NATIONAL QUALITY FORUM

Moderator: Benita Kornegay-Henry
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12:00 PM

Suzanne Theberge: Great. Hello, this is NQF. Hi, this is NQF. Who just joined?

Diana Jolles: Hi, this is Diana Jolles.

Suzanne Theberge: Hi, Diana. How are you?

Diana Jolles: Doing well. How are you?

Suzanne Theberge: Good. This is Suzanne Theberge with NQF.

Diana Jolles: Hi.

Suzanne Theberge: Welcome.

Diana Jolles: Thanks, good to be here.

Suzanne Theberge: We'll be getting started in a little bit longer, a few minutes before the hour. Thanks for joining early.

Diana Jolles: I'm good, no problem.

Suzanne Theberge: Hi, this is Suzanne with NQF. Who just joined?

Carol Sakala: Hi. Suzanne. This is Carol.

Suzanne Theberge: Hi, Carol.

Diana Jolles: Hi, Carol. It's Diana.

Carol Sakala: Hi, Diana.

Amy Bell: Hey good morning. It’s Amy Bell.

Suzanne Theberge: Hi, Amy.

Hannah Ingber: Hi, Amy, welcome.

Amy Bell: Hi, thank you.

Suzanne Theberge: Were folks on the phone, you're able to connect to the webinar as well?

Diana Jolles: I am.

Carol Sakala: Working on that now.

Suzanne Theberge: Okay, great.

Amy Bell: I'm pulling that up. Yes, I'm connected.

Suzanne Theberge: Hi, this is Suzanne with NQF. Who just joined?

Diana Ramos: Hi, Diana Ramos joined.

Suzanne Theberge: Hello, thanks for joining us.

Diana Ramos: Thank you.

Suzanne Theberge: We'll be getting started in a few moments. It'll just be a bit before the top of the hour.

Robyn Nishimi: This is Robyn.

Suzanne Theberge: Hi, Robyn. Suzanne and Hannah are here and several of our committee members are here as well. Hi, this is Suzanne with NQF. Who just joined?

Mambarambath Jaleel: Hi, Suzanne. This is Jaleel here.

Suzanne Theberge: Hello, thanks for joining us.

Mambarambath Jaleel: Thank you.

Suzanne Theberge: We'll be getting started in a few moments everyone. Give people a few more minutes to dial in.

Kimberly Gregory: Good morning. It's Kim Gregory.

Suzanne Theberge: Hi, Kim. It's Suzanne with NQF.

Kimberly Gregory: Okay, okay, thank you.

Suzanne Theberge: Carol is here, and the NQF team and several of our committee members are here and also joining.

Kimberly Gregory: Okay, great. I'll go on mute until you need me.

Suzanne Theberge: Great. Hi, this is NQF. Who just joined?

Deborah Kilday: This is Deb Kilday.

Suzanne Theberge: Great. Thanks for joining us. Hi, this is Suzanne with NQF. Who just joined?

Kimberly Gregory: Hello?

Suzanne Theberge: Hi, it's Suzanne with NQF.

Kimberly Gregory: No, this is Kim. I got disconnected somehow. Okay, thank you.

Suzanne Theberge: Glad you're back. Hello, this is Suzanne with NQF. Who just joined?

Ashley Hirai: Hi, Suzanne. This is Ashley Hirai.

Suzanne Theberge: Hi, welcome.

Ashley Hirai: Hi.

Suzanne Theberge: All right, it's just noon by my clock, but we'll give folks a couple of minutes to dial in and I see here a couple of lines connecting now so we'll wait

another minute or two before we get started. It sounds like someone just joined.

And folks who are on the phone, there is the slides that we presented on the webinar as well. So if you are at a computer and can connect to that, that would be great. I heard a couple of beeps, has anyone joined?

Matthew Austin: Yes, good afternoon. This is Matt Austin.

Suzanne Theberge: Great, welcome. All right, let's go ahead and get started. And it's a few minutes past the hour so we might as well get the call started and I don't see anybody else dialing in right at this moment.

So thank you so much for joining us today. Welcome to Perinatal and Women's Health Standing Committee Topical Meeting for the Spring 2019 Cycle.

Before we get started, just a few quick housekeeping items. First, this is Suzanne Theberge. I'm the senior project manager on the team. I'm delighted to be speaking with you again.

Just a reminder to dial in on the phone if you are only on the webinar so that you can speak, you do need to be connected to the phone line, but we will also be showing some slides on the webinar if you're able to join that as well. And please put your phone on mute if you're not actually speaking, but please don't put us on hold so that we can avoid that hold music and prevent any interference with the line. So thanks so much for joining.

I'm just going to quickly go over our agenda. We're going to do a roll call so we know who's on the phone, introduce you to some new team members at NQF, and then we're going to dive in to our topical discussions today.

We're going to be talking about measures for maternal mortality and morbidity. And then we're also going to be talking about women's health measures more generally outside of the perinatal and reproductive health measures that we've looked thus far.

We will have a comment period at the end of the call and then we'll talk about next steps, including the upcoming measure evaluation work that we're going to be starting this fall.

So with that, I will turn it over to my new colleagues to introduce themselves. Jermane, would you like to start? Are you on the line?

Jermane Bond: Yes, I'm here. Thanks Suzanne. Jermane Bond, I am about six months in the role here as a senior director at NQF and on the Quality Measurement team. I'm happy to join you.

I come from academia as an assistant research professor at the George Washington School of Public Health. And I have about 15 years of experience in research training around maternal and child health, reproductive and preconception health. I am also a native Tennessean so happy to join you.

Hannah Ingber: Hi, this is Hannah. I'm a fetal project analyst with NQF. I just recently received my MPH from Yale and I have been at NQF a little over a month now. I'm really excited to be on the perinatal team because I have strong interest in women and children's health and have mostly focused on

econometrics in my studies. So I'm happy to be here and meet all of you. Thanks so much.

Suzanne Theberge: Great thank you. Again, this is Suzanne and Robyn, not a new team member but is also on the line.

Robyn Nishimi: Sorry, I was on mute. Robyn Nishimi, happy to have everyone on the call today. I am a senior consultant working on this project and projects on population health.

Suzanne Theberge: Great, thank you. So we will just do a quick roll call of the committee members so we know who is on the phone and then we will dive right into the discussion. So Kim Gregory?

Kimberly Gregory: Here. Good morning, everyone. Thank you for joining us.

Suzanne Theberge: Great, thank you. And Carol Sakala?

Carol Sakala: Yes, here as well.

Suzanne Theberge: Thank you. Jill Arnold? Matt Austin?

Matthew Austin: Here.

Suzanne Theberge: Great, thank you. Jennifer Bailit? Amy Bell?

Amy Bell: Hey, I'm here. Thank you.

Suzanne Theberge: Great, thank you. Martha Carter? Tracy Flanagan? Ashley Hirai?

Ashley Hirai: I'm here. Thanks.

Suzanne Theberge: Great, thank you. Mambarambath Jaleel?

Mambarambath Jaleel: I'm here. Hello, everybody.

Suzanne Theberge: Thank you. Diana Jolles?

Diana Jolles: I'm here.

Suzanne Theberge: Thank you. Deborah Kilday?

Deborah Kilday: Here.

Suzanne Theberge: Great, thank you. Sarah McNeil? Jennifer Moore? Kristi Nelson? Juliet Nevins? Sheila Owens-Collins? Diana Ramos?

Diana Ramos: Here.

Suzanne Theberge: Naomi Schapiro? Karen Shea? Marisa Spalding? Sindhu Srinivas? Rajan Wadhawan? And Carolyn Westhoff?

Carolyn Westhoff: I'm here.

Suzanne Theberge: Great, thank you. All right, so the first item that we're going to be talking about today is measures for maternal mortality and morbidity.

And we are really excited at NQF to announce that we have just been awarded a new senior project on maternal mortality and morbidity. And this is brand new, it's so new that we don't even have any slides on it, but we will be

announcing it more formally and publicly in the next few weeks as that project gets going. But we wanted to kind of get a preview discussion with this committee as our - some of our topical experts in this area/

So as part of this project, one of the - we're going to be assessing the current landscape of quality measures and measure concepts focused on maternal mortality and maternal morbidity measurements, and we're going to be looking at developing a couple of frameworks for measuring one for maternal mortality and one for maternal morbidity.

We're going to be evaluating the current approaches for standardizing measurement in these areas and then we're going to be recommending some specific short and long-term approaches to improve the current state of maternal mortality and morbidity measurement.

The first part of this work that we're going to be starting later this fall will be - the staff will be working on doing an environmental scan on the current state of maternal mortality and morbidity measurement looking at what's out there, what are some innovative things that are happening, what are the gaps, and what are some of the things that we need to consider about measurement data process and other areas.

So in terms of what NQF has in the portfolio, we have currently four endorsed measures that look at maternal morbidity topics which is, you know, not very many, but we're curious about what might else be out there that you might know that might not have come to NQF yet.

And so we'd like to bring this question to you to talk and hear from you what you're aware of that has been - that might be out there and being used for internal quality improvement initiatives, what you might be using at your

institutions, what measures are possibly under development or testing, what concepts you might suggest for this area, and then of course any groups and organizations that you're aware of in this topic area/

So as I said, NQF is really just getting started on this work and we'll be announcing it much more formally, but we're hoping to hear a little bit of input from you as we get started.

So with that, I will turn it over to our co-chair, Kim, who's going to facilitate this portion of the discussion.

Kimberly Gregory: Oh, I …

Carol Sakala: Suzanne, I think - yes, we - I think we decide to switch. So this is Carol.

Suzanne Theberge: I'm sorry.

Carol Sakala: Yes, this is Carol, no worries, and welcome everyone. I'm sure we are going to have a very robust discussion in both of our major areas today and also I'm looking forward to working with you on our consensus development work that will be coming up very soon.

So I'm going to lead this part of the session today and then Kim is going to take a look at the maternal - the women's health measures outside of perinatal and women's health topics outside of - sorry, perinatal and maternal health topics.

So if we could take the questions in order, we have an hour allocated that we can use if we need to for this. The first question is whether you are aware of measures that have been developed that are in use for example within health

plans or other areas and likely would be use for QI for example right now rather than accountability in the area of maternal mortality and morbidity.

Deborah Kilday: And so this is Deb Kilday, I'll jump in and I apologize I'm going in a public place. I was unfortunately delayed on travel so I am on the webinar. But it's a great topic. It's one that I'm working very closely with the organization I support from here and we actually just ran data from a database about a million birth year over 10 years and have been peeling back the onion on how maternal complications, maternal - severe maternal morbidity and mortality have been trending within our hospital.

And it's fascinating data, there's a lot to learn from it. And in accordance, we have developed - when you look at quality improvement metrics, we developed a sundry of metrics to help support our hospitals in improving their outcomes, sort of minimum trending what their outcomes may be since they haven't looked at their data in this way before.

And I'll clarify by saying all the that we're looking at this hospital is billing data and it's really just zeroing in on the key contributors that we've identified, hemorrhage, hypertension, diabetes, cardiovascular conditions, embolism, et cetera.

So it's preliminary, but it's being very widely received by the hospitals. It's helping them really drill in to some of the other metrics that are being seized on them from other collaboratives and things of that nature. But I thought I'd share that out loud at the beginning of this discussion. It's a great discussion point.

Carol Sakala: And Deb, I think you have recently issued a report that might be good to share with the group or at minimum, the NQF staff, is that correct?

Deborah Kilday: That's correct, happy to share that.

Carol Sakala: Thank you.

Kimberly Gregory: Is that publicly available or just …

Deborah Kilday: No, it is publicly available. I'm walking, I will forward it. I'll pull up those links and forward that to you so you can share that with the group. It is publicly available.

Kimberly Gregory: Great, thank you.

Suzanne Theberge: Great, thank you.

Diana Ramos: Hi, this is Diana Ramos. So with the California Department of Public Health, we recently were awarded one of the maternal mortality grants from the CDC really looking to expand and do more work on the outstanding work that we've done already.

As you probably already know, California has the lowest maternal mortality rate in the country. And so the California Department of Public Health initially started the funding for reviews in maternal mortality and provided that grant to CMQCC.

So now going forward, we're going to be continuing to work with CMQCC and expanding - looking at further opportunities, more detailed information with CMQCC. They have the maternal data center that looks at key measures reported pretty much lifetime within 30 days of the outcome.

But some of the measurements that are viewed as a proxy for mortality are hemorrhages as previously mentioned, and also looking sometimes at ICU admissions as some of the near misses, and also as well as number of units of blood that are transfused. All of this is being - we can do this because of that CMQCC Maternal Data Center.

But there are just lots of opportunities if there is a measure that is identified that we can maybe go back and look at what we have in CMQCC, and then going forward with the new maternal mortality grant that we've received to see how that correlates and we can look at the data and that could help us further.

Carol Sakala: Thank you. This is Carol, I had a dropped call, sorry about that.

Kimberly Gregory: This is Kim, I …

Carol Sakala: Yes, Kim, do you want to, yes, contribute your thoughts?

Kimberly Gregory: There is a new - I don't know if it's a new measurement, but there is a new goal that some people have embraced in terms of reporting that is timely treatment of hypertension and the goal is 60 minutes. However, there's some data that suggest that 30 minutes is the ideal.

But for women who have preeclampsia, blood pressure is greater than 160 or diastolic rate greater than 110, they should be treated within 60 minutes and that has been advocated by ACOG, supported by CMQCC and now there are some plans that are asking to see that data. It actually has the potential to be lifesaving because a lot of these strokes that were revealed through CMQCC's maternal mortality review were basically due to undertreatment or neglect.

And then there's another measure out there that's actually being a measure of respect because of the rising numbers of women who were reporting being disrespected during their labor process and it's a little bit different than the communication measures that are a part of HCAHPS.

So those are two, in addition to the maternal morbidity as a roll-up measure or composite measure which includes the entity that Diana Ramos discussed.

Amy Bell: Okay, this is Amy Bell, I would add to what was just said. At Atrium Health, we are measuring the medications given within 60 minutes to the severe range pressures. But I think there are some organizations out there that are collecting that information. I believe it's very, very important.

We're also adding a goal for 2020 for our providers on low-dose aspirin for prevention of preeclampsia so, you know, trying to avoid the whole situation from occurring. I think before we get in that situation is also important to think about.

Kimberly Gregory: This is Kim. That's a great point and I don't know if anyone who is doing it and I know that there are a lot of collaboratives that are trying to encourage the use of progesterone, but I don't know anyone who's advocated that as a measure for people who - where it's being included.

Tracy Flanagan: Hi, this is Tracy Flanagan…

Woman: (Unintelligible)…

Tracy Flanagan: …I joined a little bit late because of competing priorities, but I think - I just want to add that I think that's a great idea. It might be hard to measure, but it's a great idea.

Carol Sakala: Hi, Tracy.

Ashley Hirai: Hi, this is Ashley Hirai with the Health Resources and Services Administration. So I just wanted to add on to the severe maternal morbidity comment, that is a national outcome measure for the Title V Maternal and Child Health Block Grant Program, and it's being used in the Alliance for Innovation on Maternal Health, maternal safety bundles and hospitals through ACOG.

I just want to mention that I believe CMS is pushing for that roll-out measure to be in maternal morbidity, and Elliott Main who runs CMQCC is working on risk adjustment and I think thus plan to submit a measure for NQF endorsement. And so I think that's great because they can be used at the population level, so we monitor at the state level and if it's risk-adjusted perhaps at the hospital level.

But I really like what Kim had mentioned in terms of timely treatment for a certain condition because I think that it gets more to the heart of what hospitals and NQF can be doing, because some of those indicators that are parts of severe maternal morbidity procedure codes now do reflect appropriate responses to the (specific) emergencies. So I just wanted to add that piece there. Thank you.

Kimberly Gregory: You know, another measure that sort of got started but then faded away is appropriate DVT prophylaxis. I know there's a consistent way in which that's being applied nationally for pregnant and/or postpartum.

Matthew Austin: Yes, so this is Matt Austin. On Leapfrog's annual hospital survey, Leapfrog does ask hospital to report on the percentage of women undergoing a cesarean

section who received appropriate DVT prophylaxis. So that's definitely like a segment of what you would be talking about, Kim.

And I think it used to be an NQF-endorsed measure and I think the measure steward made the decision not to get it re-endorsed and so - but Leapfrog has continued to use that measure.

Woman: That is correct. (Unintelligible) not resubmitted. Sorry, go ahead.

Tracy Flanagan: The difficulty with the measure is that I don't think we have complete scientific consensus -- this is Tracy Flanagan -- on how broad we want to do prophylaxis, you know, what is the threshold and what is the - what are the different strategies we want to use and how broadly we want to do it to get down to what level.

And I think that's why it becomes a difficult measure. It's not that don't want to prevent it, it's just that it's hard to define a threshold and a set of strategy that everybody agrees on.

Kimberly Gregory: Yes, Tracy, you're correct. And I also think even though we know the common cause of death, we don't really have a measure on that (at NQF), although I guess it's important. But an idea of not only how many died, but how many occurred related to (unintelligible), it would maybe give us more impetus to come up with a plan.

Tracy Flanagan: I think - and I - let me just add a comment on that because I think that's a great point. I mean, I think those of us who have been involved with CMQCC have seen the work and you know, the leading cause of death is maternal hemorrhage, the second cause of complication death is severe preeclampsia,

and it trickles down. VTE is not one of the - I mean, it's up there in the top 5, but it's not as high as far as maternal death anyway.

Carol Sakala: So thank you all. Are there any other measures that you would like to share that you're aware of that are currently in use right now in various hospitals, health systems, quality collaboratives, et cetera?

Tracy Flanagan: This is Tracy Flanagan. I just want to add one more comment on that. You know, through the years I've been on this committee, we've talked about what kind of measures we could introduce in the prenatal space which impacts morbidity in a positive way in order to decrease morbidity.

One thing we're working on in Northern California is a measure on preventing anemia on admission to the hospital by adequate supplementation and attention to anemia in third trimester, and we've actually seen positive results that are statistically significant.

And so I'm not necessarily suggesting that, but I guess my point is that it would be wonderful if we could again circle around to measures that evaluate our prenatal care to think about prevention and morbidity in the hospital setting.

Carol Sakala: That's a great point, Tracy, and just asking if that stimulates any talks about things people are doing both in the prenatal care and in the postpartum care to address morbidity and mortality issues.

Kristi Nelson: So this is Kristi Nelson, sorry, with Intermountain in Salt Lake City, Utah. We are doing - currently measuring PMAD testing both in the prenatal and then again in the postpartum phase in the clinics, and that is going to be a HEDIS measure I believe for next year.

So there may be some thoughts around, for us, in Utah, the number one cause of maternal mortality is overdosed and suicide. It accounts for about 48% of our maternal losses. So, for us, that's a huge area of focus.

Kimberly Gregory: Could you say again what you're testing for, is it drug testing in urine? I couldn't hear what you said.

Kristi Nelson: No, no, no, we're just doing the - we're just screening for perinatal mood and anxiety disorders either using the PHQ-9 or EPDS during pregnancy.

Kimberly Gregory: Thank you. Yes, yes, sorry, I couldn't hear you.

((Crosstalk))

Kristi Nelson: (Unintelligible) broke up in a friendly way.

Kimberly Gregory: Yes.

Kristi Nelson: I'm sorry. And with that - that is one - that’s our largest cause of maternal mortality here.

Kimberly Gregory: I would second that and that it is going to be an emerging HEDIS measure and I think there's a huge emphasis on perinatal depression, and identifying and hopefully mitigating some of it.

Carol Sakala: Thank you. And also in terms of recent resources, I think it was CMQCC or definitely in California that issued the report on the contribution of suicide to maternal mortality.

Ashley Hirai: And the AIM program, if you just Google it they have a bunch of measures - structural process measures that I would add that to with screening and treatment for opioid use disorder.

Carol Sakala: Okay, anything else that people are now using across the entire episode of maternal care?

Amy Bell: This is Amy Bell. We're having more discussions within our system. I think with chlamydia screening is kind of beyond just the screening piece and looking at it will actually appropriately treat those patients for chlamydia and other diseases. But I just wonder if there's any appetite for some kind of measurement for how we actually try to treat the patient.

Kristi Nelson: I think I know HEDIS measures for prenatal and postpartum depression are now linking screening and appropriate treatment for those who screen positive. That seems to be an important trend in the field.

Woman: I think she was talking about chlamydia screening though.

((Crosstalk))

Kristi Nelson: Right, but I'm just saying I - I'm just saying that I think it's really good to move in general in our measurement to add appropriate follow-up to the screening.

Woman: Good point.

((Crosstalk))

Woman: Another measure to …

Kristi Nelson: Right, multiple outcome measures for the multiple process measures that we currently have.

Woman: Maybe this is an old topic, but, you know, screening for risk for substance use and abuse, timely topic, is a part of prenatal care.

Diana Ramos: And this is Diana Ramos. One of the things that we're looking to establish, but it'd be interesting to look at for those that already have it is the maternal levels of care, whether or not the care is delivered at the right appropriate care hospital.

Carol Sakala: And again on the resources point, there's a new update about guideline. Okay, so we can come back if people additional thoughts about what you are using.

In terms of the question of what measures you are aware of that are under development or testing, I think it was Ashley mentioned that Elliott Main - no - yes, I think was Ashley that Elliott Main is working on severe maternal mortality measure that includes risk adjustment. And is there any - are there any other insights now into development or a test going on?

Matthew Austin: So this is Matt Austin. Just a clarification real quick, is that a severe maternal mortality measure or severe maternal morbidity measure?

Carol Sakala: If I said mortality, that was wrong. It's severe maternal morbidity, but with needed risk adjustment.

Matthew Austin: Okay, great. Thank you for clarifying.

Carol Sakala: Kim, is the measure that you're developing, would you consider it to be relevant to this topic or is it something a little different?

Kimberly Gregory: No, actually it's more related to satisfaction.

Carol Sakala: Okay.

Kimberly Gregory: No, you would be dissatisfied if you died, so it would not fit here.

Carol Sakala: Okay. Okay, well, it doesn't surprise me as I mentioned to - in our preparation call every chance I get, I identify in policy circle the need for resources to fill gaps in our field. I wish I was hearing a lot more about things that are under development at this time. But it's fairly expectable that there wouldn't be a lot right now.

Let's move to the issue of measure concepts that you would suggest for this area. It seems like we've identified a lot of concepts already that are being used for QI purposes, surveillance purposes. So which one among those and also that may not have been mentioned would you prioritize for moving to the level of measures that would be submitted for national endorsement and part of our portfolio?

Kimberly Gregory: Well, I think one of the things that we missed or we didn't bring up is; A, postpartum measure and I know there was one and then it was retired. But I think in the light of the fact that we mentioned the morbidity actually can impact the mortality as it occurs postpartum, we should revisit that.

And I think that Tracy's point about the anemia brings up the point that we don't have any kind of measure to measure the quality of the content of the

prenatal care. And so I think that those are two big areas that are right for development.

Carol Sakala: So I have a couple ideas on this question and I'll just throw them in during the flow. There is growing recognition -- and it follows up on some of the comments you already made, Kim -- there is growing recognize of the importance of patient-reported outcome measures and also patient-reported experience of care measures.

We have a factsheet at the National Partnership for Women and Families on the many, many ways why the CAHPS surveys of experience of care do not map well to our clinical area. We'd be happy to share that with anyone who's interested. And the reason I bring up - well, it's also adaption of CAHPS' clinician and group facility and health plan measures is provision in the Quality Care for Moms and Babies Act that is filed in both chambers for Congress.

And the reason that I bring this up in this context is all of the anecdotal information where women are saying that they were not listened to, that they were not respected, that they were ignored, delayed in care, et cetera, and also from family members, for women who were no longer with us to make these reports.

So it seems to me that we're really ripe right now for measures - maternal - women-reported measures of the experience of receiving both maternal and newborn care that's adapted for our field and for these issues that we're hearing about.

And also I'd like to put in a plug for women-reported composite measure of the outcomes of the full episode of care to get into the idea of prevention of

things that are occurring in the postpartum period, and make really good use of postpartum visits that do occur right now. We, in listening to mother surveys, have identified a broad range of new onset maternal morbidity and we've been able to document in many cases, those persist to six or more months.

And so I would encourage development of those two measure concepts for our field right now in line with broader recognition of the person-reported outcome measure significance.

Tracy Flanagan: I - this is Tracy again, I'm saying yes, yes to everything you're saying. I don't know if it's a purview of this committee, but I continue to struggle with really poor tools that are available to evaluate all of the things that you said, including the entire episode of prenatal care.

Kimberly Gregory: So this is Kim. So the patient-reported outcome she said is something that we are working on. It's about halfway through the NQF pathway so we got a way to go, but we are definitely trying to come up with the patient-reported outcome measures for the childbirth experience, specifically the hospital experience.

And then one of the - again, another measure that we have seen in the past that I know that there are some interests in the physiologic birth measure which is another patient-reported experience I guess. I'll just throw that out there.

Carol Sakala: Thanks, and I could just add to that that it's a - there's a formal definition in the revitalized (metric) data definitions project. And in listening from others, in California survey which is hospital birth in 2016 population they sampled from birth certificates, we were able to apply that measure and it came up at 5% of hospital birth met the criteria in the revitalized project.

And in contrast to that, I would say we identified a lot of interests in women in moving more in that direction. Kim, do you have more to say about that?

Kimberly Gregory: Well, it doesn't surprise me. It's hard to get a physiologic birth once you get in the hospital. It's hard to teach physiologic birth once you're in the hospital. Doctors just want to do them.

Carol Sakala: And that also would be a very preventive strategy so it is related to this current concept - current discussion to work upstream, reduce the number of cesareans and keep women on a healthy pathway where they are not getting into a cascade of interventions and other things.

And also that approach to care requires a lot of attention, so they would be - the care providers would be in close touch and contact with the women and be identifying any deviations from normal quite quickly.

So other measure concepts to identify or to uplift from all the ones we discussed earlier that would be priority for development should resources become available?

Okay, so the last question is, are you aware of any groups or organizations working on measurement and measure development in this topic area? We've already touched on that a little bit, but welcome further thoughts there.

Kimberly Gregory: I guess the only organization that hasn't been brought up and I don't know what they're doing with it is ICHOM which is International - I don't know, ICHOM I believe.

Matthew Austin: That's Consortium for Health Outcomes Measurement.

Kimberly Gregory: Right, and so they are putting together what they think might be some reasonable childbirth measures, but nothing that we haven't already discussed.

Tracy Flanagan: Kim, was that your voice?

Kimberly Gregory: Yes, ma'am.

Tracy Flanagan: Hi, Tracy, you know, I started that committee three years ago or so and there was a whole measure set that was put forward as a potential measure set that was actually really patient-centered. I don't think it's new work, I think it's older work unless there's new work going on.

Kimberly Gregory: No, it was quite interesting. That's the work I was referring to.

Carol Sakala: Yes, so, Tracy, this is Carol. I was also on that group and it was - I think they had great measure concepts. It was intended to be measuring outcomes and measuring things that are important to women themselves, all good, but they drew a lot on measures that hadn't been gone through the testing process to meet the NQF requirement.

So that said, it's out there. There is also a paper from our group that was published in one of the BMC publications, I'm not sure which one. But a lot of those are - they are pushing them out for use without - and having drawn them from the QI work, tools that have been used in research context, et cetera, but haven't gone through that kind of testing that our committee would, but it would be required to take a look at for inclusion. So there could be some further development there of measures in that (sub).

Tracy Flanagan: Great point, yes, I completely agree. And I would also say that in sitting in that committee, the context was international, meaning all kinds of healthcare settings, so some of which came on that felt at a lower threshold than we're thinking about, or in some ways, the higher threshold. But your point is great. I was thinking more of it as a place to turn for other groups that had thought about this, not necessarily tested it.

Carol Sakala: Yes, so I'm aware too that in addition to what we're all using for QI tools that have been developed for research, there are so many out there that could be assessed for their suitability for bringing forward and testing so that we don't have to reinvent the wheel from the ground up. So there's a lot of potential out there. We had the resources to support developers in this work.

Okay, well, if there are no further thoughts, I think we can probably move to the women's health measure gap section of this session.

Suzanne Theberge: Yes, thank you so much, everyone, for really great discussion and ideas, and we will certainly be in touch with more information. We'll let you know when the project - we'll send you the formal announcement when we get that out and we'll let you know more information as that project gets going, including our upcoming call for nominations for committee members and other times that we'll be meeting. So thanks so much.

And now we will move on to the other half of our discussion today. We thought it would be interesting to have this committee - this is perinatal and women's health committee. And so we thought it would be interesting to have you talk about what other measure gaps there are in women's health more broadly outside of the perinatal time period and outside of the kind of limited time that we have right now, it really focuses on obstetric care and then perinatal care in this portfolio.

So we did take a look at our full portfolio. NQF has 541 endorsed measures and of that 541, 29 of those look at women's health topics. And the way that we sorted out measures, we decided that measures that focus on conditions that exclusively or largely apply to women like cervical cancer or osteoporosis would be included in this subset of measures.

But measures that include women in the population, measures for populations that are disproportionately women or measures that affect a large number of women are not included. So we don't have like cardiovascular measures in here even though lots and lots of women have cardiovascular conditions. We don't have measures for skilled nursing facilities even though that is disproportionately women population. We're really looking at women's health topics.

And so there are 29 measures. I think the bulk of them outside of the perinatal and reproductive health arena, you know, are breast cancer measures and osteoporosis measures, and then we have a couple of measures on hysterectomy and a few other things.

We put all those into the memo in Appendix A and also put them in the Excel file that we attached to the invite. But we couldn't really get the list up on a slide in a way that was easier to read, so we thought we would refer you to the memo as needed.

But just for some more background information, when we get measures in the door in NQF, we look at what type of clinicians is going to treat this condition, and so that's how we assigned them to a topic area. We're looking for the clinicians that treat a particular condition to be the ones that are evaluating it.

So, typically, our osteoporosis measures go to the Primary Care and Chronic Illness Committee. Our breast and cervical cancer measures go to the Cancer Committee. Vaccination measures are all in Prevention and Population Health. So even the ones that would apply to pregnant women, you know, would go into that because that's where we keep all of our vaccine measures. So - and then if we would - if we needed to, we would pull an expert or two from another committee to pull in any expertise that might be needed on the committee.

So that's kind of the summary of how we get to where we put measures and what we have. And you know, I can be pulling up the list and reviewing it quickly verbally. It is in the memo. But as I said, you know, we've got cervical cancer screening, chlamydia screening, several measures for osteoporosis including screening, and then management.

We have several measures on various breast cancer treatments, then we've got all the measures that are in this portfolio which will include the pregnancy and delivery, and then the other HPV vaccination for female adolescents, a couple of measures around hysterectomy care and that's about it.

So we wanted to hear what you thought, where are the gaps here. So there's obviously a lot of conditions that are not being addressed in that portfolio and so we'd like your feedback on what you see would be some really important quality measures to look at in the future.

Rajan Wadhawan: Hey, this is Raj Wadhawan from Florida. I have a question, do we have any measures around postpartum depression?

Suzanne Theberge: No, we do not.

Rajan Wadhawan: So that might be a consideration. I don't know how others feel about it, if anybody else had an opinion, but that may be a valuable thing to look at and something that's really important.

Diana Ramos: Yes, this is Diana Ramos. In California, there's a new legislation that's going to require that and I think having something that would be a push to help adhere to the new regulation, that's a great idea.

Rajan Wadhawan: Thank you.

Kimberly Gregory: So this is Kim. I think one thought is I think that that HPV vaccine should be measured in both women - I mean, boys and girls. It'd be ludicrous if just - I mean, we all know we're not just fascinating girls and so we should be tracking it in both sexes even though the main outcome we're trying to present is cervical cancer. So I think that that's a gap.

Suzanne Theberge: Okay.

Kimberly Gregory: But is there anyone aware of any other measures that are currently in development that would fit the women's health portfolio?

Amy Bell: This is Amy Bell. I was just …

((Crosstalk))

Kimberly Gregory: I'm not sure about whether this is in the pipeline, but it certainly seems that there was a lot of talk about trying to find measures to capture the churn and the people falling off of coverage and trying to find ways to have

qualified beneficiaries to stay on the program through the life course instead of continuing to come on and off.

Amy Bell: I agree. This is Amy Bell. I think to tie in the last two thoughts together would be around HPV. Currently, it's for female adolescents. That was the CDC coming out with recommendations for vaccination at the age of 45. I believe that's something we should consider endorsing it for a different age group.

Kimberly Gregory: That's a great point. I've forgotten about that. Thank you.

Deborah Kilday: Okay, well, I'm going to borrow from the previous question. If you're not aware of any measures that are currently in development or testing, are there any concepts that you would suggest that we should be thinking about?

Tracy Flanagan: This is Tracy Flanagan. One of the things we've been measuring for 10 years now is the percent of hysterectomies done minimally invasive. And it's kind of amazing to me that women are subjected to large incisions when it could be done in two small incisions with no net change in complications, and a lower hospitalization, have faster recovery. So I would vote for a minimally invasive incision choice for hysterectomy.

Amy Bell: Tracy this is Amy Bell, I agree with that. We are starting to look at for next year making it part of decision compensation goals, that concept with uterus that are less than 250 grams just to have a kind of a marker to get for.

Tracy Flanagan: Just to let everybody know, you know, we started this work about seven or eight years ago and we were at I think around 60% when we first started the work of minimally invasive defined laparoscopic or vaginal irrespective of size of uterus. We are at 96% and it makes my heart ache to know that

women in the community are not offered a minimally invasive approach consistently.

Kimberly Gregory: That's pretty impressive. Okay, well, I'm not hearing a wealth of other options. So should we move the agenda and maybe get to the action time in the game?

Carol Sakala: Kim, this is Carol and I just wanted to share that I invited my colleagues at the National Partnership for Women and Families to sit down and brainstorm on this topic, and we have a list that we identified that it'd be happy to share with folks.

We identified - and a lot of this would be something like screening and follow-up as the approach to it. We identified intimate partner violence, disordered eating. Cyberbullying was mentioned and I do not know if that is disproportionately women or not. Another one was burden of caregiving which definitely disproportionately women and has adverse impacts for their health, their economic security, et cetera. Fibroids were mentioned, endometriosis.

We did discuss a few minutes ago postpartum depression, but we would add prenatal depression and also prenatal and postpartum anxiety. In The Listening to Mothers in California survey, the screeners that we included identified more prevalent anxiety than depression and also more prevalent in the prenatal period than in the postpartum period. And certainly, prenatal anxiety is closely related to stress and birth outcomes.

People also identified that the consistent reports of women's pain is not taken seriously, so that could be some kind of assessment there. A comment was

made that the reproductive health world has a real blind spot in the health of trans-women, so we would throw that out.

And then people also said that everything should be stratified whenever feasible and make sense by race and ethnicity. And someone who is working on the WPSI, the Women's Preventive Services Initiative I think it is, identified the example of - that cervical cancer screening may need to have a more frequent interval for Latinos. I can't provide background information about that, but those are the things that our group discussed and asked me to carry forward to this discussion.

Kimberly Gregory: Thank you. I know actually WPSI is in the process of coming out with an endorsement for screening for anxiety and there's a lot with that we're discussing.

Amy Bell: Carol, this is Amy Bell. I would just echo the recommendation about really looking at data and performance by race and ethnicity. We are being asked more and more about our senior leaders, how we are performing in this maternal morbidity and mortality related to that.

So being able to have more data infrastructure in place to pull that information I think would be extremely helpful. But also I think, as a nation, we need to be able to look at our information that way and more timely than how we are able to get some information now.

Deborah Kilday: Hey, Amy, this is Deb Kilday, I want to kind of second that process. We can dive a little bit deeper into our data and it can be more timely. And more timely accurate data that identifies population specifically will give us more insight on exactly how we can approach an improvement effort.

Amy Bell: Yes, I completely agree.

Tracy Flanagan: This is Tracy. I think I agree with what everybody just said. What if we look at some of the - our existing ones and ask for a race/ethnicity cut on all the data?

Amy Bell: I think that would be great. I don't know how feasible it would be for organizations to pull it, but if we can get to that level and detail, that would be a nice way.

Tracy Flanagan: Well, I know that it's extravagant. Premier hospitals can pull it that way. We are pulling it that way for our members and it is proven to be quite powerful.

Amy Bell: I will say that one - this is Amy again. One issue that we have run into is just the accurate information that could end to the medical record by our registration committee. And if don't appropriately ask questions and assume certain races or assume certain ethnicity, then our data can be very skewed. So I think this is a work to do at the facility level to change that.

Diana Ramos: And this is Diana Ramos. The other thing too to consider when you're looking at race and ethnicity outcome is also to look at the geographic variation and distribution because that also adds a lot of information and opportunity for intervention.

Woman: Were you thinking of rural and urban, or something else?

Diana Ramos: Rural, urban, east, west, I mean, just the different states, you'll see different outcomes so - and not to assume that just because it's African-American, you're going to have the same trend nationwide. But you actually - we see that with a lot of outcomes, you know, with obesity, hypertension, et cetera.

Woman: Speaking of new measures, I don't know if anybody has tested that or if there's any testing in place about appropriate weight gain during pregnancy. I don't think any of us mentioned that any time during this call. But I think that's an important measurable thing that can happen to both as a preventive thing as well as lifelong prevention.

((Crosstalk))

Jermane Bond: Hi, it's Jermane from NQF. Sorry, go ahead.

Amy Bell: Sorry, go ahead. This is Amy Bell one more time. I think that it would be important if there's a way to get this information that's looking at the social determinants of health. I know that can be kind of like probably more (than a piece). But I think it would be important to be able to measure as we are addressing some of those social determinants for all age of women.

Jermane Bond: Great point. This is Jermane Bond from NQF. I just wanted to ask the question of group about a particular measure that we haven't heard much about potential measure or measure concept and I wonder if the group has heard or been involved with any measures of paternal involvement in the perinatal period or in women's health.

((Crosstalk))

Kimberly Gregory: You know, I don't understand your question of paternal involvement. I cannot …

Woman: Oh paternal.

Jermane Bond: Yes, paternal. Yes, there is a growing body of research that speaks to the fact that when a father or expectant father is involved, women are likely to receive early prenatal care and often have less stress during pregnancy and potentially better outcomes. I just wondered if the group has thought about that or has heard anything in that regard.

Jennifer Bailit: This is Jennifer Bailit. I have some really concerns about that. I think that data is associative and not necessarily causal. Also, we don't have any clear evidence on that. I also don't want to incentivize people to be in a situation where they're encouraging women to stay with somebody who's not good for them because of a measure. So I am concerned that without a balancing measure, we could do some real harm with that particular concept.

Kimberly Gregory: I also - well, I think that there is good data about social support and I guess the idea of a measure of social support could have some merit especially given the dynamic and fluidity with which our relationships are now.

Carol Sakala: Kim, I like that concept much better.

Kimberly Gregory: Okay, so, Suzanne, I was just going to the next slide.

Suzanne Theberge: Sure, so, yes, we can now open the lines for NQF member and public comment if the committee is done with this discussion. And thank you very much for all of your thoughts and input. We will be writing all of the stuff and sharing that summary with you, and sharing this with also our developer colleagues especially some of the thoughts on the expansion of some of the existing measures, the HPV measure and some of the other ones. We can share that with the developers.

So with that, we can now open the lines for NQF members and public comments. So if anybody from the public would like to make a comment, you can do so now either via phone line or via the chat box, and we'll just pause now to see if anybody has a comment.

Okay, hearing none, I will turn it over to Hannah who's going to talk briefly ant next steps. Hannah?

Hannah Ingber: Thanks, Suzanne. So we're going to speak a little bit about the fall 2019 measure cycle. We're excited that we have two measures that were submitted in time for the Intent to Submit deadline.

One is late onset sepsis and meningitis in very low birth rate neonate; and the other is patient-centered contraceptive counseling. We've been working with the measure developers and are very excited to bring that to the panel in the next cycle.

There was a method panel right now for review, so we'll be bringing some more updates on that soon.

We also have our call for nominations period opening soon for next cycle and welcome any input on that from the committee. The submission deadline is November 8.

So also next cycle we have three meetings given that we have measures, so we have our orientation meeting on January 10, our measure evaluation webinar on February 7, and our committee post-comment webinar on May 8. And those invitations have gone out to remaining committee members.

We thank you for your time and I'll hand it back to Suzanne.

Suzanne Theberge: Thanks. Thank you, Hannah. And I'll just add a little more context, we may be pushing the neonatal infection measure to a later cycle because it may be competing some of the other measures that you've looked at previously. So we may end up only looking at one measure this cycle, but the good news is that we are going to be evaluating a new measure so that's exciting.

And we'll have more information for you in November once the final measure submission deadline has passed and we have the full set of information. But for now you can hold those three days.

We will need everyone to attend the orientation call in January. We have made some changes to the criteria and the process since you've asked evaluated measures so we want to make sure that you all have that information before we send out the measure - more measures to you in mid-January. So we're really excited about that.

And again, we are going to be sitting a few new committee members this fall. We'll let you know when that call for nominations opens on October 1st and we thank those committee members who are stepping down and look forward to having some new folks joining the committee.

So with that, we'll pause and see if there are any other questions before we adjourn. Great. Well, thank you so much, everyone, for your time today. We really appreciate your input and your comments, and we'll be in touch with the meeting summary and with more information about our upcoming work in the next few weeks. So we can give you back about 15 minutes. Thank you so much.

Kimberly Gregory: Thank you, everyone. Have a great day.

Carol Sakala: Thank you.

Woman: Thank you.

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