Evolving the Maternal Health Quality Measurement Enterprise to Support the Community-Based Maternity Model

Anna Kemmerer and Tanya Alteras, MPP

Introduction

There is growing evidence and consensus that the community-based model of maternity care – one that centers on the use of midwives, doulas, birth centers, and other perinatal community health workers – is tremendously valuable to addressing the ongoing maternal mortality and morbidity crisis. Over the past decades, the growth of the medically-based maternity model – focused more on clinical maternity care – not only eradicated more traditional methods of delivering maternity care, but led to the development of perinatal quality measures that prioritize clinical process, yet de-center the patient voice and undervalue patient autonomy.

There is broad support for transforming maternity care to expand affordable access to the community-based model. This transformation should be accompanied by quality measures that focus on patients' experiences receiving care from providers other than OB/GYNs and outside of hospital settings, that, when combined with traditional clinical measures, create a comprehensive set of measures for use across hospital and community-based settings alike. Patient-Reported Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) – including ones that assess the extent to which respectful care is being received – are key to centering the experiences of those most impacted by the maternal mortality and morbidity crisis.

The quality measurement enterprise moves slowly, however. While significant progress is being made in increasing the uptake of the community-based maternity model, the development and implementation of respectful maternity PREMs and PROMs is not moving as quickly. Through its Learning Community meetings, the Maternal Health Hub, a project led by the Health Care Transformation Task Force with support from the Commonwealth Fund, identified several organizations that are developing innovative patient-focused measures to fill existing gaps and better serve birthing people across all modes of maternity care.

A previous Maternal Health Hub issue brief summarizes the challenges in the current system and solutions needed to expand affordable access to the community-based model of maternity care.

Terminology

Birthing persons is a term used to describe pregnant persons that is inclusive of all genders and gender identities. Not all birthing people identify as ***women*** or ***mothers***.

This resource uses both gendered and non-gendered language such as birthing persons, pregnant people, mothers, and women to reflect the terminology used by various stakeholders and found in the referenced literature.

Gender neutral language is used when not directly citing an external resource to be inclusive of all birthing persons.

Creating a New Measurement Paradigm

Perinatal measures currently used in payment programs focus on clinical factors and processes, such as the timeliness of prenatal care, or the percentage of birthing individuals who received postpartum care. These clinical measures, while relevant to the overall health outcome of a birthing person, do not provide any data on patients' experiences with their maternity care at any stage (prenatal, labor and birth, and post-partum). However, changing the maternity measurement paradigm comes with several challenges:

The Centers for Medicare and Medicaid Services (CMS) Core Measures for Maternal and Perinatal Care:

- Prenatal and Postpartum Care (PPC-AD)
- Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)
- Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)

- ***Maternity Care Measures Do Not Assess Team-Based Care:*** One of the hallmarks of the community-based maternity model is the emphasis on team-based care delivery, with a team comprised of a midwife, doula, perinatal health workers, and community-based supports. The medical maternity model that the current maternity quality measurement portfolio is designed to assess may employ a team-based care model, but that is not the baseline. Layered on top of this is the fact that the medical model (for maternity care as well as for most other conditions and patient populations) is fragmented, lacks interoperable data infrastructure, and generally does not support the measurement of coordinated team-based care.
- ***Lack of Patient-Reported Outcome and Experience Measures (PROMs/PREMs) Implemented in Payment Programs:*** Across the quality measurement enterprise there has been a lag in the implementation of PROMs and PREMs in payment programs. This results in a lack of measures that are meaningful to patients, particularly when used in tandem with clinical quality measures. The Centers for Medicare and Medicaid Services (CMS) have made a commitment – via the Meaningful Measures 2.0 initiative – to prioritize patient-reported measures in support of the goals of promoting health equity, closing gaps in care, and empowering consumers to make informed choices.[1] This commitment will hopefully elevate the push for development of PROMs and PREMs that better reflect the community-based maternity model.
- ***The Quality Measurement Enterprise Has Not Historically Prioritized Health Equity:*** Over the past several decades various organizations have made efforts to address health disparities within the context of quality measurement. In 2012, the National Quality Forum (NQF) endorsed twelve measures focused on health care disparities and culturally competent care for racial and ethnic minority populations, as well as developed a protocol for assessing disparity-sensitive measures.[2] While important, these measures do not focus on maternity care, nor do they look specifically at institutional or structural racism in the maternity care system. Given that the clinical/medical maternity system perpetuates worse outcomes for Black, Indigenous, and People of Color (BIPOC) individuals, quality measures should assess how a patient's experiences can be impacted by structural discrimination.

Where Does the Field Currently Stand?

Developing PREMs to Assess Autonomy, Respect, and Mistreatment

Acknowledging the lack of tools related to measuring a birthing individual's experience, The Birth Place Lab at the University of British Columbia (UBC) developed several measures that assess a patient's experience with their maternity care. The tools were developed in response to the Changing Childbirth in British Columbia: Women Exploring Access to High Quality in Maternity Care project, which brought together childbearing individuals, community partners, and UBC researchers to develop surveys to assess the experience of birthing individuals. Over 2000 birthing individuals in British Columbia participated in the survey, which contained a core set of 310 questions, with supplemental target items to address the unique factors and preferences germane to recent immigrants and refugees, formerly incarcerated women, and those who have experienced homelessness and/or substance abuse. The results were then analyzed and used to develop several tools to assess and improve maternity care. A deeper dive into three of the tools that are unique in their ability to assess the birthing person's experience with autonomy, respect, and mistreatment follows:

- The Mothers Autonomy in Decision Making (MADM) Scale assesses a birthing individual's perceived autonomy in their maternity care experience. The scale analyzes a birthing individual's ability to lead the decision making; if they are given enough time to consider their options; and if their care choices are respected after the decision is made. The questions are answered on a scale of one to six, with six strongly agreeing that a patient's autonomy was respected in the interaction. The sum of all the answers correlates with a developed scale; those with a lower total sum experienced less autonomy in their birthing experience, whereas those with a higher score experienced greater autonomy.
- The Mothers on Respect (MORi) index evaluates the nature of respectful patient-provider interactions and their impact on a person's comfort, behavior, and perceptions of racism and discrimination. The scale focuses on three domains: a birthing individual's sense of autonomy and comfort when accepting or declining care options; evidence of the birthing individual modifying their behavior as a result of fear of anticipated disrespect; and perceived differential treatment as a result of a non-modifiable socio-demographic factor (race, ethnicity, sexual orientation, health insurance status, etc.). The three categories are combined into one final score with a higher score indicating more respectful care.
- The Mistreatment (MIST) Index is a set of patient-designed indicators of mistreatment that align with the seven dimensions of mistreatment identified in the Bohren typology[3]. The seven components assessed are physical abuse, sexual abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between birthing individuals and providers, and poor conditions and constraints presented by the health system. This tool does not score responses; rather it provides a check box for individuals to mark if they feel mistreated along any of these seven dimensions. Used in tandem with the two tools described above, it can provide insight into why a patient may have recorded an occurrence of mistreatment. In using this tool, appropriate standards should be in place so that if a patient marks the questionnaire affirmatively, they receive timely and respectful follow up that investigates the incidence.

Another helpful tool, designed specifically for assessing hospital-level care, is the Undisturbed Labor and Birth Index. This index assesses the status of a hospital's quality efforts across 18 domains that impact the experience and quality care provided to the patient. Examples include curating a supportive physical environment, providing culturally safe care, access to midwifery care, integration of care across birth settings, and access to non-pharmacological pain management. For each domain, the organization is asked questions such as: are there policies and programs in place that relate to quality improvement in each domain or is staff training available to improve the domain? Participating organizations receive a score that indicates their status vis a vis the domains, which helps them identify specific areas that need investment and attention to improve the quality of care provided to patients.

Initial Findings from the Use of PREMs

Results from a UBC study assessing the effectiveness of these measures provide evidence of positive outcomes resulting from use of the community-based model of care. The MADM scale showed that birthing individuals who used midwifery care reported greater autonomy than those under obstetric care. For participants who filled out the MORi, birthing individuals who used midwifery care submitted higher scores (which correlates with more respectful care), and those with planned home births reported the most respected care. It is important to note that vulnerable populations, and those with medical and social risk factors, reported lower scores on the MORi, indicating that more needs to be done – in both clinical and non-clinical birthing care – to address the needs of those most underserved.[4,5]

These measures have great potential to impact the maternal quality measurement enterprise. If adopted at a widespread level, they can be used to assess the experience of a patient and compare performance of providers and health systems across health care organizations. This could accomplish multiple, critically important goals: (1) holding providers accountable for providing more respectful, autonomous care; (2) providing birthing individuals with insights into the care they can receive from different providers and health systems; and (3) offering CMS and commercial payers tools to support the development of alternative payment models aimed at expanding access to the community-based maternity model.

The Future of Quality Measurement

Foundational Work by the National Birth Equity Collaborative

The National Birth Equity Collaborative (NBEC) recognizes the need for a better foundation for this work in order to provide a progressive path for quality measurement in the future. In partnership with the National Committee for Quality Assurance (NCQA), NBEC is developing a framework for quality measurement in maternity care that aligns all levels of the health care system toward birth equity. This project – Birth Equity Accountability through Measurement (BEAM) – strives to create a measurement framework that supports equitable care for birthing people by addressing racist policies and practices, centering patients' voices in measurement, and promoting joint accountability for all organizations participating in a patient's care. The project is in its early stages, but will soon develop and test measures within the lens of the framework, and eventually inform national evaluation programs for quality improvement and accountability.

Conclusion

The traditional field of quality measurement needs to expand to include measures that have a distinct focus on whether care is delivered in a way that that puts patients and their experiences at the center of their care delivery, which will help address structural and institutional racism in the maternity space. The innovations occurring currently in the field are a great place to start; however, a broader range of measures is needed to further support and drive implementation of effective community-based maternity models.

The Maternal Health Hub is run by the Health Care Transformation Task Force and supported by the Commonwealth Fund. The Hub leads a monthly Learning Community webinar series to identify and share learnings on essential components of equitable payment approaches that improve maternity care outcomes and lowers costs. To learn more about the Maternal Health Hub, please go to www.maternalhealthhub.org.

References

[1] https://www.cms.gov/medicare/meaningful-measures-framework/meaningful-measures-20-moving-measure-reduction-modernization

[2] https://www.qualityforum.org/Publications/2012/09/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards_Technical_Report.aspx

[3] https://pubmed.ncbi.nlm.nih.gov/26126110/

[4] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0171804

[5] https://www.sciencedirect.com/science/article/pii/S2352827317300174?via%3Dihub