NATIONAL QUALITY FORUM

Meeting Summary

Perinatal and Women's Heath Standing Committee Web Meeting

The National Quality Forum (NQF) convened a public web meeting for the Perinatal and Women's Health Standing Committee on February 9, 2018.

Welcome, Introductions, and Review of Web Meeting Objectives

Suzanne Theberge, NQF senior project manager, welcomed participants to the web meeting. She provided opening remarks and reviewed the following meeting objectives: discuss balancing measures for the Perinatal and Women's Health Standing Committee's measure portfolio and receive an update from developers on competing neonatal measures.

Balancing Measures for the Perinatal and Women's Health Standing Committee's Measure Portfolio

The Committee held a rich and informative discussion on the need, if appropriate, for balancing measures to the measures in the Perinatal and Women's Health Standing Committee's portfolio. This topic was one identified as needing further discussion in the 2015-2016 cycle of work. Balancing measures are measures that can be monitored to potentially mitigate an unintended or adverse consequence of a specific measurement focus. Balancing measures help ensure that changes made in response to one measure do not worsen outcomes in a separate or related area of care. For example, a decrease in cesarean sections, which is considered a positive outcome, should not increase compromised newborns or stillbirths. The Committee discussed half the measures in the portfolio and plans to continue the discussion on a future webinar (to be scheduled). While the Committee also discussed measures for internal quality improvement purposes, NQF is interested in measure development focused on balancing measures for use in accountability programs.

0033 Chlamydia Screening in Women (CHL) - National Committee for Quality Assurance

The Committee agreed that this measure did not need a balancing measure, per se, but had suggestions for the developer to improve and expand the measure to provide better quality care and improve outcomes. Committee members noted that African American women are screened inappropriately more than white women and suggested that the developer stratify the measure reporting by race. Committee members discussed the inclusion of males in the measure and noted that expanding the population to include males would increase testing rates, leading to improved public health outcomes. Finally, Committee members noted that there are potential drops in contraceptive coverage forthcoming, which will likely lead to reduced access. Since the measure relies on claims data and uses contraceptive coverage as one of the inclusion criteria to show a patient is sexually active, reduced access to contraception could negatively affect performance on this measure.

0469 and 0469e PC-01 Elective Delivery (paper measure and eMeasure) - The Joint Commission

During the previous cycle of work, the Committee had identified 0716 *Unexpected Complications in Term Newborns*, as a balancing measure for 0469 and 0469e. The Committee agreed that this was an important balancing measure, but noted that a measure addressing maternal morbidity and mortality would also be a key balancing measure. Committee members noted the many improvements in this measure over time; the developer has added several additional exclusions that make the measure much stronger. This measure is intended to discourage "frivolous" early inductions, or those performed for nonmedical reasons, such as scheduling convenience. Committee members discussed potential sequelae of early induction for the mother, including the general risks of induction of labor, prolonged hospital stays, infections, and the increased risk associated with cesarean sections as potential aspects of a maternal morbidity balancing measure.

0470 Incidence of Episiotomy - Christiana Care Health System

During the previous cycle of work, the Committee had identified 0716 *Unexpected Complications in Term Newborns* as a balancing measure for 0470. Committee members agreed that one of the major problems with episiotomies is that they increase the likelihood of third and fourth degree lacerations, which can have long-term health implications for women, as well as the immediate effects. Committee members noted that one of the points of this measure is to encourage doctors to think seriously before doing an episiotomy (except in cases where it is clinically indicated, such as shoulder dystocia), and that 0470 can be used as a tool to eliminate the outdated practice of performing them routinely.

0471 PC-02 Cesarean Birth - The Joint Commission

During the previous cycle of work, the Committee had identified 0716 *Unexpected Complications in Term Newborn*s as a balancing measure for 0471. However, Committee members also noted the need for a measure assessing maternal complications. Committee members discussed various maternal complications that are tracked at their own institutions for quality improvement purposes, such as chorioamnionitis (inflammation of the fetal membranes due to a bacterial infection), third or fourth degree lacerations, and hemorrhage; as well as neonate complications such as newborn sepsis and low Apgar scores at 5 minutes. Anecdotally, Committee members have noted no increase in these complications as cesarean section rates have dropped, and agreed that tracking these indicators is important for quality improvement. The Committee strongly highlighted the need for a maternal mortality and morbidity measure, and agreed that reducing the rate of cesarean sections in nulliparous, term, singleton, vertex (NTSV) pregnancies is important and that more data tracking for both maternal and neonatal outcomes is needed.

0476 PC-03 Antenatal Steroids - The Joint Commission

Committee members noted the importance of this intervention in reducing poor neonatal outcomes, including mortality. They held an extensive discussion on whether steroids are being overused, and ultimately agreed that a balancing measure is not needed. They noted, however, the need for more provider education to ensure that risks to the mother are appropriately balanced with care for the neonate. The full course of steroids is 48 hours, but benefits are

shown to happen within 6 hours, and if it is clinically indicated, delivery sooner, in order to reduce maternal mortality, is more important than the full course of steroids. Committee members noted some concern with overuse of steroids, which can lead to maternal hyperglycemia and diabetic ketoacidosis, as well as concerns about providing the steroids too early (they are indicated for within 7-10 days of delivery). However, the providers on the Committee agreed that it is impossible to know whether preterm labor will lead to early delivery, and that the current standard of care (one dose and if needed, one rescue dose) has not been shown to cause any complications for either babies or mothers. Extrapolating from patients who did deliver early has shown clear benefits and very limited to nonexistent harms from this practice.

2902 Contraceptive Care – Postpartum – U.S. Office of Population Affairs

The developer of this measure is currently working on a patient-reported experience of contraceptive care measure that both the developer and Committee agree will be an important balancing measure; the developer plans to submit the new measure for endorsement once testing is completed. The Committee agreed that it is too early in the use of this measure to fully assess whether other balancing measures are needed. It discussed the practice of inserting IUDs immediately postpartum, and noted that while there is a higher overall expulsion rate when inserted immediately after birth, the number of women covered at six months postpartum is ultimately greater; however, this needs to be assessed against the need for care and the costs associated with expulsion and a second insertion. Committee members noted that several major teaching institutions are currently starting post-placental insertion as a standard practice, and more data should be available in the next year or so to assess how much of an issue expulsion is.

2903 Contraceptive Care – Most & Moderately Effective Methods - U.S. Office of Population Affairs

The Committee did not note any additional balancing measures other than the one previously identified and under development—the patient-reported experience of contraceptive care measure.

2904 Contraceptive Care - Access to LARC – U.S. Office of Population Affairs

As with the other two contraceptive care measures, the patient-reported experience of contraceptive care measure will be an important balancing measure. Committee members noted that another possible balancing measure would need to be an eMeasure, as it would require the element “what is your plan for pregnancy in the next year?” which is currently not something that can be assessed via a standard element in claims/paper records. Data show that approximately 35 percent of women are not at risk for unwanted pregnancy and would not be included in the denominator, but these data are not currently in a format that can be used to develop a measure (it comes from the National Survey of Family Growth data and is not available in clinical records). Committee members noted that access on the institutional side (availability of IUDs on site, trained providers to insert, etc.) is a major limiting factor, and must come before patients are asked whether they received counseling on this subject.

Update on Competing Neonatal Measures

Kate Buchanan, NQF senior project manager, provided background on the three measures of neonatal infection that the Committee identified as competing during its 2015-2016 project: 0304 *Late Sepsis or Meningitis in Very Low Birth Weight (VLBW) Neonates (risk-adjusted)*, 0478 *Neonatal Blood Stream Infection Rate (NQI 03)*, and 1731 *PC-04 Health Care-Associated Bloodstream Infections in Newborns*. In 2016, the Committee requested that the developers come back in 18 months with either a single measure or that they harmonize the three measures so that they are no longer competing. During the web meeting, the Committee received an update from the developers.

0478 Neonatal Blood Stream Infection Rate – Agency for Healthcare Research and Quality

Pamela Owens, PhD, and Mia DeSoto, PhD, MHA, MSc, of the Agency for Healthcare Research and Quality (AHRQ) reported that AHRQ currently does not have an analytic contractor. Consequently, the agency has not made significant progress on harmonization efforts. In the past 18 months, AHRQ focused its efforts on converting the measure indicators from ICD-9 to ICD-10. In September 2017, AHRQ released version 7 of the measure, which includes numerators and denominators with ICD-10 codes: To update the risk adjustment with the quality indicators, AHRQ needs one year of ICD-10 coded data, and those data will be available in summer 2018. AHRQ plans to release the ICD-10 coded risk-adjusted version of the measure in December 2018/January 2019. Moving forward, AHRQ plans to use the ICD-10 risk-adjusted measure to work with the other developers regarding harmonization efforts.

1731 PC-04 Health Care-Associated Bloodstream Infections in Newborns – The Joint Commission

Catrina Patino, MBA/MSN, RN, and Susan Yendro, RN, MSN, of The Joint Commission (TJC) updated the Committee on its harmonization efforts. In 2016, the Committee asked TJC to look at the effects of updating the coding to ICD-10. At present, the TJC does not have this quantified, but does have nationally aggregated performance data from 2014-2016. In 2014, the national aggregated rate of infection was 3.2 percent; the rate decreased in 2015 to 2.4 percent; and again in 2016 to 1.1 percent. It is important to note that in January 2016, the threshold reporting requirement was lowered from hospitals with 1,000 deliveries a year to all hospitals with at least 300 deliveries a year. While the number of reporting hospitals has increased, the number of infections has decreased over the past 3 years.

Another previous request of the Committee was to compare the different populations of the three measures. TJC looked at the denominator cases for #1731 and #0304. It found that 70 percent of patients with a reported infection for #1731 weighed more than 1,500 grams. Measure #0304 would not capture these patients, since its specifications only include infants with a birth weight between 401 and 1,500 grams. Currently, TJC is running a comparison between #1731 and #0478 to ascertain differences between the two measures. There are some patients that #0478 captures that #1731 does not, since #1731 only includes patients with an admission age of less than or equal to 2 days, while #0478 includes patients up to 28 days in age. The TJC will update its analysis with newer versions of #0478 as the versions become available.

TJC is in the process of updating the comparison document that it previously submitted to NQF, which includes updates on any harmonization opportunities. TJC will compare differences in

ICD-10 codes, differences in initial patient population, and any differences in the numerator and denominator inclusion/exclusion criteria and how each of these impacts the population included.

0304 Late Sepsis or Meningitis in Very Low Birth Weight (VLBW) Neonates (risk-adjusted)

Erika Edwards PhD, MPH, Vermont Oxford Network (VON), reported to the Committee that there are no updates to the measure, which is collected by data contacts at VON member hospitals. A recent analysis determined that the median risk-adjusted rate of late onset sepsis in VLBW infants was 10 percent in 2014 at 756 reporting hospitals. Dr. Edwards noted that similar to #0478, #0304 is applied to any infant admitted within 28 days of birth.

Committee Discussion

The Committee confirmed with Dr. Edwards that an infant who is discharged from the hospital and then develops an infection and is readmitted is not captured by #0304.

The Committee inquired about the next steps on efforts to harmonize the competing measures. AHRQ replied that once it has an analytic contractor in place, the agency will be able to work with TJC and VON on harmonization efforts. TJC said it is preparing for conversation and will update its harmonization document with the risk-adjusted version of #0478 to help direct the discussion.

The Committee asked if the developers anticipate being able to determine the sensitivity of codes. TJC responded that it is looking at this.

Public Comment

Ms. Buchanan opened the web meeting to allow for public comment. The Committee received one comment that requested the Committee specify week and day when discussing a gestational age cutoff or range (e.g., 39 weeks, 0 days).

Additionally, the commenter stated that when the Committee assesses 0471 *PC-02 Cesarean Section*, "it is important to either include a balancing measure for complicated pregnancies or use a rate that does case mix adjustment such as the Society for Maternal Fetal Medicine rate. Otherwise a patient with a placenta previa would count as unnecessary cesarean." Following the call, NQF staff reached out to The Joint Commission, the steward of 0471 who responded to the comment: "As of January 1, 2018, ICD-10 codes for placenta previa were added as exclusions to Table 11.07. We do not expect a large change in the rate as a result of adding these to the table. The Technical Advisory Panel (TAP) felt that most placenta previa cases would deliver prior to 37 weeks. For those cases that do deliver past 37 weeks, these exclusions would remove them from the measure population. Additionally, we are considering balancing measures."

Next Steps

Ms. Buchanan thanked the Committee for their participation. This is the last meeting of the fall 2017 cycle of work. The Committee did not receive any measures for the spring 2018 cycle, but the Committee will meet twice in the upcoming months. NQF staff will work with the co-chairs to identify topics for the calls, including the continuation of the balancing measures discussion.