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 November 8, 2018.

Welcome, Introductions, and Review of Web Meeting Objectives

Suzanne Theberge, NQF senior project manager, welcomed participants to the web meeting. Ms. Theberge provided opening remarks, conducted a Committee roll call, and briefly reviewed the three presentations planned for the webinar.

Predictors of Hospital Satisfaction in Childbirth

Kimberly Gregory, MD, MPH, Committee Co-Chair, presented on the work of the Maternal Quality Indicator Work Group and the Childbirth PRO Partnership, which is assessing predictors of hospital satisfaction in childbirth. The research team is looking at patient-reported outcomes (PROs) of maternity care via a three-phase project.

Dr. Gregory summarized some of the results from the first two phases (phase 3 is ongoing). The first phase, assessed during pregnancy, looked at what women want in maternity care and how different patient characteristics (demographics, clinical status, etc.) affect this. The second phase, done both during pregnancy and after childbirth, assessed whether women got the care they wanted, what gaps there were in the care they wanted compared to what they received, and then determined which of these patient-reported outcomes predicted hospital satisfaction. Dr. Gregory reported that phase 1 identified 39 PROs across 19 domains of care, some of which were universal (wanted by all/almost all women) and some of which were specific (wanted by some women, likely to vary by patient characteristic). For example, the researchers found that the importance of respect of spiritual/cultural needs varied by race, with 77.1 percent of black women wanting this, versus 61.5 percent of Asian women. Variations were found by both sociodemographic factors (e.g., age, education, race and ethnicity), as well as clinical factors, such as birth parity, prior cesarean, or pregnancy complications. Other patient characteristics found to be statistically significant included history of discrimination or abuse, social support, and provider preference. The researchers also noted several important postpartum characteristics that are not normally addressed in advance, including confidence in the birth process and belief that they would cope well with pain. The research team then developed models for each PRO for women anticipating vaginal birth and found linkages between various characteristics. For example, women planning to have a support person or women who were confident filling out medical forms were more likely to want "skin to skin" contact with the baby immediately following birth.

In phase 2, the researchers conducted postpartum follow-up to assess whether women received services they had said they wanted, and added questions that could not be asked antepartum. The team then looked at how satisfied women were with the birth or hospital, hypothesizing that when there is a difference between what was preferred/expected antepartum and what actually happened during delivery, satisfaction would be affected. Indeed, the team found the

least satisfied women were those who wanted something and did not receive it, such as reassurance from their provider, one of the universal PROs the study identified. Similarly, women who wanted reassurance and got it were the most satisfied. Dr. Gregory noted that several of the PROs addressed things that the providers could ascertain in advance to ensure patients' preferences were met, such as whether they want their partner in the room during labor and delivery. She also cited the example of women who did not want breastfeeding encouragement, yet who still were provided this, as another example linked with lower satisfaction. However, she also noted that there can be challenges; for example, there are some women who are making a well-educated decision not to breastfeed who should not be receiving this information multiple times, while others did need this information and were ultimately glad to have it.

In the overall analysis, the researchers found that patients with self-reported poor or fair maternal mental health, history of discrimination, negative memories from previous childbirth, most days reported as stressful, and worried about birth, were less satisfied with the hospital, whereas patients whose spiritual/cultural needs were respected, were involved in pain management decisions, had support, and had high medical literacy were more satisfied. There also were links between gaps in care (patients wanting and not getting something) and lower satisfaction. Dr. Gregory also reported that certain service expectations are associated with increased patient satisfaction, such as safety, skin-to-skin contact with the baby, and control. In addition, some patient characteristics are linked to specific preferences that providers can discover in advance, which can assist hospitals with educating patients, managing expectations, and respecting patient preferences.

Dr. Gregory reported that the project's third phase has just gone live and will collect data from 3,000 women across 10 hospitals in California. With this additional data the research team hopes to provide improvement strategies that ensure all women receive the universal PROs, that help identify vulnerable patients, and that encourage providers to ask about preferences directly. Ultimately the group plans to develop performance measures and submit them to NQF for endorsement.

The call was then opened for Committee discussion. Committee members supported the project and noted high interest in future measures. One Committee member commented on the breastfeeding education and satisfaction issue, noting tools exist to help providers identify women who would benefit from more information versus those who are making an informed choice. Another Committee member asked how to use this information at a systems level, and Dr. Gregory explained that theoretically there is clustering in patient types that could be used at the hospital level, but not at a one-size-fits-all level. Professor Vedam, the next presenter, noted that this work lines up beautifully with her study and asked how to ensure that satisfaction is an appropriate metric, noting patients often will say they are satisfied because they went home with a baby, but are reluctant to link the experience of birth to satisfaction with their care. Dr. Gregory agreed there are challenges, but believes providers can do things to improve experiences.

Who Defines Quality and Safety? Measuring Respectful Maternity Care in North America

Saraswathi Vedam, RM, FACNM, MSN, SciD (hc), a professor of midwifery at the University of British Columbia who runs the Birthplace Lab in Vancouver, BC, was invited to present to the Committee on her work in person-centered maternity care, including measurement and evaluating how people define quality and safety. Professor Vedam presented on a participatory research project she conducted that led to the development and validation of three new quality measures. She also described how these measures allowed her team to examine and describe quality in pregnancy and birth care from the servicer's perspective, and the differential treatment by race, place of birth, and model of care that emerged.

The first study looked at the maternity care experience in British Columbia, which had recently implemented midwifery care. Through four working groups of constituents, researchers found that the participants were interested in access to care, preferences for care, experiences with maternity care, and decision making. Shortly after, the research team convened similar groups in the United States, particularly focusing on communities of color and women who chose home or birth center birth. In the U.S. group, participants added the domains of respect of autonomy, racism, mistreatment, nonconsented care, and predictors of resilience to the ones identified in Canada. Through literature reviews of previously validated surveys and iterative work with the original working groups, as well as new focus groups, the research team developed specific survey items. Following a pilot of 4,000 responses, the researchers developed a seven-item scale, the Mothers Autonomy in Decision Making Scale (MADM), to measure the level of autonomy in decision making. Results were found to vary by provider type, place of birth (hospital with a doctor, hospital with a midwife, freestanding birth center, and home), and by race/ethnicity of respondent (less autonomy for black and Latina respondents). The team also developed the Mothers on Respect Index (MORi) to assess how respected patients felt during care. Again, differences by provider, place of birth, and race/ethnicity were found. The respondents, particularly in the United States, viewed low scores on several items in this scale as abuse and disrespect by the provider, and the researchers noted that the items line up with the WHO typology for mistreatment. Higher rates of mistreatment were found by sociodemographic factors; the baseline level of experiencing one of these aspects of mistreatment was 17 percent in the whole population, with increases by low socioeconomic status, elevated pregnancy risks, and social risks. Mode of birth, particularly unplanned cesarean section, was linked with high levels of experiences such as scolding, shouting, and having treatment withheld.

Professor Vedam stated that research into the mistreatment scale is ongoing. She noted that the WHO is now saying that the experience of care should be considered as an outcome in and of itself, and that the research team will continue to look more broadly at what quality means and how patients define it.

Ms. Theberge then opened the call for Committee discussion and questions. Dr. Gregory asked how this work can be used to make a difference. Professor Vedam responded that the decision making piece of the research had found that 95 percent of women in Canada, and 91 percent of white women in the United States, said their preference was to lead decisions, but

overwhelmingly, providers were making some decisions (such as the decision for a cesarean). Professor Vedam believes this information can be used to train providers to improve shared decision making and to emphasize models of care that allow more time for patients and providers to talk. She noted that the research team has created a model for person-centered decision making that is now being taught in both Canada and the United States. Professor Vedam noted that the group is working on submitting measures to NQF.

Listening to Mothers in California and Blueprint for Advancing High-Value Maternity Care: Highlights from New National Partnership for Women and Families Resources

Carol Sakala, PhD, MSPH, Committee Co-Chair, presented on the recent results of the National Partnership for Women and Families' Listening to Mothers survey. This round of the survey was the first done at a state level, in California, and it included the first use of the survey in Spanish; new survey modalities; and differences in sampling and weighting (for this round they oversampled black women, women with midwifery-attended births, and women with VBAC [vaginal birth after cesarean]). California has 12 percent of the nation's births and is a leader in maternity care quality improvement, but also has maternal demographics that differ from the national profile in important ways. However, the results were generally consistent with the national Listening to Mothers survey results.

The survey found that many women use quality information to choose a provider and hospital, but that only one in three were aware of variation in quality across obstetricians and across hospitals. In California, most women give birth in hospitals, but the survey found that many would be interested in a birth center and in using a midwife and a doula at future births. The survey also found that while women do not want unnecessary interference with childbirth, they experienced high rates of interventions, with 40 percent experiencing attempted labor inductions and at least 37 percent of those lacking an evidence-based induction. Dr. Sakala noted that inductions are undercounted in birth certificates, and the survey collected data that were previously unknown or hard to collect.

While most women reported respectful care, there were variations by sociodemographic factors: 11 percent of black women versus 1 percent of white women reported being treated unfairly due to their race or ethnicity, and 13 percent who primarily spoke an Asian language at home and 10 percent who spoke Spanish (versus 2 percent who spoke English) reported being treated unfairly due to their language. The survey also examined postpartum issues and found 9 percent had no postpartum care visits, and 17-18 percent of Medi-Cal beneficiaries reported never having sources of practical and emotional support since giving birth. Finally, the survey asked about mental health and found that positive screens were more frequent for anxiety than for depression, both during pregnancy and after birth. In addition, just one in five who screened positive for these conditions in pregnancy and one in three who screened positive after birth received mental health counseling or treatment, demonstrating access issues. Dr. Sakala noted that these results correlate with known issues and there should be an increased focus on the postpartum period. Dr. Sakala stated that the survey included several open-ended questions (what was the best part of your care when you were in the hospital for giving birth, what was the worst part and anything else you'd like to tell us), which are still being analyzed.

Dr. Sakala reported that the National Partnership also released a consensus report from 17 national multistakeholder and multidisciplinary leaders including past presidents of the American College of Obstetricians and Gynecologists, the American College of Nurse Midwives, and the Association of Women's Health, Obstetric, and Neonatal Nurses, as well as experts in payment reform, performance measurement, quality improvement, consumer advocates, and clinical and policy researchers. This report focused on systemic solutions to the challenges identified in the survey. Dr. Sakala noted the need to balance the focus on high-risk and complicated situations with care that minimizes both over- and underuse. The report identified 22 high-level recommendations, with action steps across six 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

Dr. Salaka noted particularly relevant elements to the Committee included filling measure gaps, implementing episode payment programs and maternity care homes, and building out quality improvement resources and initiatives to enable success with greater accountability. She also highlighted the report's list of resources that should be available for women, such as publicly reporting performance on meaningful measures, making care navigators available to help women select care, and collecting women-reported experience and outcomes of care measures.

Ms. Theberge then opened the call up for Committee discussion. A Committee member asked about trends, and Dr. Sakala noted that while some trends were observed, such as the continued gaps between the care women want and what they receive, as well as the lack of care in the postpartum period, they also were able to collect new information, such as information about anxiety and mental health during pregnancy. She noted that the ongoing gaps in care are well documented, and while the new information is helpful, it is time to address the issues in a systemic way. A Committee member remarked on the different model of childbirth in other places, which includes birth centers. Dr. Sakala noted that many women are interested in this model of care, which frequently has better outcomes, so this is one avenue for larger systems to pursue.

Public Comment

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

Next Steps

Navya Kumar, project analyst, summarized the next steps for the Committee, which include the second fall cycle call on March 15, 2019, and the call and meeting dates for the spring 2019 measure evaluation cycle. Ms. Theberge noted that, at this time, NQF anticipated there would be measures to evaluate. Ms. Theberge concluded the call by thanking everyone for participating.