processes when possible when receiving higher acuity care care*

Six Established Strategies for Improvement

22 high-level recommendations with action steps and extensive documentation, arrayed across 6 strategies:

- Innovative care delivery and payment systems , with QI
- Performance measurement
- Consumer engagement
- Interprofessional education and team-based care
- Optimal workforce composition and distribution
- Priority research

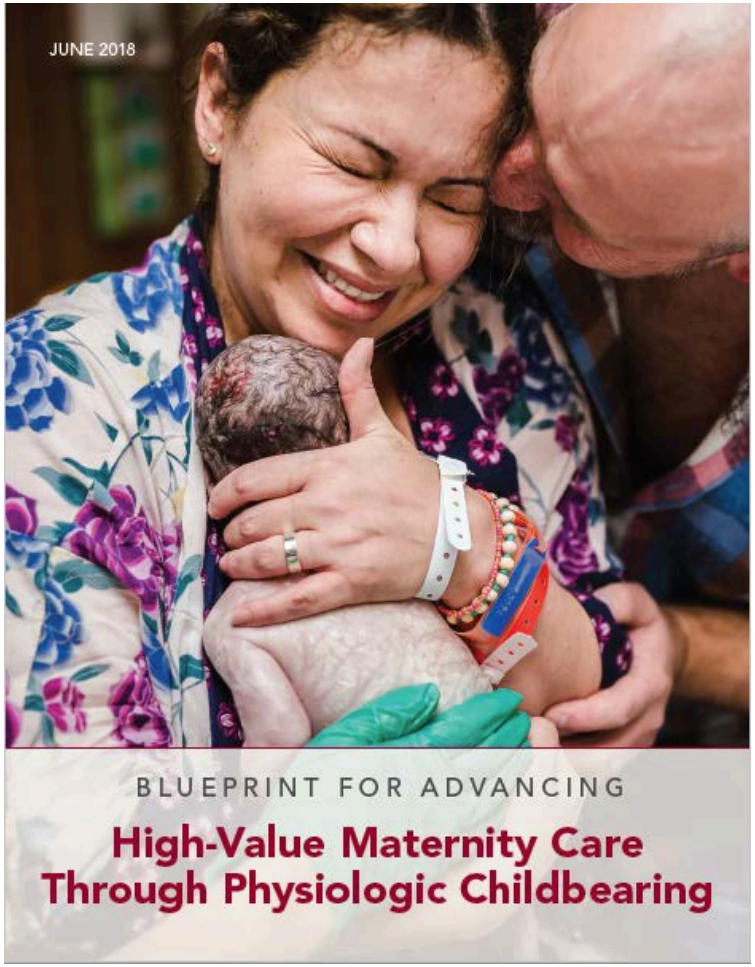
Elements Especially Relevant to Committee

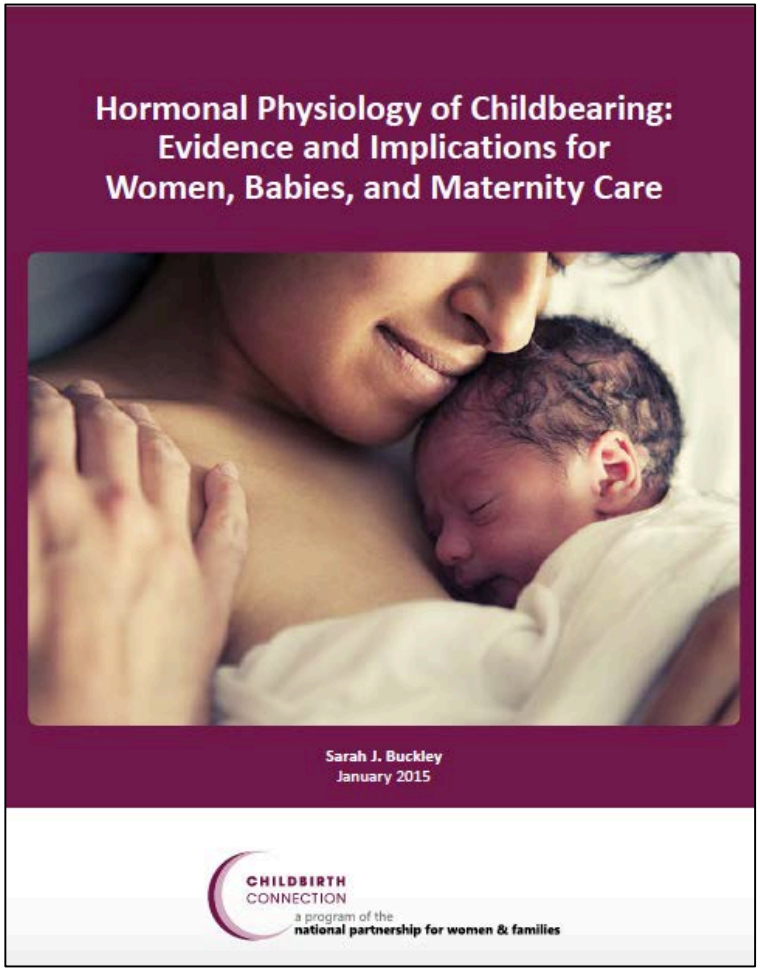
- Fill measure gaps relevant to
  - *overuse, underuse, including physiologic childbirth, VBAC*
  - *woman-reported experience and outcomes of care*
  - *clinician and health plan levels to align with facility measures*
- Implement episode payment programs and maternity care homes
  - *select more impactful game-changing measures, as available*
- Build out QI resources and initiatives to enable success with greater accountability

Elements Especially Relevant to Committee

- Publicly report performance on meaningful measures through user-friendly, evidence-based portals
- Make care navigators available to help women identify and interpret relevant performance results
- Through patient portals and other distribution channels, collect woman-reported experience and outcomes of care measures
  - *feed back to service providers*
  - *publicly report to enable informed choice of care*

Find Blueprint and Background Report





http://www.NationalPartnership.org/Blueprint

http://transform.childbirthconnection.org/physiology

Thank You

For more information:

Contact me

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NQF Member and Public Comment

Next Steps

Next Steps

- Fall 2018 Cycle
  - *Second Committee Webinar: March 15, 2019, 1:00-3:00 pm ET*
- Spring 2019 Cycle
  - *Intent to Submit Deadline: January 5, 2019*
  - *Measure Submission Deadline: April 9, 2019*
  - *Committee Orientation Webinar: May 13, 3:00-5:00 pm ET*
  - *Measure Evaluation Webinar #1: June 21, 1:00-3:00 pm ET*
  - *Measure Evaluation Webinar #2: June 24, 3:00-5:00pm ET*
  - *Post-Evaluation Webinar: June 28, 1:00-3:00 pm ET*
  - *Post-Comment Webinar: September 20, 12:00-2:00 pm ET*

Contact Information

- Email: perinatal@qualityforum.org
- NQF phone: 202.783.1300
- Project page: http://www.qualityforum.org/Perinatal_and_Womens_Health.aspx
- SharePoint page: http://share.qualityforum.org/Projects/Perinatal%202015/SitePages/Home.aspx

Adjourn