CHILDBIRTH CONNECTION
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national partnership for women & families
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January 13, 2011

Carolyn Clancy, MD
Director
Agency for Healthcare Research and Quality
Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850

Attn: Office of Extramural Research, Education and Priority Populations

Re: CHIPRA PQMP Priorities (75 Fed. Reg. 75469-75471)

Dear Dr. Clancy:

As consumer organizations committed to improving the quality of health care of women, children and adolescents, including prenatal and reproductive health services, Childbirth Connection and the National Partnership for Women & Families appreciate the opportunity to comment on priorities for the pediatric quality measures program, and, in particular, those for enhancement of the initial core measurement set and the development of new measures.

The CHIPRA initiative and its associated funding afford us a much-needed opportunity to focus national resources and attention on performance measurement in the realm of child health care, including the promotion of healthy birth, and we applaud you and your agency for your vigorous implementation of this new program. Our comments and suggestions are organized to correspond to the structure of the *Federal Register* notice of 12/3/10.

1.g. *Increase the ability to rely on non-Medicaid and CHIP data sources.*

As our nation's capacity to capture and share data electronically increases, it is important to explore opportunities to link multiple reliable data sources to identify quality problems and successes. The core measure set already includes an NQF-endorsed measure – the Cesarean rate for low-risk first birth women – that relies on birth certificates as its data source. In its December 2010 report, *Toward Improving the Outcome of Pregnancy III*, the March of Dimes strongly recommends enhancing the linkages between our vital records system, hospitals, and others to create perinatal databases – such as the Massachusetts Pregnancy Early Life Longitudinal (PELL) - to support epidemiologic research and program evaluation. We would also encourage exploration of secure linkages between the health and education systems to allow

development of outcome measures such as appropriate control of children's asthma with school attendance.

2. *Development or enhancement of measures in key topic areas*

b. Availability of services

Citing Level A evidence, practice bulletins of the American College of Obstetricians and Gynecologists recommend counseling and offering Vaginal Birth After Cesarean (VBAC) to most women with one or two previous cesareans, a recommendation that arose through the 2010 NIH Consensus Conference on Vaginal Birth After Cesarean: New Insights. Nonetheless, access to VBAC has plummeted since the mid-90s. About one-half million childbearing women annually have a history of cesarean, and many desire but cannot find a willing hospital or caregiver to support their vaginal births (*Listening to Mothers II* survey report, available at www.childbirthconnection.org/listeningtomothers/). A prior cesarean, and especially multiple prior cesareans, is associated with numerous serious conditions for women and fetuses/newborns, including placenta accreta, placenta previa, hemorrhage, and emergency hysterectomy. Other risks of cesareans to newborns include: iatrogenic prematurity, surgical injuries, respiratory problems, and interference with breastfeeding. An appropriate performance measure could contribute to reversing this trend and reducing the total cesarean rate. Performance measures we recommend the agency consider include: facilities with immediate access to 24/7 surgery; VBAC rate in low-risk women; the proportion of low-risk women with one or two previous cesareans who were counseled, offered or referred for VBAC; and facility access to VBAC, as indicated by a VBAC rate of five percent or higher.

d. Content rather than utilization measures

Well child/well adolescent measures. The core measure set includes the NCQA HEDIS® well child/well adolescent measures. While these are valid access measures, they are inadequate for determining whether or not the visit(s) encompassed critical aspects of the child's appropriate growth and development. We recommend they be replaced with composite measures incorporating the elements of well child care – screening, counseling, immunizations, and healthy physical development assessment. The National Quality Forum is currently considering a number of child health measures and such a measure or measures may be in their final endorsed set. Those measures would be appropriate candidates for incorporation in any update of the core set.

Prenatal care measures. The core measure set includes the HEDIS measure of the number of prenatal visits. As with the well child/well adolescent measures, this measure offers no information on what aspects of care were addressed during those visits. We would encourage development of a composite measure that would incorporate measures to capture whether certain standard screens and processes were done (HIV and STI screens, blood typing and antibody testing, counseling on medication, alcohol and tobacco use, offering tobacco cessation medication support, etc).

Postpartum care measures. The proposed initial core set of measures for Medicaid-eligible adults, currently posted for public comment, includes the NCQA postpartum care rate measure. This, too, is an access measure and does not capture any information about the comprehensiveness of that care (depression screen, continued tobacco cessation support, nutrition, family planning, lactation support, etc.). (*Listening to Mothers II report*, available at www.childbirthconnection.org/listeningtomothers/). We recommend development and testing of such a measure or measures to fill this critical gap.

e. Specific care settings and conditions.

e.i and iv. Perinatal and inpatient. The national *Listening to Mothers II* survey found that almost half of babies were primarily with hospital staff in the first hour after birth, 10 percent due to the need for special care, but 39 percent for routine care. A growing body of research, summarized in the Cochrane Review on Early Skin-to-Skin Contact for Mothers and Their Healthy Newborn Infants, finds numerous shorter- and longer-term benefits and no downsides to maternal-newborn skin-to-skin contact in the period after birth. Benefits include favorable impact on breastfeeding at one to four months, on maternal affectionate and attachment behaviors, and on infant crying. A quality measure is needed to provide incentives for routine skin-to-skin contact of women and healthy newborns in the period after birth.

e.vi. Care coordination/care transition measures. Effective care coordination – between primary care and specialist, between inpatient and outpatient, between primary care sites when the child moves to another geographical area or must change providers because of a change in health plan coverage or aging from adolescent to adult care, between health care providers and other settings where care is provided (school, special camp), etc. – is central to maintaining a child's optimal health and development. There are, however, no care coordination measures in the recommended core set except for the questions asked of a parent in the HEDIS CAHPS 4.0 and its chronic conditions supplement, and these are directed primarily at access rather than coordination. We recommend the development of care coordination measures, including those between sites of care, have a high priority. Integration of such activities with the Office of the National Coordinator for Health Information Technology's meaningful use activities could be fruitful.

e.vii. Additional measures related to family experiences of care

Maternity care. The generic Consumer Assessment of Healthcare Providers and Systems (CAHPS) clinician, facility, and health plan surveys do not adequately capture many dimensions of the experience of maternal and newborn care, including the fact that two patients receive care at this time. Other limitations are inadequate measurement of the diverse settings of care (e.g., hospital but not birth center focus), of the diverse caregivers (e.g., physicians but not midwives or nurse-practitioners), of the various dimensions of pain, the complexities of medication administration, etc. As childbearing women and newborns constitute 23 percent of those discharged from U.S. hospitals, by far the nation's most common and costly hospital condition, specific adaptations of the CAHPS provider, facility and health plan surveys are urgently needed. We would further recommend consideration of incorporating questions from the CDC PRAMS

population survey tool which is now widely used by states and helpful in identifying disparities in care as well as gaps in community support systems.

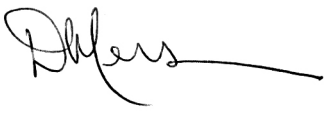
Adolescent self-reports. In its 2008 policy statement the American Academy of Pediatrics' Committee on Adolescence (*Pediatrics* 2008; 121:1263-70) stressed the importance of building a trusting, confidential relationship between adolescent and clinician as a foundation for discussion and addressing risky behaviors or emotional problems. The Committee recommended the development and implementation of "feasible, valid and reliable quality measures…that use adolescent self-reported data to help assess the quality of preventive care provided to youth." The Young Adult Health Care Survey (YACHS) developed by CAMHI and endorsed by the National Quality Forum is one example of a survey that targets this issue, but it has had limited use, possibly because it is long and expensive to administer. We would recommend a review of YACHS and/or similar surveys, in conjunction with possible adoption of a composite well adolescent visit measure, to determine the feasibility of developing a shorter survey that focuses particularly on the quality of clinician-adolescent communication. It would also be desirable that such a survey be capable of administration electronically.

e. viii Health outcome measures

Outcomes are of paramount concern to consumers, purchasers, and other stakeholders. Outcome measures are also urgently needed to help shift incentives from volume to value. Over 4 million babies are born annually in the U.S., most at term and without serious risk factors at the end of pregnancy. During the intrapartum period, this largely healthy population is exposed to high rates of procedures: 6 of the 10 most common hospital procedures are maternity related, and cesarean section is the nation's most common operating room procedure. Within its Overuse focal area, the National Priorities Partnership has identified the priority of addressing unwarranted maternity care interventions. A measure of outcome in term newborns without significant risk factors at the end of pregnancy can provide an incentive for more appropriate care of low-risk women and newborns. The National Quality Forum is currently considering endorsement of a Healthy Term Newborn measure (Patient Outcomes Project Phase III-Child Health, OT3-031-10). We strongly encourage adoption of this quality measure as a CHIPRA measure. We also recommend pairing it with a companion composite maternal outcome measure, in light of the significant burden of new-onset maternal postpartum physical and mental morbidity documented in Table 1 of the *New Mothers Speak Out* report, available at www.childbirthconnection.org/listeningtomothers/. Both measures should also be tested for potential to identify disparities in care.

Thank you for this opportunity to comment.

Sincerely,



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