NATIONAL QUALITY FORUM

Perinatal and Reproductive Health Standing Committee Off-Cycle Webinar

Senior Project Manager – Suzanne Theberge

September 11, 2017

Agenda

- Welcome and Introductions
- Overview of off-cycle work
- Presentations:
  - ***Setting a Target & Lowering Episiotomy Rates:*** *Missy Danforth, Leapfrog*
  - ***California: Reduction in C-Section Rates:*** *Elliott Main, MD, California Maternal Quality Care Collaborative*
  - ***Ohio: Dissemination of Early Elective Delivery Quality Improvement:*** *Michael Marcotte, MD, Ohio Perinatal Quality Collaborative*
  - ***Hospital Accreditation & Perinatal Care Certification****: Susan Yendro, RN, MSN, The Joint Commission*
  - ***Update on Development of Contraceptive PRO-PM Measures****: Christine Dehlendorf, MD, MAS, University of California, San Francisco*
  - ***Implementation of Contraceptive Measures:*** *Brittni Frederiksen, MPH, PhD, Office of Population Affairs (OPA)*
- Committee Discussion
- Public Comment
- Next Steps

Welcome and Introductions

Standing Committee

J. Matthew Austin, PhD
Jennifer Bailit, MD, MPH
Amy Bell, MSN
Tracy Flanagan, MD
Gregory Goyert, M.D
Kimberly Gregory, MD, MPH
Ashley Hirai, PhD
Mambarambath Jaleel, MD
Diana Jolles, CNM, MS, PhD c
John Keats, MD
Deborah Kilday, MSN
Nancy Lowe, CNM, PhD
Sarah McNeil, MD
Jennifer Moore, PhD, RN
Kristi Nelson, MBA, BSN
Juliet M Nevins, MD MPA
Sheila Owens-Collins, MD, MPH, MBA
Cynthia Pellegrini
Diana E. Ramos, MD, MPH
Carol Sakala, PhD, MSPH
Naomi Schapiro, RN, PhD, CPNP
Karen Shea, RN, MSN
Marisa Spalding , JD, MPH
Sindhu Srinivas, MD, MSCE
Rajan Wadhawan, MD
Carolyn Westhoff, MD, Msc
Janet Young, MD

Off-Cycle Activities

- What is considered “off-cycle”?
  - *During the periods in which no measures are being reviewed, or the “off cycle”, these are Standing Committee activities that may occur outside a funded project’s scope.*
  - *In order to enable ongoing engagement of committee members throughout their two (or three) year terms, NQF will host quarterly, two-hour web meetings or conference calls for each Standing Committee during the off cycle timeframe.*

- Potential Activities:
  - *Ongoing updates on NQF policy/process*
  - *Addressing and setting measurement priorities for topic area*
  - *Reviewing current measurement landscape*
  - *Follow–up from the Consensus Development Process*
    - » Deferred decisions
    - » Directives from CSAC or Board of Directors
    - » Related and competing measures/harmonization
  - *Ad hoc reviews*
  - *Topic area consultation to other Committees*
  - *Collaborative opportunities with developers, specialty societies, and implementers*

Setting a Target & Lowering Episiotomy Rates

Missy Danforth, Vice President for Hospital Ratings - Leapfrog

USE OF NQF-ENDORSED MEASURES TO IMPROVE PERINATAL & REPRODUCTIVE HEALTH CARE

September 11, 2017

Missy Danforth, Vice President of Health Care Ratings

The Leapfrog Group

The Leapfrog Group

- National, not-for-profit organization
- Founded by large purchasers in 2000 in response to 1999 IOM Report *To Err is Human*
- Collect and publicly report information about the safety and quality of inpatient hospital care
- Our hospital ratings are used by all national health plans, many regional health plans, and transparency vendors

Leapfrog's mission is to trigger giant leaps forward in the safety, quality and affordability of U.S. health care by using transparency to support informed health care decisions and promote high-value care.

THELEAPFROGGROUP

Leapfrog Hospital Survey

- Annual, voluntary national survey
- Includes measures that matter most to health care purchasers and consumers
- Evidence-based and aligned with other national measurement organizations
- 23 national measures covering 6 domains of hospital care
  - Inpatient Care Management
  - Medication Safety
  - **Maternity Care**
  - Injuries and Infections
  - Pediatric Care
  - Inpatient Surgery
- In 2016, over 1,850 hospitals, which represent 61% of all hospital beds, submit a survey each year
- Results are publicly reported by hospital at www.leapfroggroup.org/compare-hospitals

THELEAPFROGGROUP

Maternity Care

- The Maternity Care section of the Leapfrog Hospital Survey includes several measures:
  - Elective Deliveries (NQF 0469)
  - Cesarean Births (NQF 0471)
  - **Episiotomy (NQF 0470)**
  - DVT Prophylaxis for Women Undergoing Cesarean Section (formerly NQF 0473)
  - Bilirubin Screening for Newborns
  - High Risk Deliveries
    - Volume/Death or Morbidity
    - Antenatal Steroids (NQF 0476)

- The NQF-endorsed Episiotomy Measure was first added to the survey in 2012

THELEAPFROGGROUP

Progress in Lowering Rates of Episiotomy

	2012	2013	2014	2015	2016	2017 (as of July 31)
N=	833	950	991	1220	1321	***1198***
Average rate	13	12.1	11.3	10.2	9.7	***7.9***
Leapfrog's Target Rate	12%	12%	12%	5%	5%	***5%***
% Hospitals Meeting Leapfrog's Target Rate	44% (n=366)	63% (n=602)	66% (n=650)	32% (n=393)	36% (n=481)	***44% (n=524)***

THELEAPFROGGROUP

An Initiative to Reduce the Episiotomy Rate: Association of Feedback and the Hawthorne Effect With Leapfrog Goals

Zhang-Rutledge, Kathy MD; Clark, Steven L. MD; Denning, Stacie RN; Timmins, Audra MD; Dildy, Gary A. MD; Gandhi, Manisha MD

Obstetrics & Gynecology: July 2017 - Volume 130 - Issue 1 - p 146–150

OBJECTIVE: To assess the association of education, performance feedback, and the Hawthorne effect with a reduction in the episiotomy rate in a large academic institution.

METHODS: We describe a prospective observational study of a project conducted between March 2012 and February 2017 to assist clinicians in meeting the Leapfrog Group (www.leapfroggroup.org) target rates for episiotomy. Phases of this project included preintervention (phase 1, March 2012 to April 2014), education and provision of collective department episiotomy rates (phase 2, May 2014 to December 2014), ongoing education with emphasis on a revised Leapfrog target rate (phase 3, January 2015 to February 2016), and provision of individual episiotomy rates to practitioners on a monthly basis (phase 4, March 2016 to February 2017). We analyzed the department episiotomy rates before, during, and after these efforts. Cases of shoulder dystocia were excluded from this analysis. Statistical analysis was performed using a two-tailed Student *t* test and χ^2 test with $P<.05$ considered significant.

RESULTS: During the study period 1,176 episiotomies were performed in 16,441 vaginal deliveries (7.2%). In phase 2 (2,352 vaginal deliveries), there was a nonsignificant drop in the episiotomy rate with education alone (9.0–8.2%, $P=.21$). In phase 3 (4,379 vaginal deliveries), the episiotomy rate demonstrated an additional, significant drop to 5.9% ($P<.001$), but this reduction did not reach the new Leapfrog goal of 5%. In phase 4 (3,160 vaginal deliveries), the hospital episiotomy rate again dropped significantly from 5.9% to 4.37% ($P=.007$) and met the target rate of 5%. This reduction was sustained over a 12-month time period. During this same time period, the rate of operative vaginal delivery among vaginal births increased (4.5–5.4%, $P=.003$) and there was no significant change in the rates of third- and fourth-degree perineal laceration (3.8–3.3%, $P=.19$).

CONCLUSION: Education, performance feedback, and the Hawthorne effect were associated with a reduction in the episiotomy rate in a large academic institution without a reduction in the rate of operative vaginal delivery or an increase in the rate of third- and fourth-degree lacerations.

Purchasers Are Focused on Improving Maternity Care Outcomes

THELEAPFROGGROUP

WHY SCBCH IS A PART OF THE LEAPFROG MOVEMENT

You care enough about your employees and their families to invest significantly in health benefits. Are you getting what you pay for? Leapfrog purchasers advocate for giant leaps forward in safety and quality of hospital care, saving lives and dollars.

SAVE LIVES

IMPROVE QUALITY

REDUCE COSTS

Employers pay a price for hospital errors and unnecessary procedures. With Leapfrog, members and health care purchasers are steering employees to better care that saves lives and dollars. The Leapfrog Group is a voluntary program aimed at mobilizing employer purchasing power to alert America's health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded. Among other initiatives, Leapfrog works with its employer members to encourage transparency and easy access to health care information as well as rewards for hospitals that have a proven record of high quality care and quality of life.

Employers pay a price for hospital errors and unnecessary procedures.

With Leapfrog, members and health care purchasers are steering employees to better care that saves lives and dollars.

Consumer Groups Also Want This Data

The Leapfrog Hospital Survey now reports episiotomy rates

BY AMY ROMANO

The Leapfrog Group, a patient safety organization comprised of employers and other purchasers of employee health coverage, has reported measures of maternity care safety for several years, most notably with their survey of hospital rates of early elective deliveries. This year's Leapfrog Hospital Survey highlights hospital rates of episiotomy. The public can compare episiotomy rates within a city, state, or region. An episiotomy is a surgical cut to enlarge the vagina for vaginal birth. Evidence suggests that routine or frequent use of episiotomy does not benefit babies but increases mothers' pain, reduces pelvic floor strength, and may predispose women to extensive tears that involve anal sphincter muscles. Despite the evidence, episiotomy rates remain high in some settings.

To view episiotomy rates, visit the Leapfrog Hospital Survey. Enter your city, state, and/or zip code and click "Compare Now." Then click the green "i" button in the "Maternity Care" column to access individual hospital rates. For more sources of provider- hospital- and state-level maternity data, visit the TMC Data Center.

CHILDBIRTH CONNECTION

a program of the
national partnership for women & families

THELEAPFROGGROUP

California:
Reduction in C-Section Rates

Elliott Main, MD, Medical Director,
California Maternal Quality Care Collaborative

NQF Webinar
September 11, 2017

CMQCC
California Maternal
Quality Care Collaborative

California: Collaborative Efforts to Reduce Cesarean Rates—

NQF 0471 PC-02 Low-risk First Birth CS Rate

Elliott K. Main, MD
Medical Director
California Maternal
Quality Care Collaborative
main@CMQCC.org

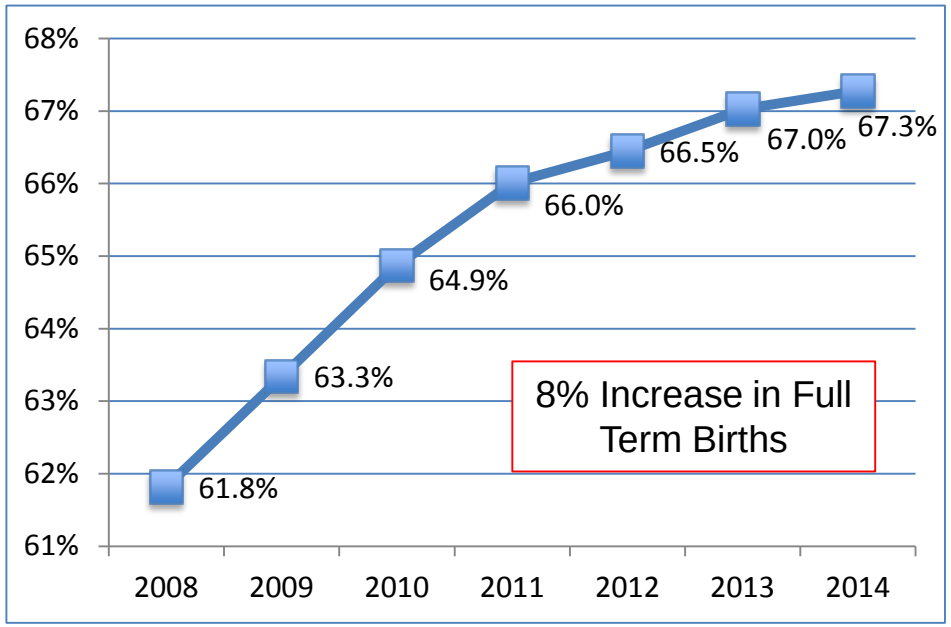
Cathie Markow, RN MBA
Administrative Director
California Maternal
Quality Care Collaborative
cmarkow@stanford.edu

California Maternal Quality Care Collaborative

- ✓ Multi-stakeholder organization established in 2006: providers, state agencies, hospitals, purchasers, payers and public groups with focus on Maternal Care, based at Stanford University
- Sister organization with CPQCC (neonatal care)
- Hosts California Maternal Mortality Review Committee
- Launched Maternal Data Center in 2012
- Developer of nationally recognized QI toolkits:
  - ❑ Early Elective Delivery; OB Hemorrhage; Preeclampsia; CVD in Pregnancy; Prevention of OB VTE; and Supporting Vaginal Birth/Preventing Cesarean
- ✓ Organizer of large-scale learning collaboratives
  - ❑ Last collaborative engaged 126 California hospitals covering Hemorrhage and Hypertension
  - ❑ Currently working with ~100 hospitals on Primary CS

Reducing Early Elective Deliveries Resulting in a Large Increase in Full Term Babies

Percent of California Births Born at Full Term (≥39 weeks gestation)



CMQCC developed a nationally adopted Quality Improvement toolkit, implementation collaboratives for hospitals & partnered with many organizations (including the March of Dimes and The Joint Commission) to **reduce elective births before 39 weeks** (full Term). Projects started in 2009

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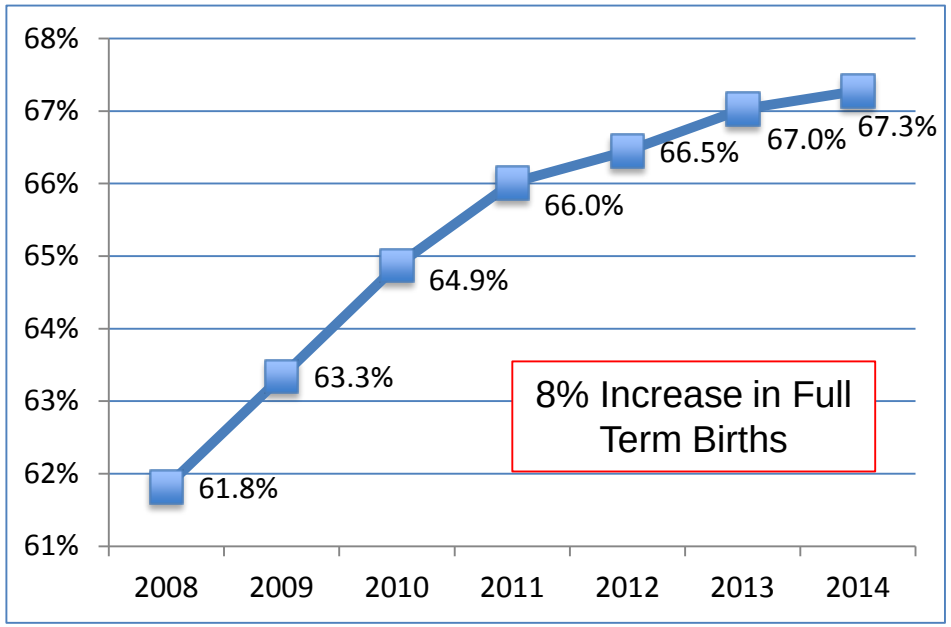
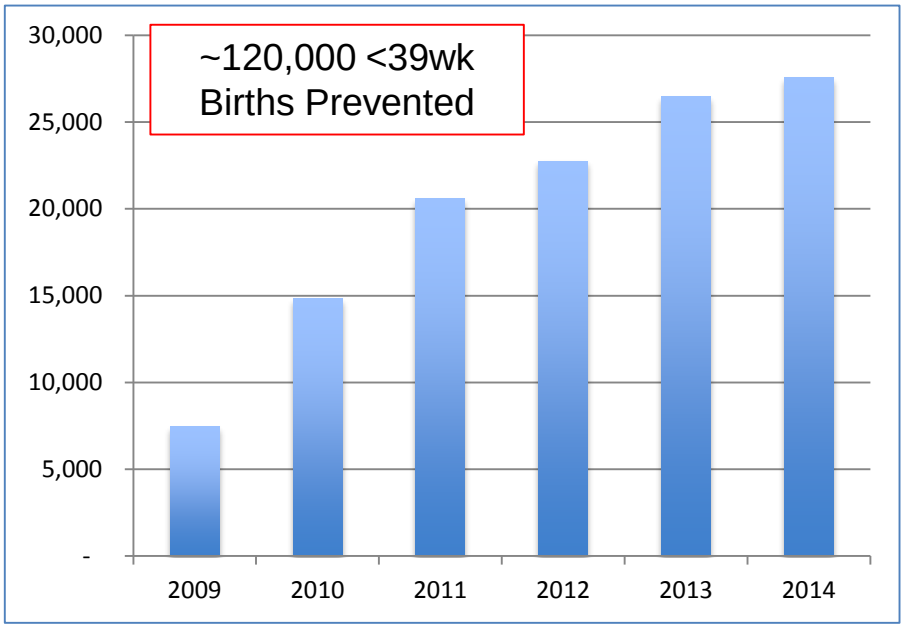


Number of Annual FEWER California Births ≥35 and <39 weeks)



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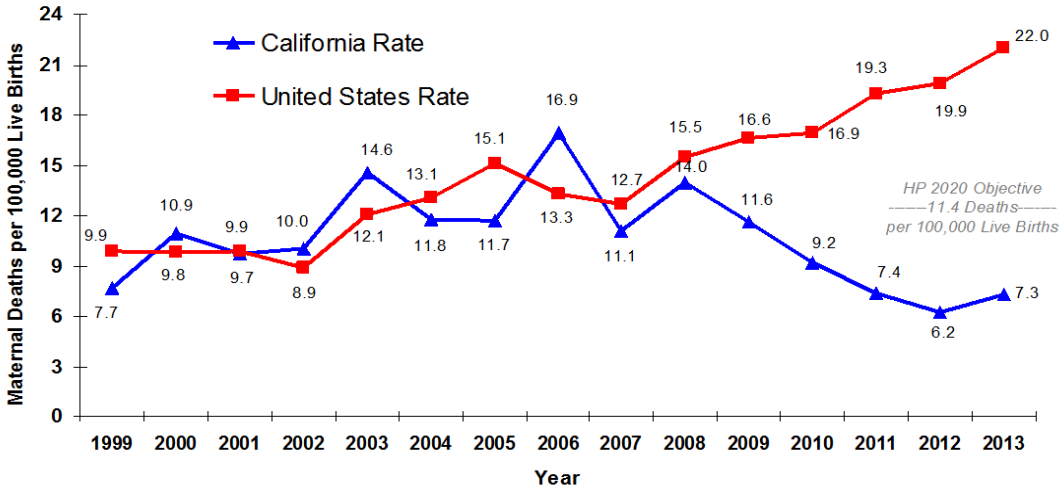
The impact on prevention of early births has been dramatic: each year has seen a progressive reduction in births between 35 and 39 weeks--which have a much higher chance of complications and Intensive Care Unit admissions. (California has ~500,000 annual births)

Maternal Mortality Rate, California and United States; 1999-2013

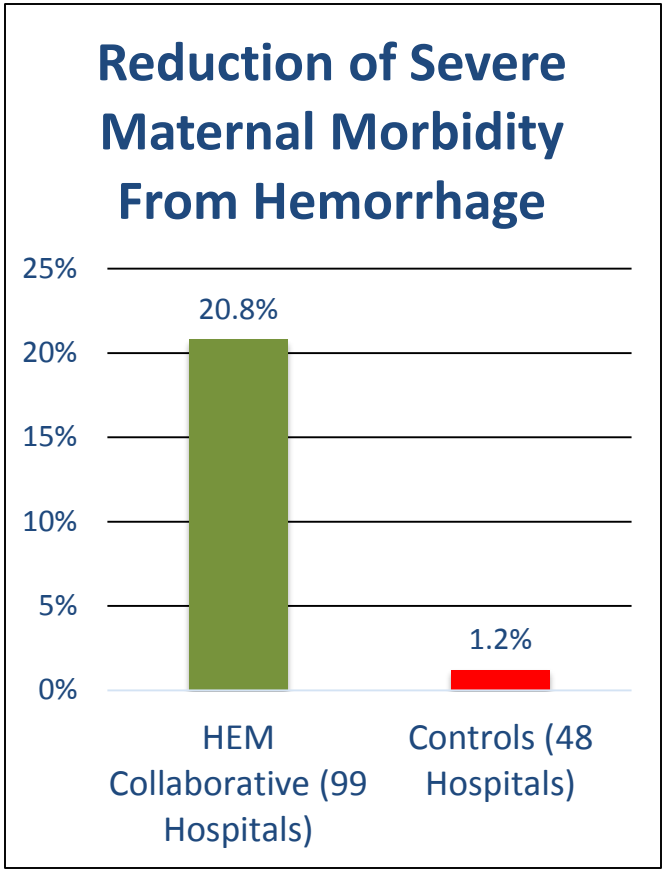


SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2013. Produced by California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, May, 2015.

https://archive.cdph.ca.gov/data/statistics/Pages/CaliforniaPregnancy-AssociatedMortalityReview.aspx

California Partnership For Maternal Safety: Hemorrhage Collaborative

(>290,000 patients/year)



Main EK, Cape V, Abreo A, Vasher J, Woods A, Carpenter A, Gould JB. Reduction of severe maternal morbidity from hemorrhage using a state perinatal quality collaborative. Am J Obstet Gynecol. **2017** Mar;216(3):298.e1-298.e11.

Overall (Total) and NTSV (low-risk) Cesarean Rates

United States (NCHS): 1990-2013

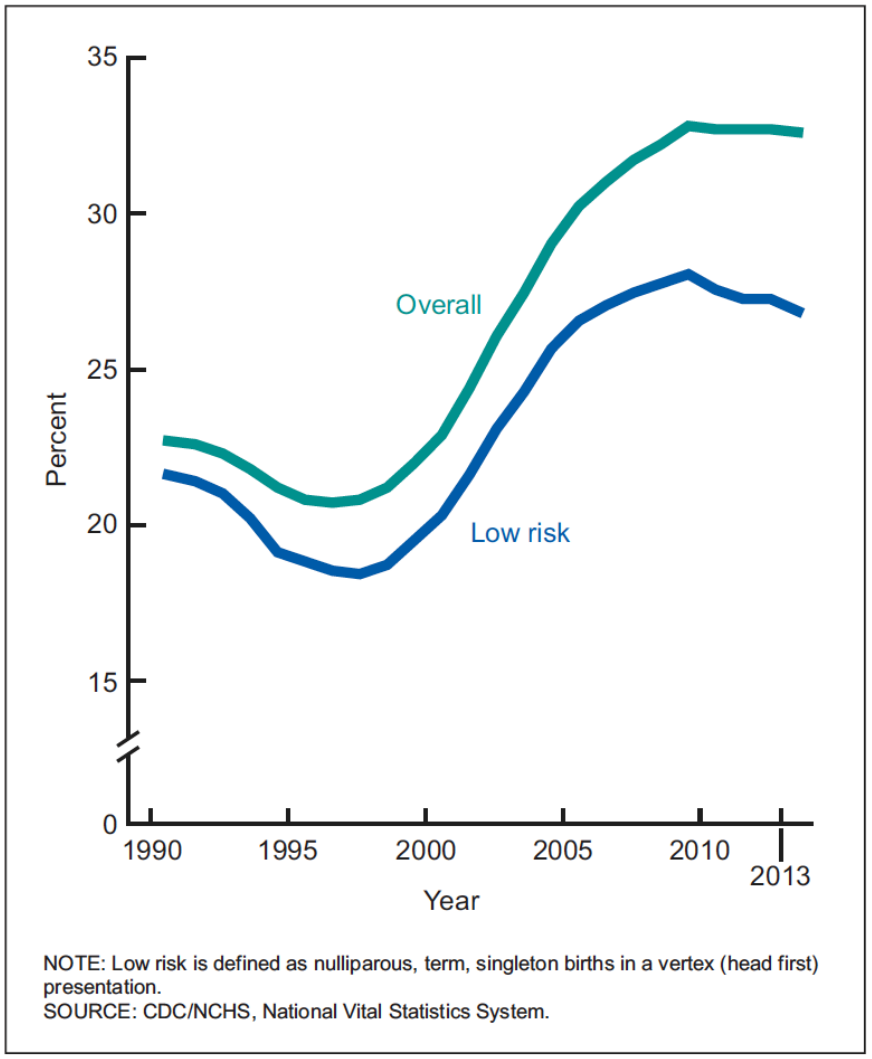


Figure 1. Overall cesarean delivery and low-risk cesarean delivery: United States, final 1990–2012 and preliminary 2013

HP 2020 Target: 23.9%

Overall (Total) and NTSV (low-risk) Cesarean Rates

United States (NCHS): 1990-2013

For the Last 30 Years, Reducing Cesarean Section Rates has been the "Third Rail" for Obstetric Quality Programs

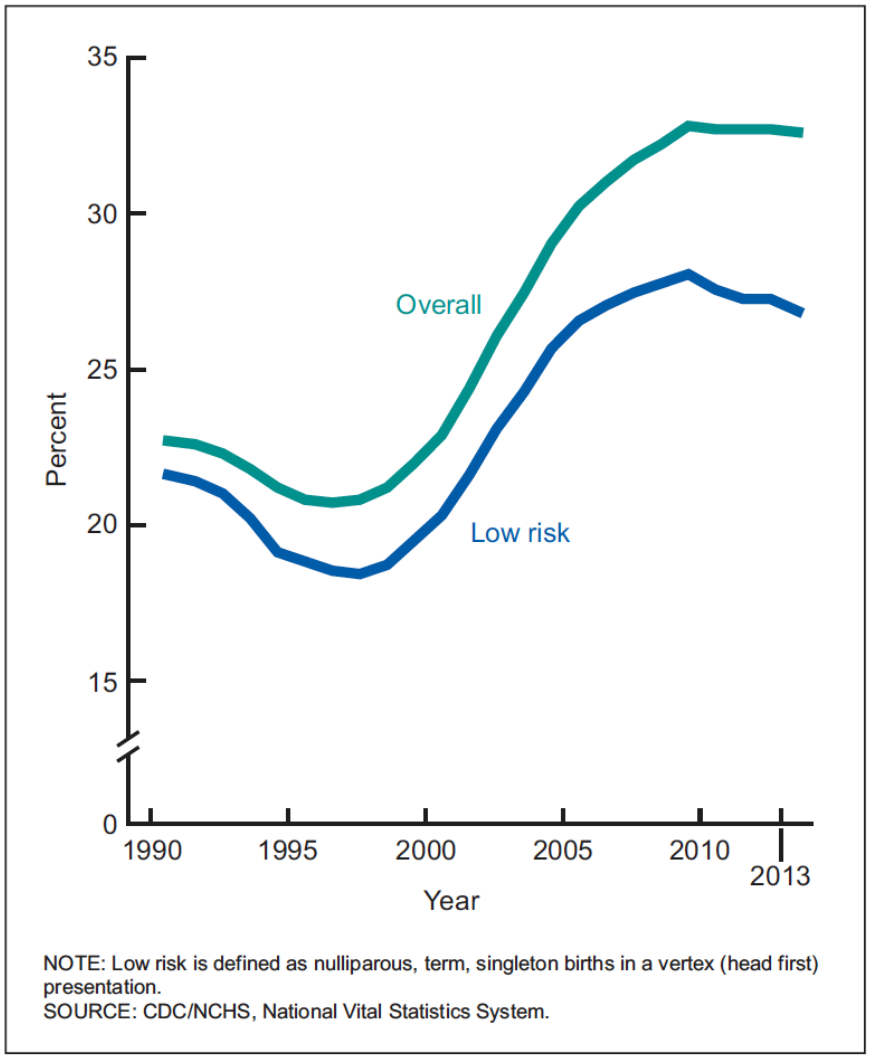
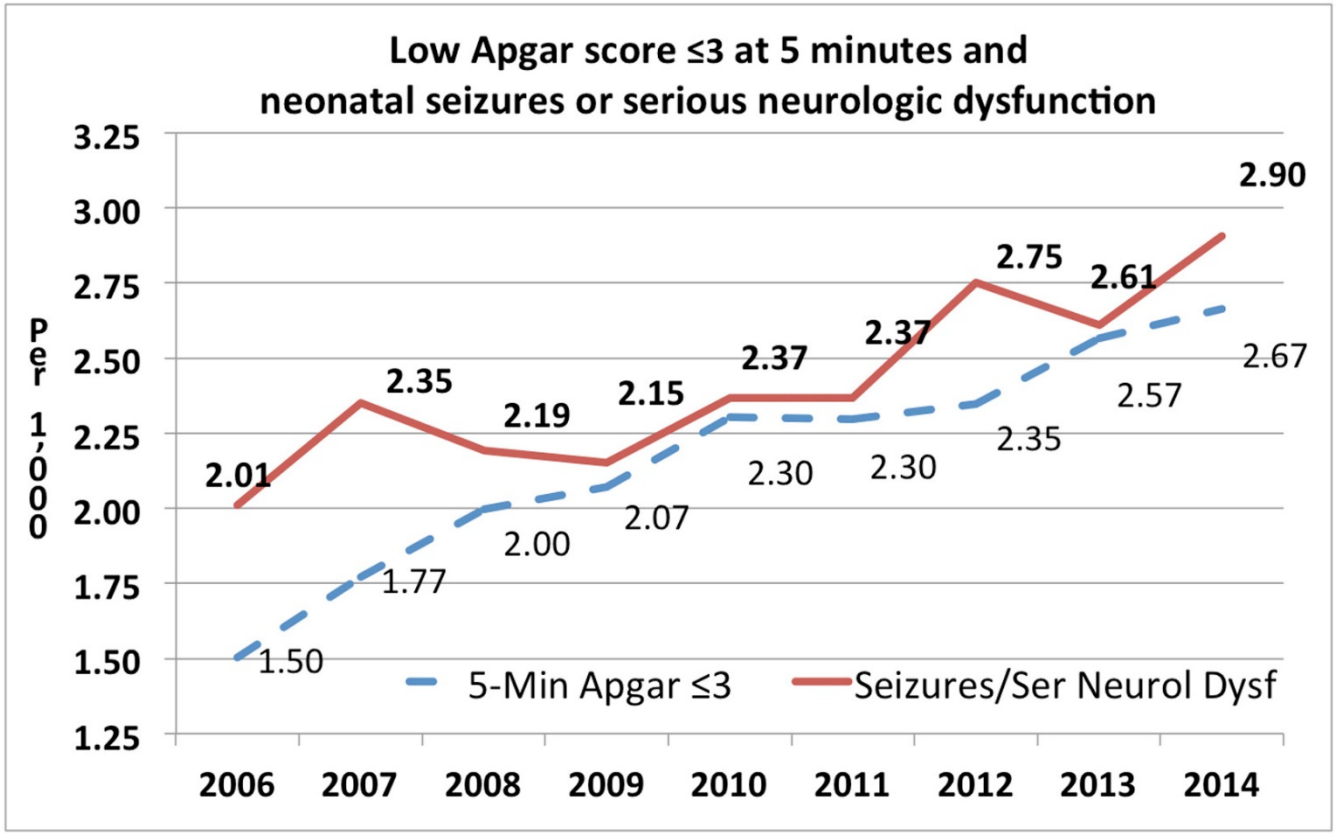


Figure 1. Overall cesarean delivery and low-risk cesarean delivery: United States, final 1990–2012 and preliminary 2013

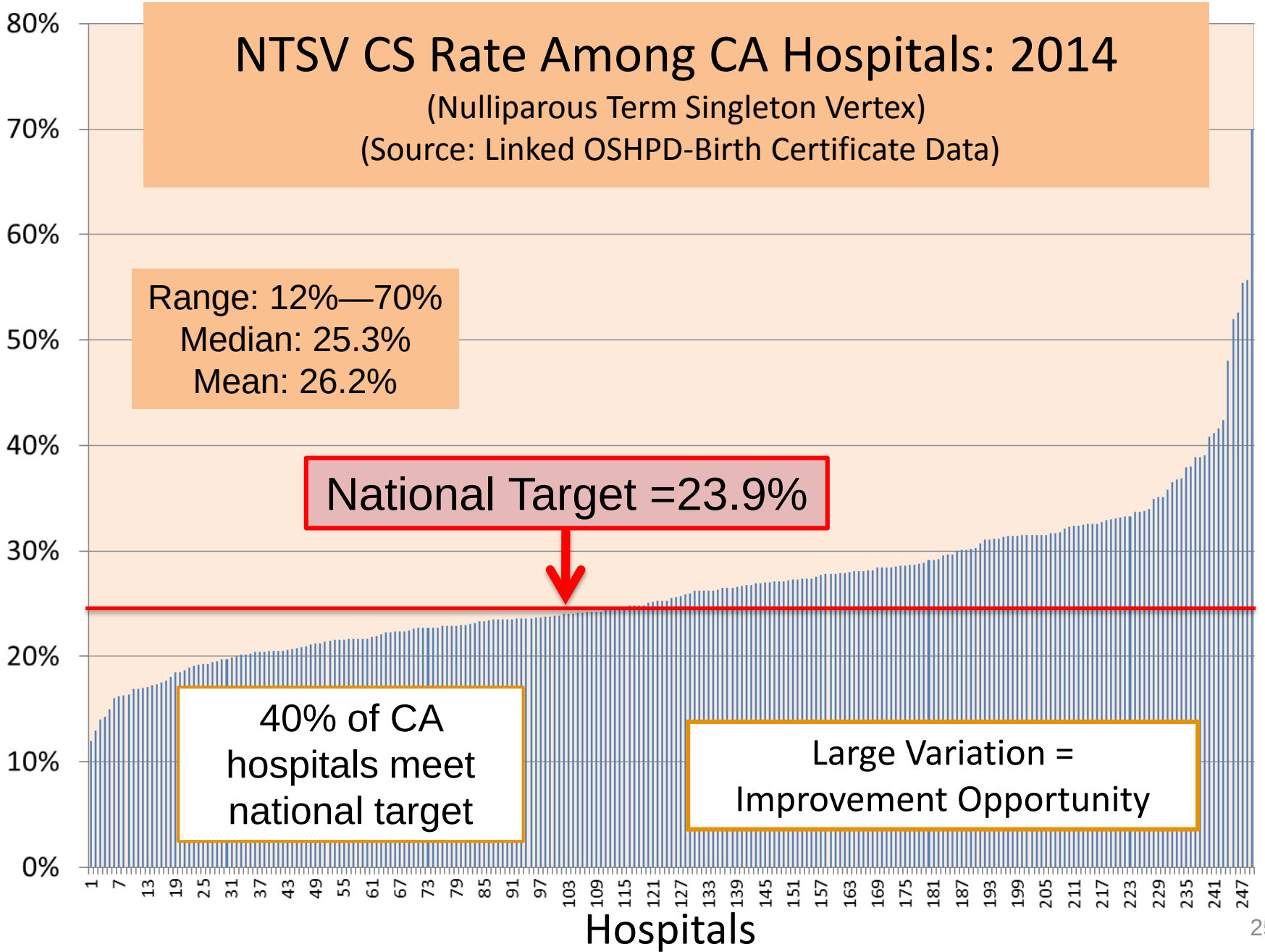
HP 2020 Target: 23.9%

Rising Rate of Low APGARs and Serious Term Neonatal Neurologic Complications



US CDC Natality data: term singletons with BWt > 2,500g

Am J Obstet Gynecol 216: S517-8, 2017


NTSV CS Rate Among CA Hospitals: 2014
(Nulliparous Term Singleton Vertex)
(Source: Linked OSHPD-Birth Certificate Data)
Range: 12%—70%
Median: 25.3%
Mean: 26.2%
National Target =23.9%
40% of CA hospitals meet national target
Large Variation = Improvement Opportunity
80%
70%
60%
50%
40%
30%
20%
10%
0%
1 7 13 19 25 31 37 43 49 55 61 67 73 79 85 91 97 103 109 115 121 127 133 139 145 151 157 163 169 175 181 187 193 199 205 211 217 223 229 235 241 247
Hospitals

Major Maternal Complications: Vaginal Births versus Primary Cesareans, Repeat Cesareans, and Vaginal Births After Cesarean

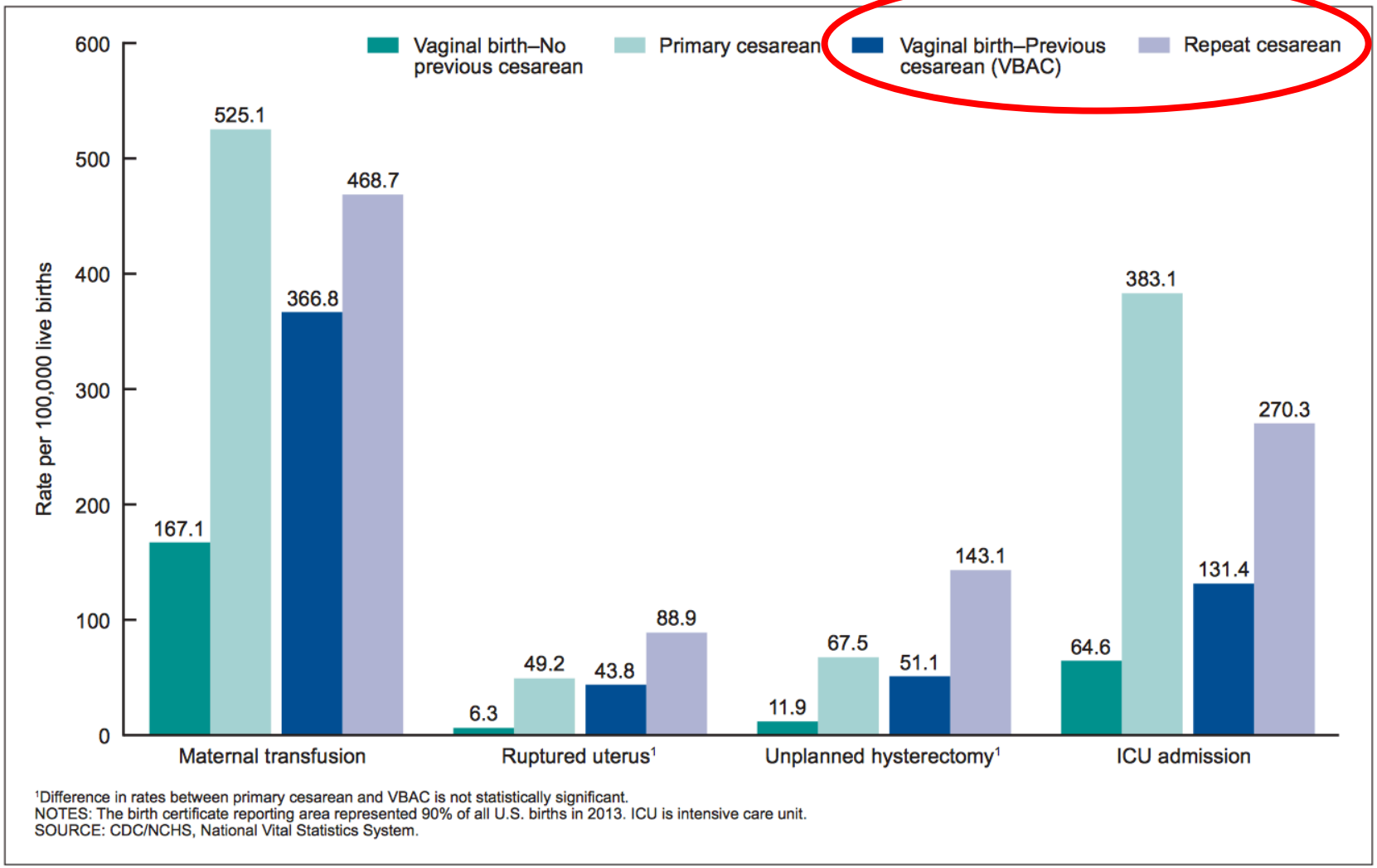


Figure 1. Maternal morbidity, by method of delivery and previous cesarean history: 41-state and District of Columbia reporting area, 2013 https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_04.pdf

Not just placenta accreta…

People 8/3/2017

Charles V, Charles IV and Kira Johnson
// COURTESY CHARLES JOHNSON

How Judge Hatchett's Son Is Coping After His Wife's Childbirth Death

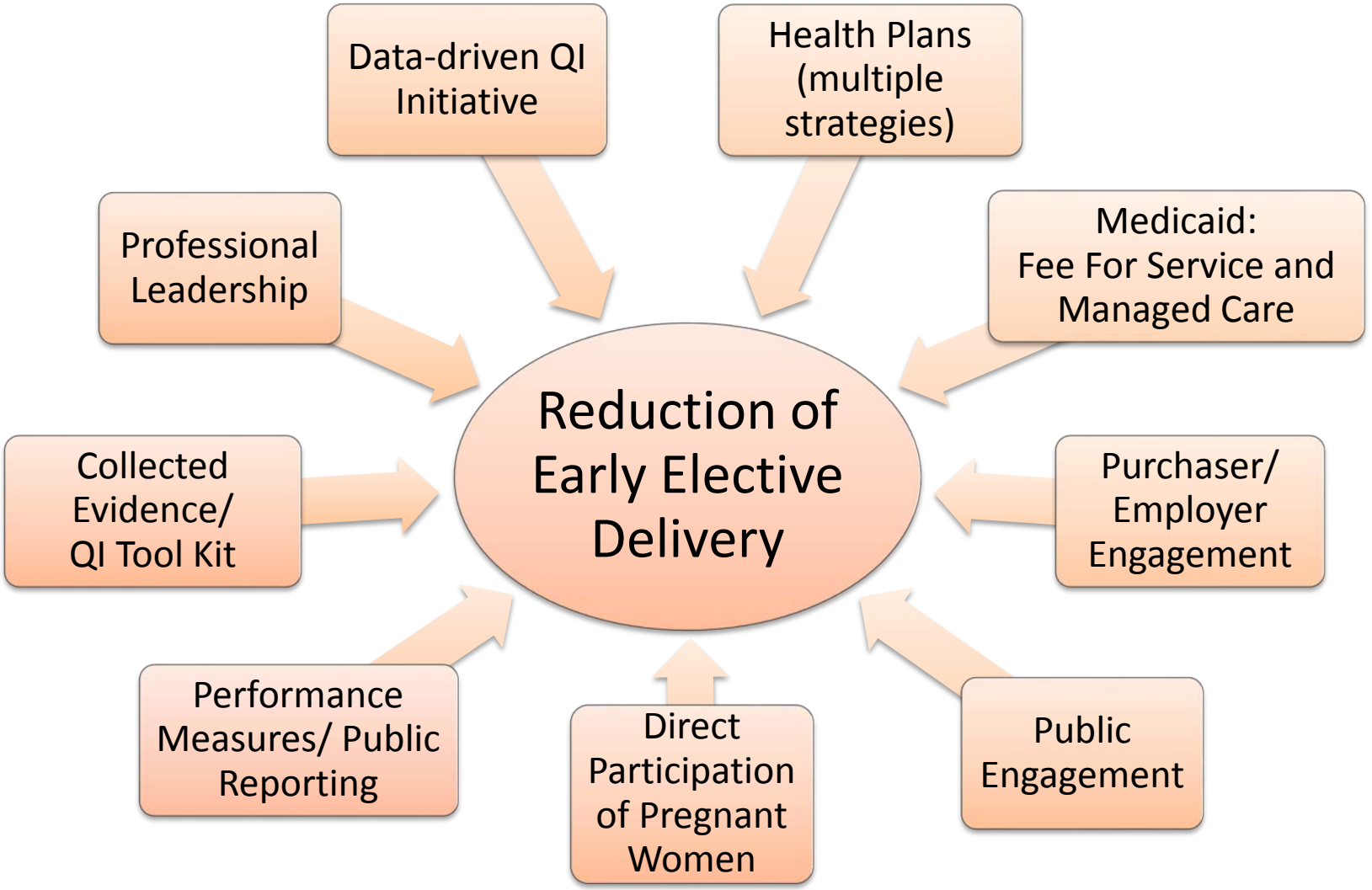
(Healthy woman with complications resulting in death during "routine" repeat Cesarean)

COSMOPOLITAN

8/21/2017

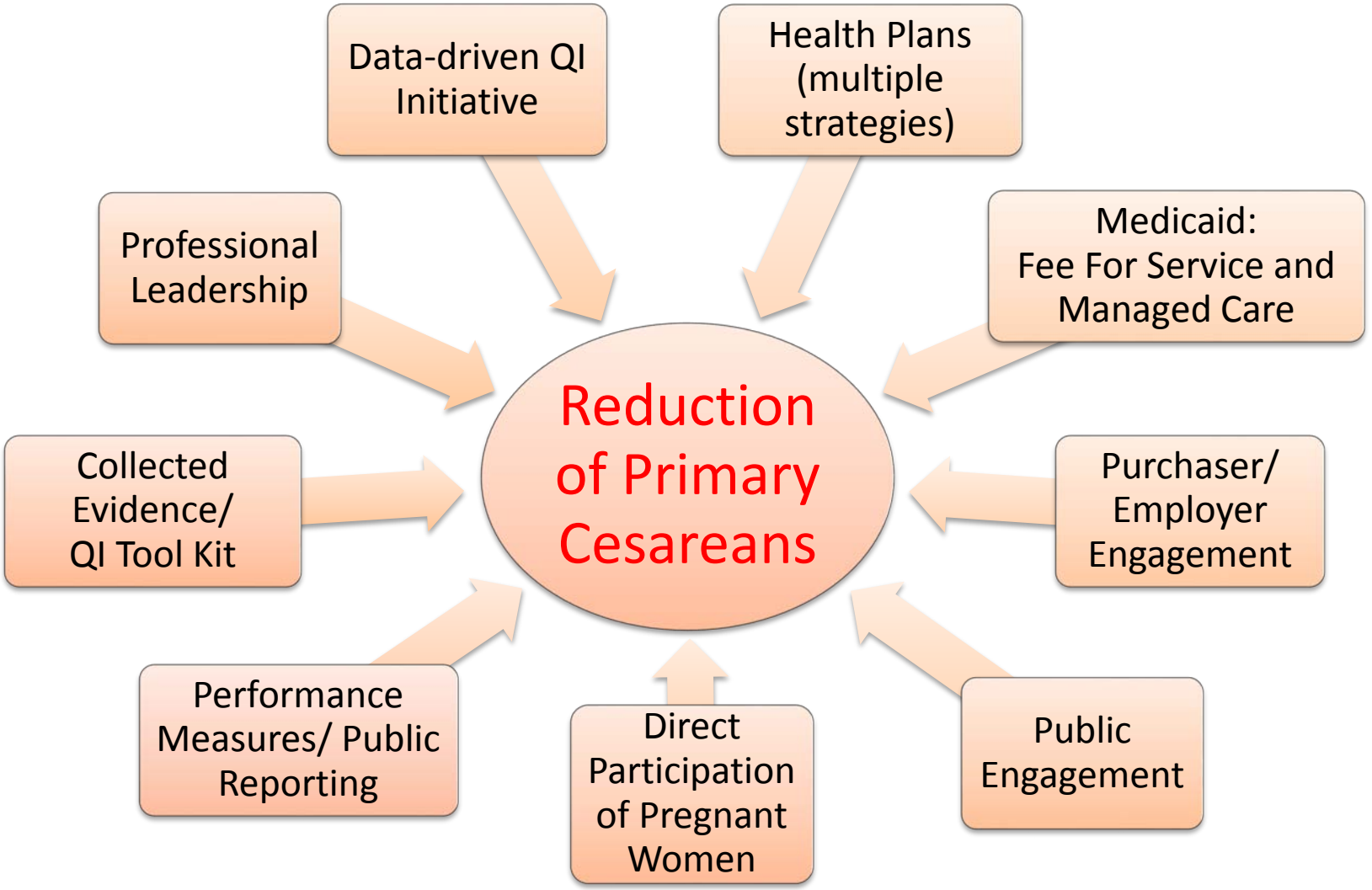
(Healthy woman with major complications during "routine" repeat Cesarean: "Near Miss" now with PTSD)

Collaborative Action: Collective Impact



Multiple Leverage Points are much more effective than one or two alone

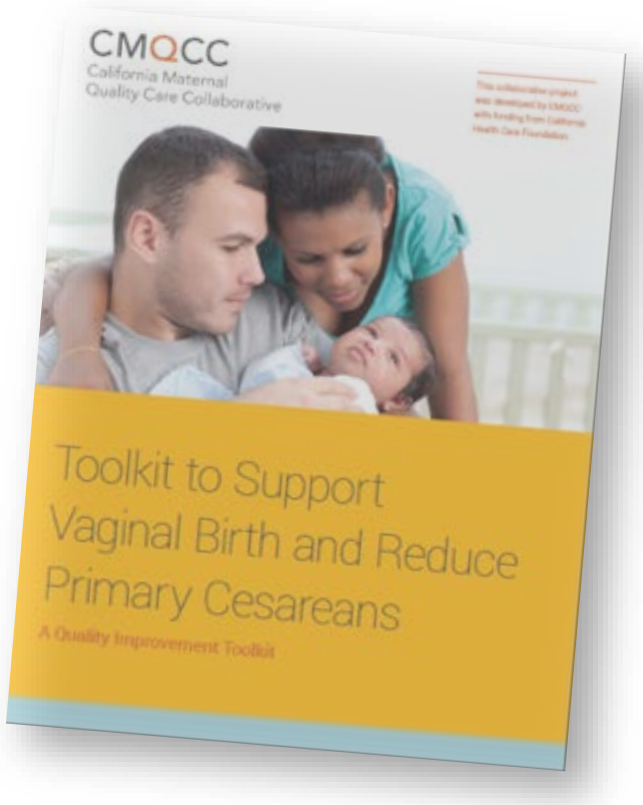
Collaborative Action: Collective Impact



Multiple Leverage Points are much more effective than one or two alone

The CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

- Comprehensive, evidence-based "How-to Guide" to reduce primary cesarean delivery in the NTSV population (159pp)
- Serves as the resource foundation for the CA QI collaborative project
- The principles are generalizable to all women giving birth
- Available on the CMQCC website: www.cmqcc.org
- Has a companion ***Implementation Guide***



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

May 24, 2016

John Wachtel, MD
Chair: District IX
American Congress of Obstetricians and Gynecologists

Dear Dr. Wachtel:

In representing the American College of Obstetricians and Gynecologists (ACOG), we would like to congratulate you and all the contributors involved in the development of the CMQCC "Toolkit to Support Vaginal Birth and [illegible]. ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate, and the plan to disseminate and implement the [illegible] are laudable.

Clearly, the rising Cesarean delivery rate, and particularly the primary Cesarean rate, is concerning to all involved in the provision of women's healthcare, and although there have been a number of efforts nationwide to address this problem, they have been met with mixed success. This excellent resource, and the plan for encouraging awareness and implementation, is unquestionably a commendable program to address this issue and should set a benchmark for achieving success in reducing the primary Cesarean delivery rate. We look forward to the program's implementation, and to hear of the future successes.

Again, we express our sincere [illegible] this toolkit. Congratulations, and best wishes moving forward!

Sincerely,

Hal C Lawrence MD

Hal. C. Lawrence III, MD
Executive Vice President and CEO

Christopher M. Zahn, MD
Vice President, Practice Activities

We have had the honor to review this comprehensive toolkit and ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate.

This excellent resource, and the plan for encouraging awareness and implementation is unquestionably a commendable program to address this issue and should set a benchmark for achieving success in reducing the primary Cesarean delivery rate.

CMQCC Maternal Data Center

Rapid-cycle data: metrics available within 45 days after every month

PDD—Discharge Diagnosis File
(ICD9/10 Codes)

Monthly uploads:
BOTH mother and infant PDD

Birth Certificate
(Clinical Data)

Monthly uploads: electronic files for ALL California births

Automated Linkage of all 3 files

CMQCC

Maternal Data Center

Chart Review
(select metrics/QI projects)

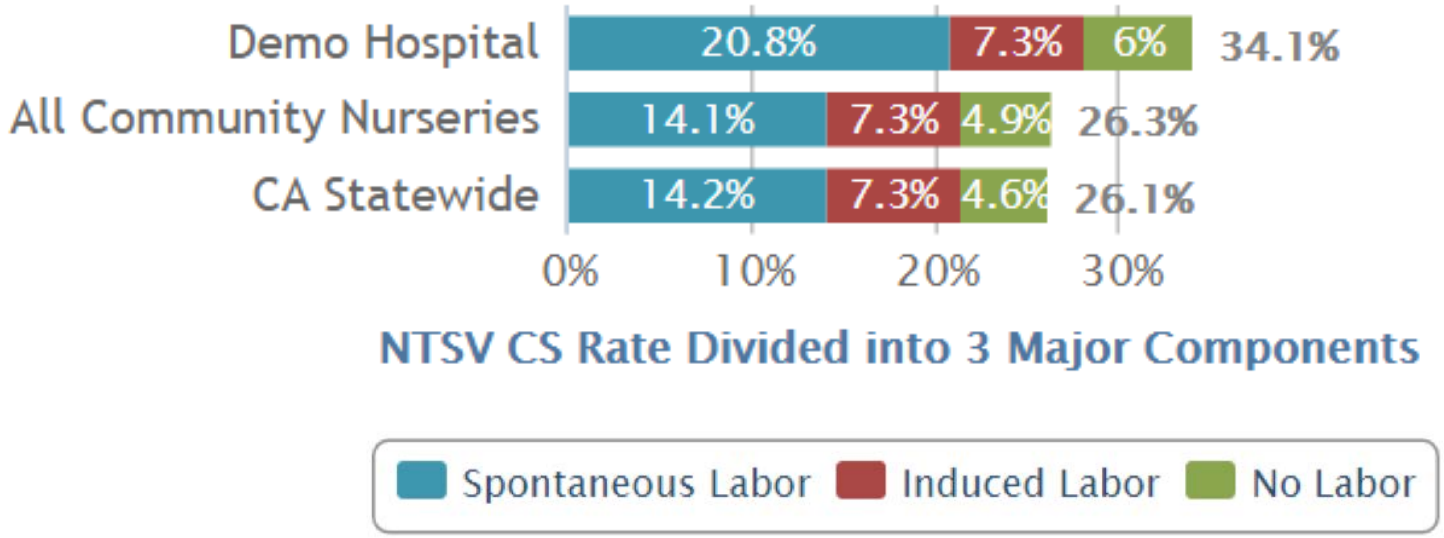
Supplemental files or limited chart reviews

Interactive Analytics Guide QI Practice

Links over 1,000,000 mother/baby records each year

Measure Analysis:
Identify Drivers of the CS Rate

What Drives Our Nulliparous Term Singleton Vertex (NTSV) CS Rate?



Screen Shot from the CMQCC Maternal Data Center

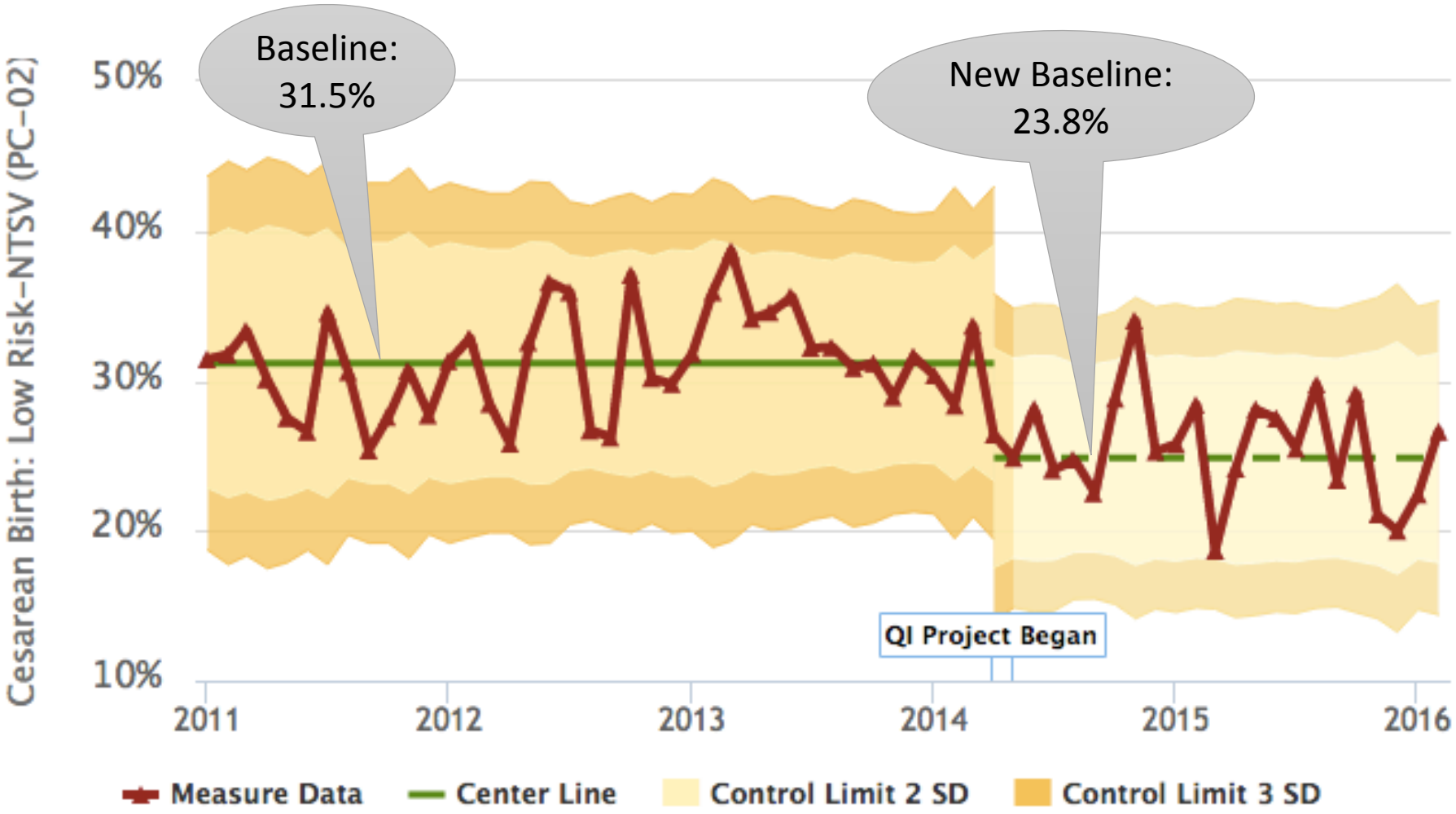
Provider-Level Cesarean Rates

Screen Shot from the CMQCC Maternal Data Center

Note the two busiest providers had widely different rates

Provider	Total Deliveries	NTSV Cesarean Section Rate	NTSV Cesarean Section D	Total CS Rate	Total CS D
Oct 2012 – Sep 2013 Statewide		27.6%	163090	33.2%	478231
Sample Medical Center	5844	32.2%	2369	37.9%	5844
G5xxxx	52	13.6%	22	9.6%	52
G6xxxx	47	36.8%	19	40.4%	47
G7xxxx	68	20.8%	24	42.6%	68
G8xxxx	60	15.4%	26	21.7%	60
A8xxxx	190	42.7%	75	44.7%	190
A6xxxx	52	35.0%	20	42.3%	52
A5xxxx	2	No Cases	0	100.0%	2
A4xxxx	114	35.3%	51	46.5%	114
A8xxxx	214	18.3%	82	28.0%	214
A9xxxx	481	36.2%	163	43.2%	481

Monthly QI Control Chart: NTSV CS Pilot Project



CMQCC Supporting Vaginal Birth QI Learning Collaborative

- ✓ 4 “waves” of 25 to 38 hospitals, all with rates >24%
- ✓ Divided into groups of 6-8 hospitals, each led by a mentor pair (MD/RN)
- ✓ Each mentor group had monthly check-in and sharing conference calls supported by CMQCC staff
- ✓ Structure/Process/Outcome metrics shared by Maternal Data Center
- ✓ CMQCC Toolkit: starting resources, more added by work groups
- ✓ Focus on Labor Practices that lead to CS indications

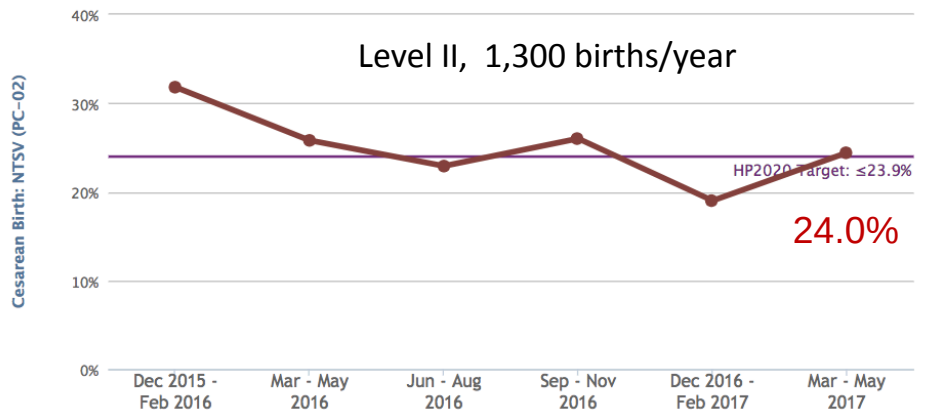
CMQCC Supporting Vaginal Birth QI Learning Collaborative

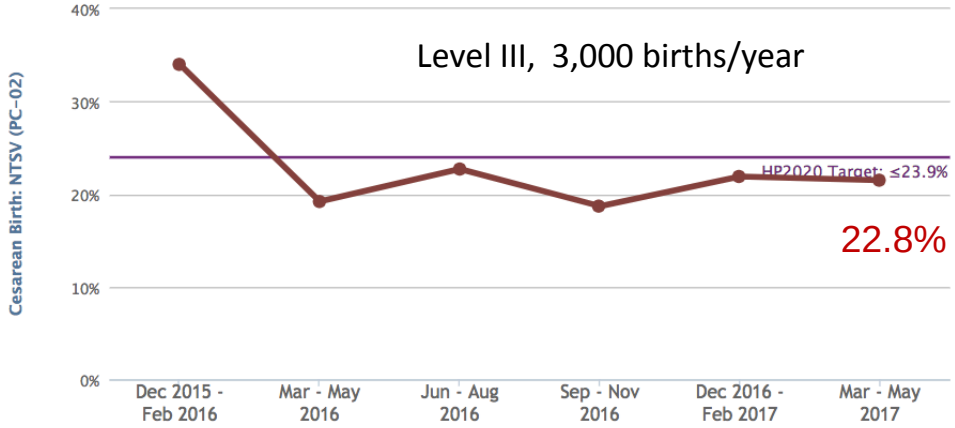
- ✓ Wave 1: 25 hospitals launched in May 2016
- ✓ Divided into groups of 6-8 hospitals, each led by a mentor pair (MD/RN)
- ✓ Starting NTSV Rates: 24.5 to 33.5% (mean=28%)
- ✓ 12month results (out of 18 month collaborative):
  - ❑ 8 hospitals did not change significantly
  - ❑ 17 hospitals had significant reduction
  - ❑ 11 of 25 hospitals are now below 23.9%
  - ❑ Overall Mean =26%
- ✓ Waves 2-4 launches: Jan, Sep, and Nov 2017

Any Downsides?

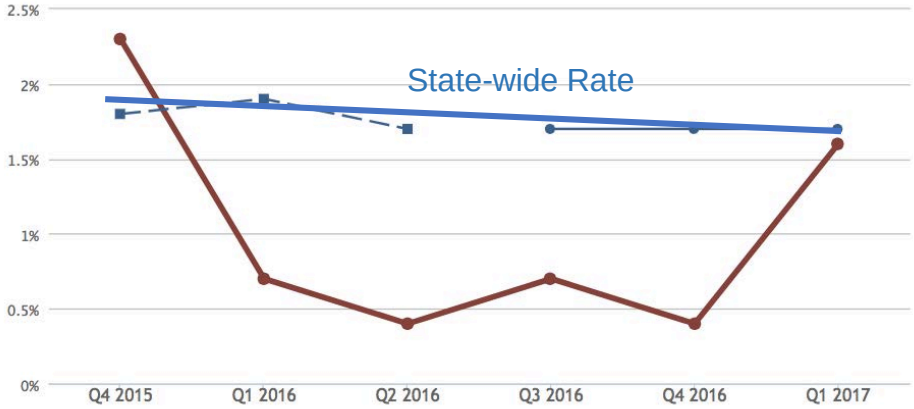
- Balancing measures are very important
- More vaginal births: Any increase in 3rd or 4th degree lacerations?
  - Gradual reduction from the prior 4 year baseline
- Most important measure is Healthy Babies
  - NQF measure “Healthy Term Newborns” (#0716) recently reconfigured as “Unexpected Newborn Complications”
  - Asks whether term babies without preexisting conditions had any major complications during birth or neonatal period

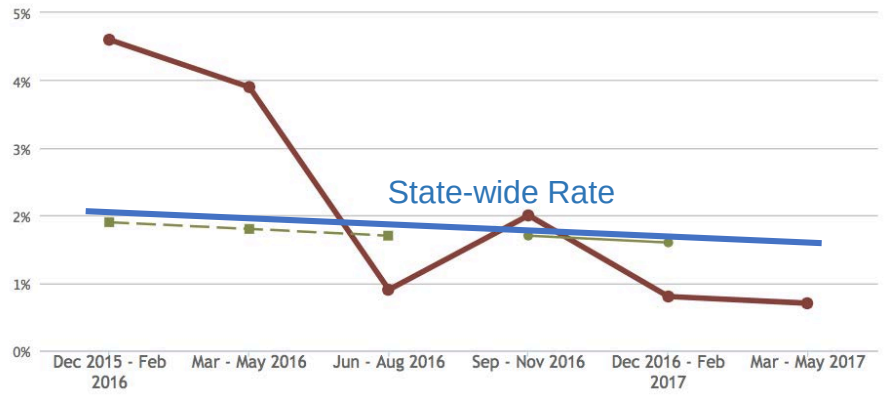
CMQCC Collaborative: Examples of Hospitals Demonstrating Significant Progress-1





NTSV (PC-02) Cesarean Rate

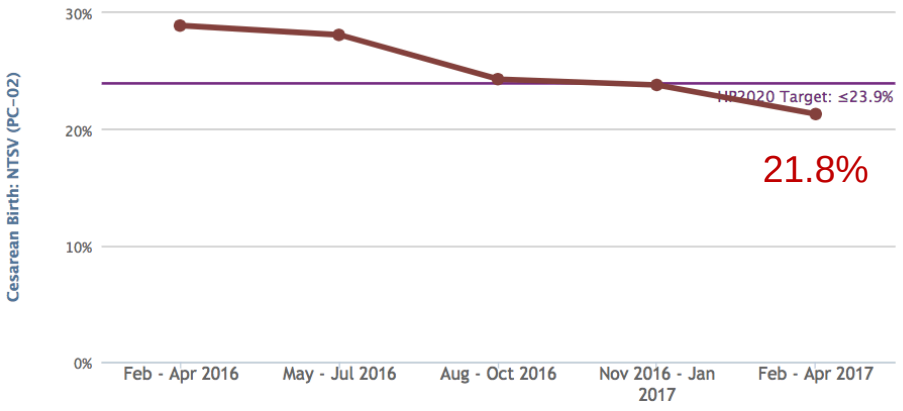




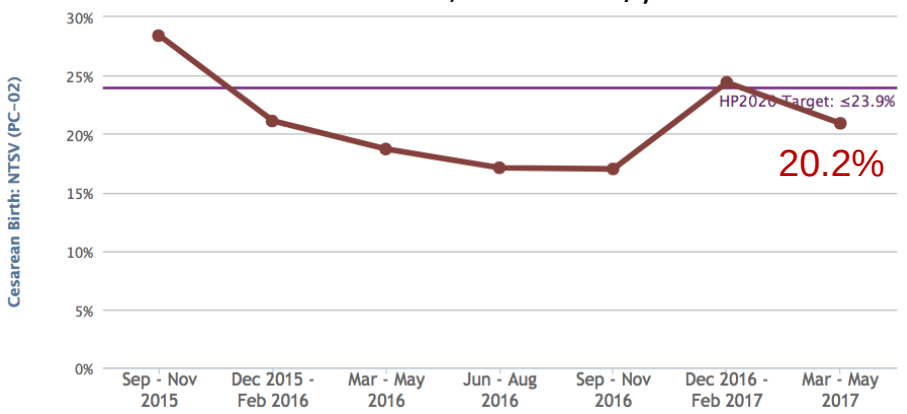
Severe Neonatal Morbidity (Term Unexpected Complications Measure)

CMQCC Collaborative: Examples of Hospitals Demonstrating Significant Progress-2

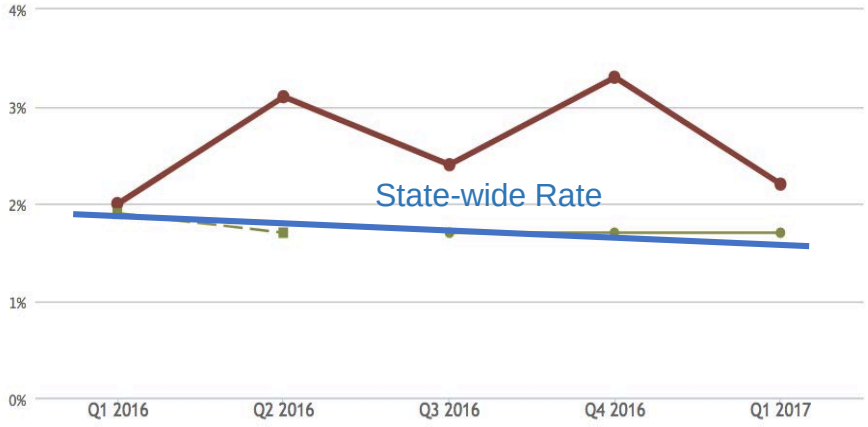
University 2,000+ births/year

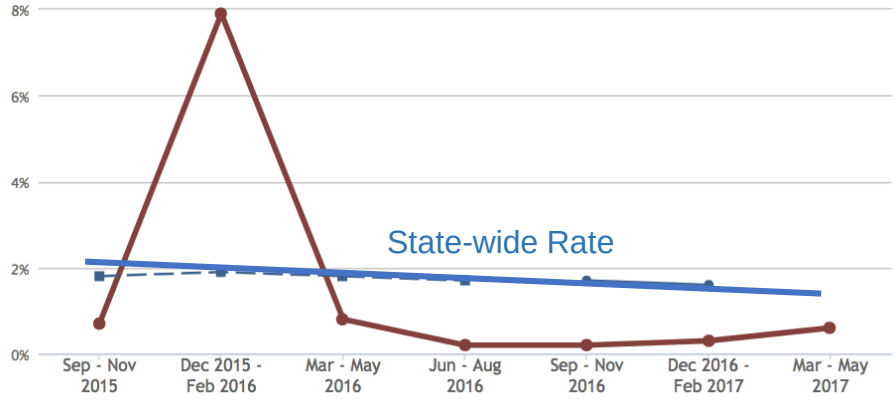


Level II 2,000+ births/year



NTSV (PC-02) Cesarean Rate

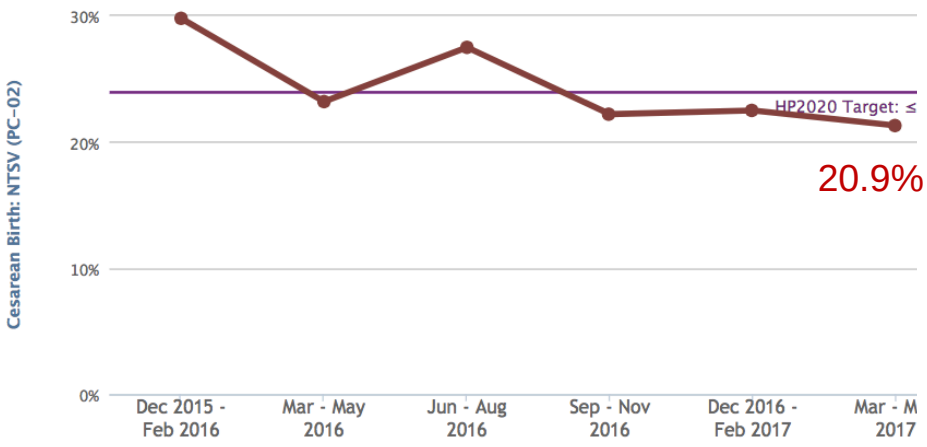




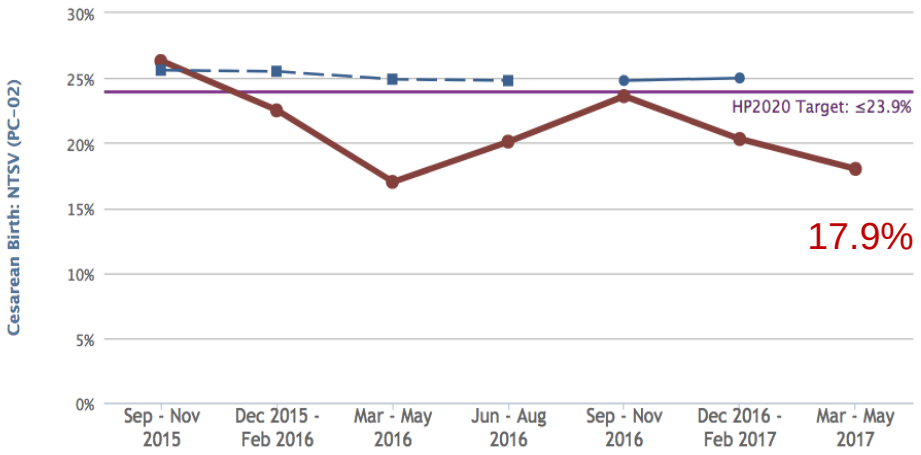
Severe Neonatal Morbidity (Term Unexpected Complications Measure)

CMQCC Collaborative: Examples of Hospitals Demonstrating Significant Progress-3

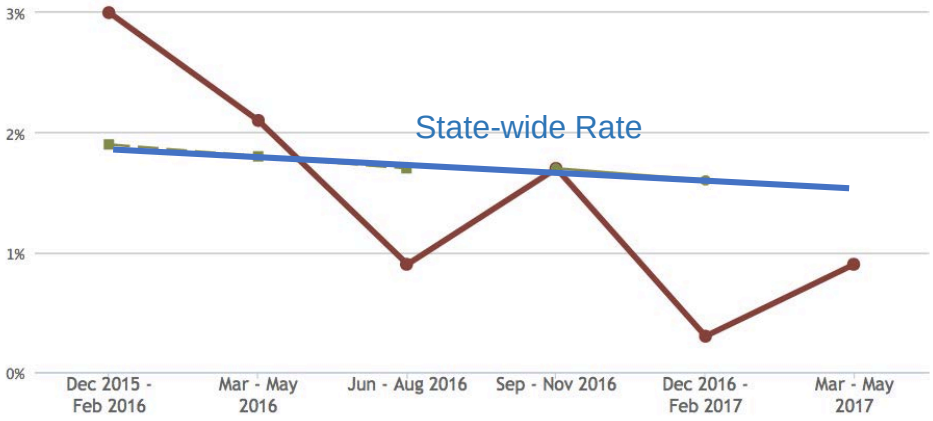
Level II 2,000+ births/year

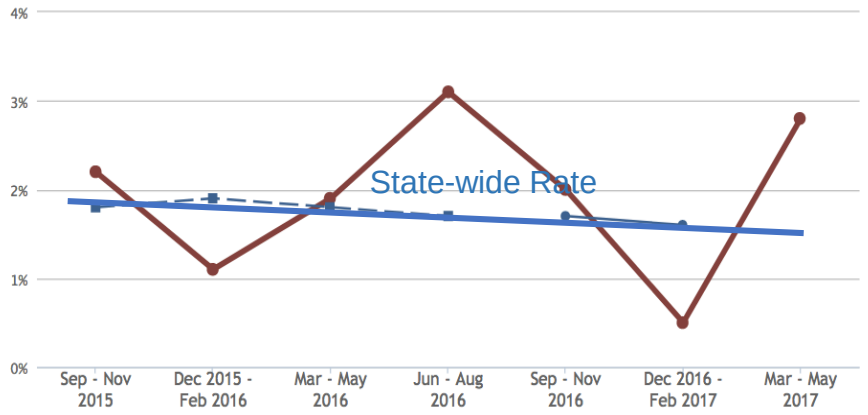


Level I 1,000+ births/year



NTSV (PC-02) Cesarean Rate



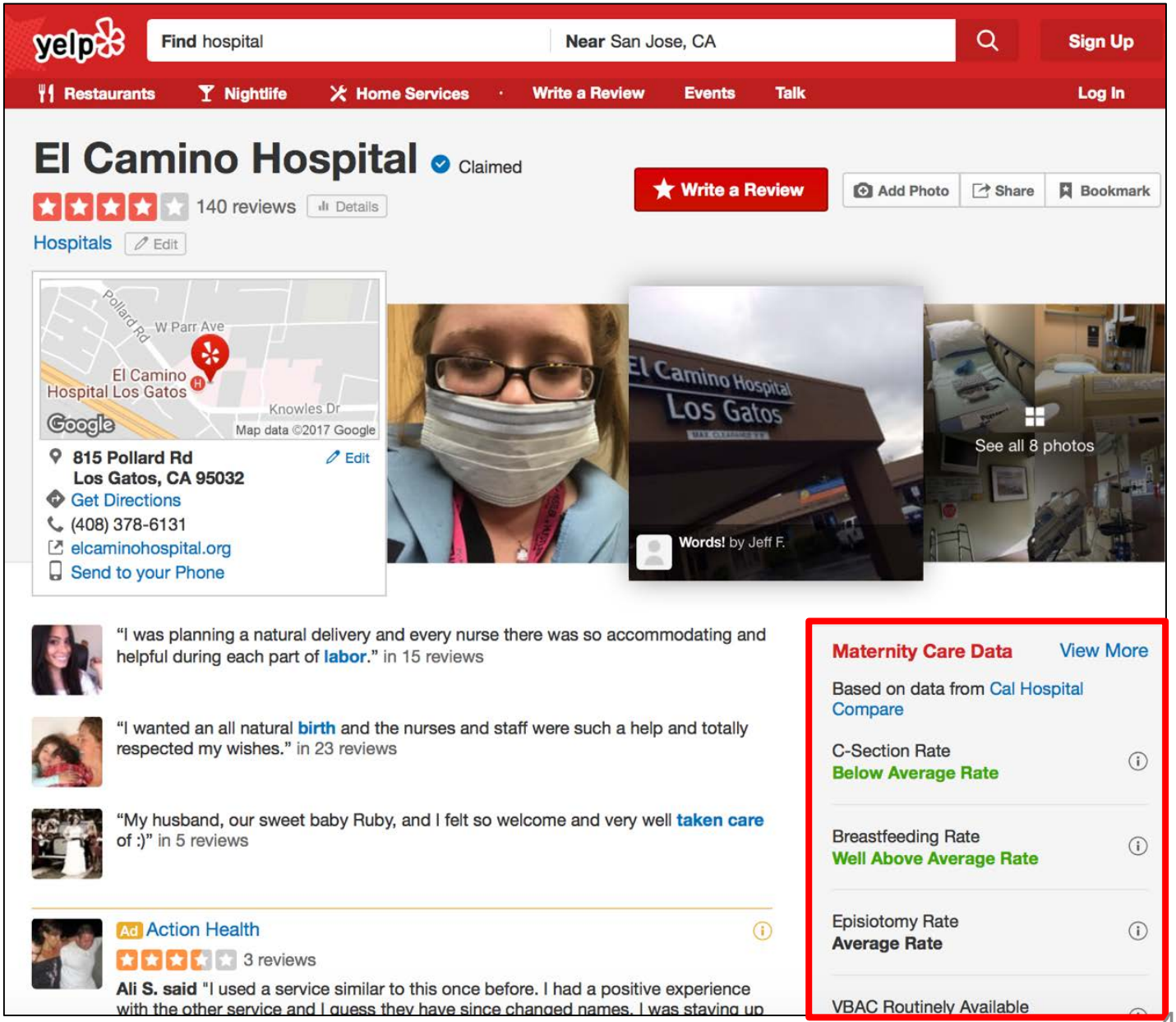


Severe Neonatal Morbidity (Term Unexpected Complications Measure)

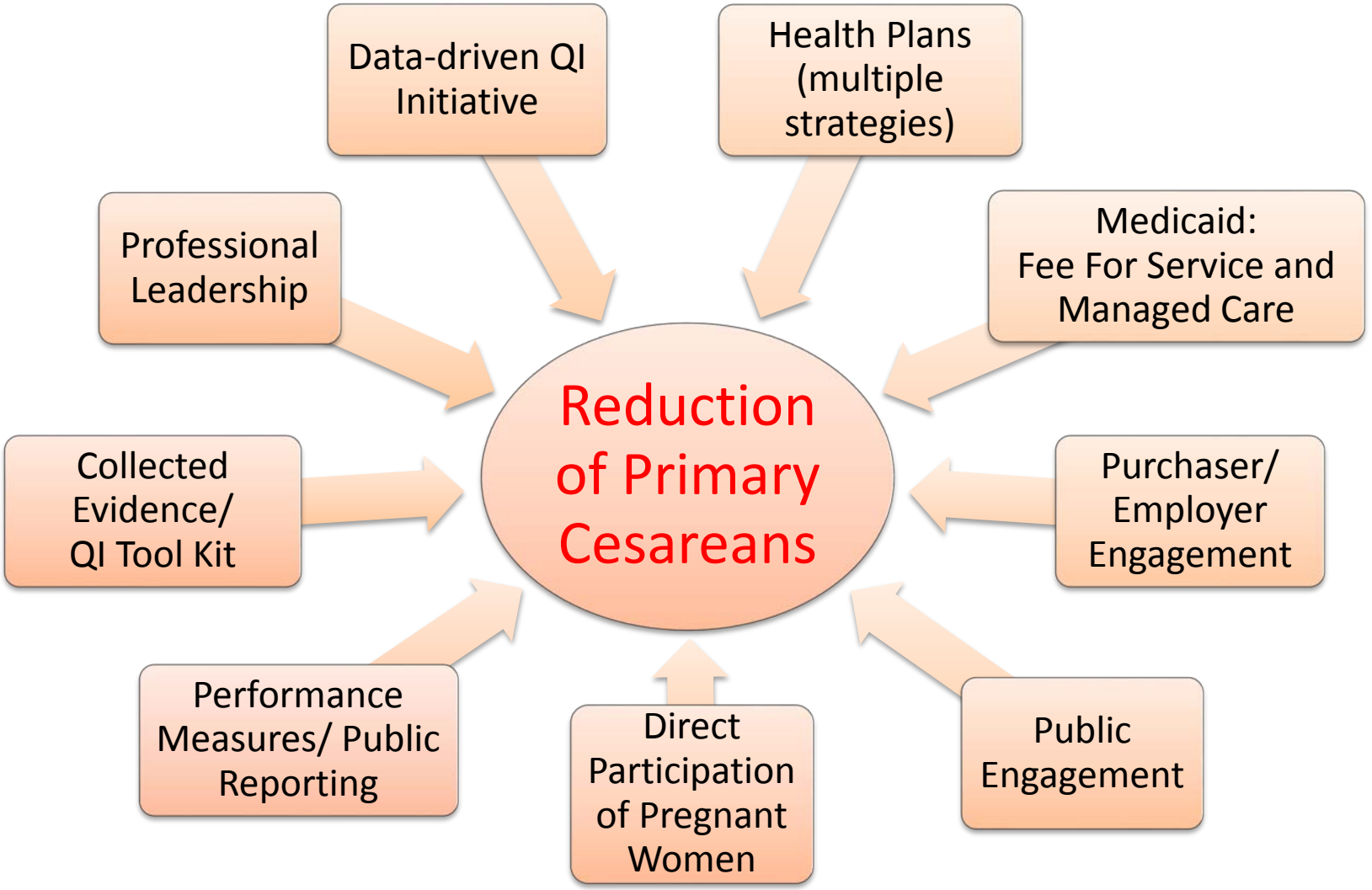
Joint Action in Support of the Collaborative

- Transparency
  - The Joint Commission mandate for reporting NTSV CS rate for all hospitals
  - Public Reporting of CA state data on Cal Hospital Compare of national maternity metrics (NTSV, Episiotomy, VBAC, Breast Feeding)
  - CA Secretary of Health Hospital Honor Roll for NTSV meeting HP 2020 target
  - Sharing of Cal Hospital Compare data with Yelp, live July 2017, other social media may follow suit

Yelp Maternity Data (start 7/17)



Collaborative Action: Collective Impact



Multiple Leverage Points are much more effective than one or two alone

Thank You!

main@CMQCC.org

acastles@CMQCC.org

Ohio: Dissemination of Early Elective Delivery Quality Improvement

Michael Marcotte, MD, Director of Quality and Safety for Women's Services, TriHealth

Ohio Perinatal Quality Collaborative

Ohio: Dissemination of Early Elective Delivery Quality Improvement

Michael P Marcotte, MD

Director of Quality and Safety for Women's Services

TriHealth

OB Clinical Content Expert, OPQC

September 11, 2017

Through collaborative use of improvement science methods, reduce preterm births & improve perinatal and preterm newborn outcomes in Ohio as quickly as possible.
<Insert Attribution Language here>

Ohio Perinatal Quality Collaborative

Obstetrics

- 39-Week Scheduled Deliveries without medical indication
- ANCS for women at risk for preterm birth ($24^{0/7}$ - $33^{6/7}$)
- Progesterone for Preterm Birth Risk
- Increase Birth Data Accuracy & Online modules
- Spread to all maternity hospitals in Ohio

Neonatal

- BSI: High reliability of line maintenance bundle
- Use of human milk in infants 22-29 weeks GA
- Neonatal Abstinence Syndrome
- NICU Grads Project

Ohio Perinatal Quality Collaborative

Participating Sites

Ohio Department of Health

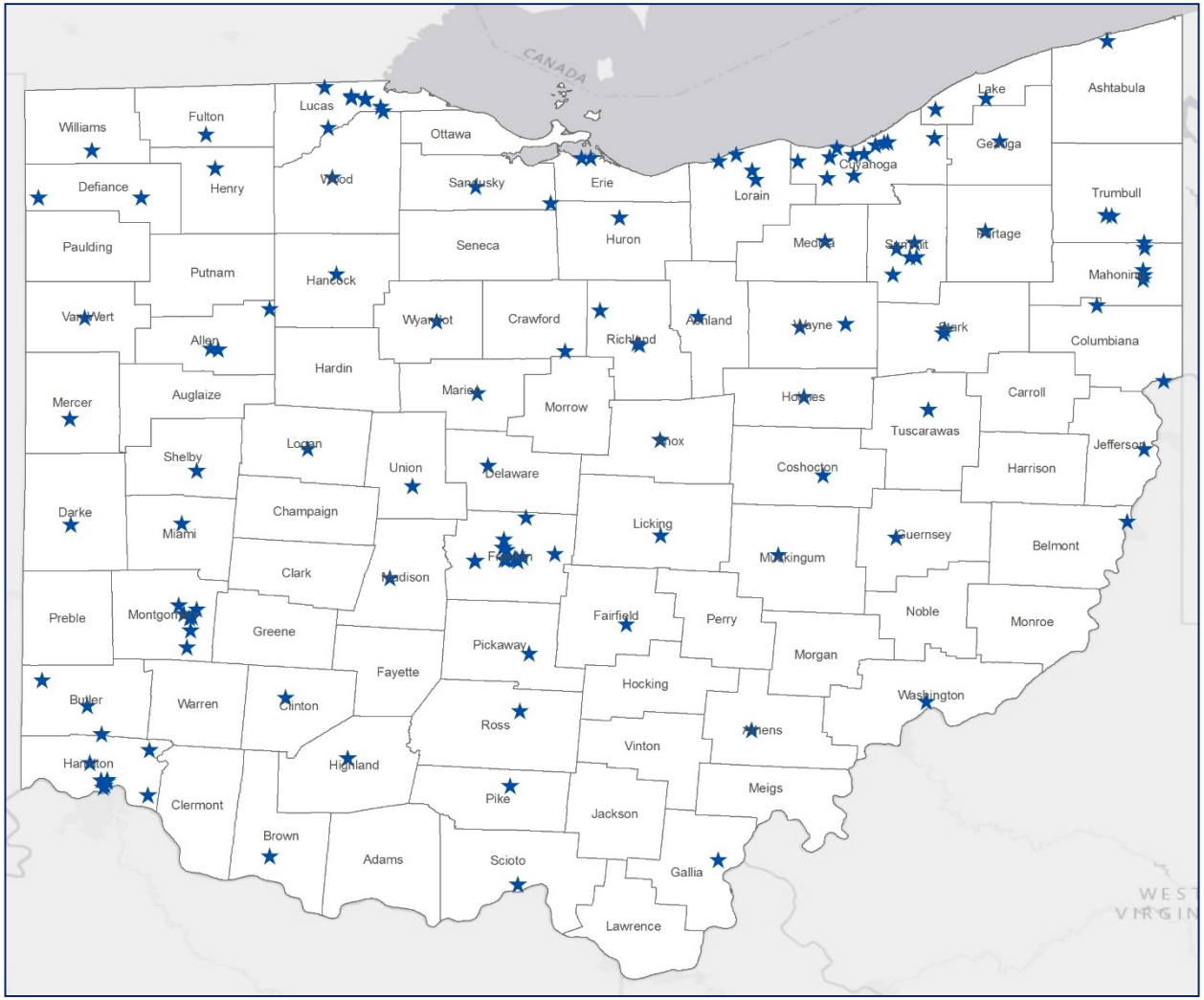
Ohio Department of Medicaid
John R. Kasich, Governor
Barbara R. Sears, Director

MedTAPP Medicaid Technical Assistance and Policy Program

Ohio Colleges of Medicine Government Resource Center

CDC Centers for Disease Control and Prevention

OPQC Ohio Perinatal Quality Collaborative



105 (of 107) Maternity Hospitals

52 (of 54) Level II & III NICUs

5 Children's Hospitals NICUs

23 Outpatient OB Clinics

9 Federally Qualified Health Centers

It takes a village…

Early Elective Delivery

OPQC 39 Week Project – three phases

Pilot, expansion, full implementation

2008-2013

OPQC OB 39 week Project

20 Charter Hospitals

49% of Ohio Births

39-Weeks Charter Project

Kick-off: September 2008

15 Pilot Sites

17% of Ohio Births

39-Weeks Pilot Dissemination and Birth Certificate Accuracy Project

Kick-off: March 2012

70 Remaining Maternity Hospitals
(2 chose not to participate)

32% of Ohio Births

39-Weeks Dissemination and Birth Certificate Accuracy Project

Kick-off:
Wave 1: February 2013
Wave 2: May 2013
Wave 3: July 2013

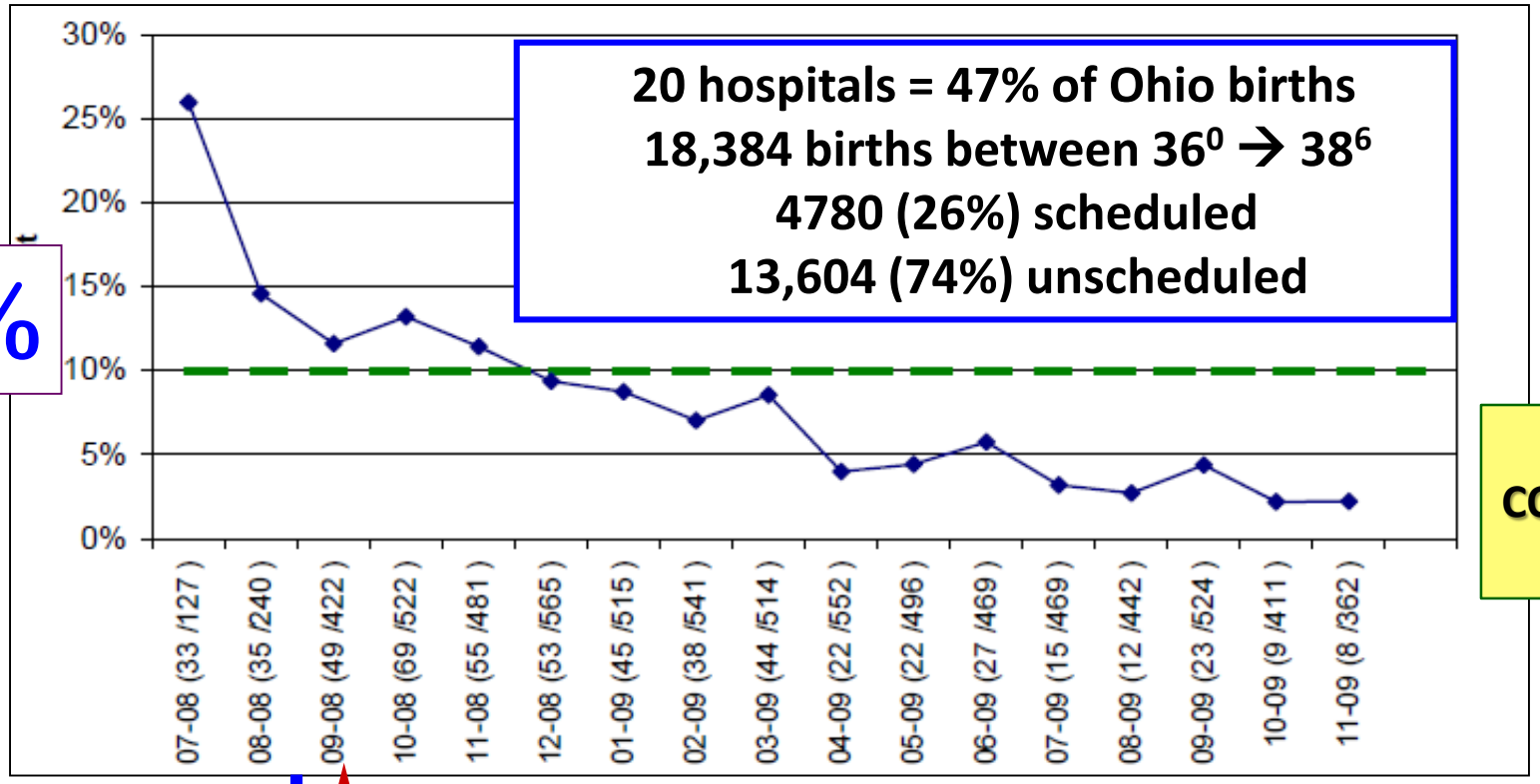
OPQC Ohio Perinatal Quality Collaborative

OBSTETRICS

A statewide initiative to reduce inappropriate scheduled births at $36^{0/7}$–$38^{6/7}$ weeks' gestation

The Ohio Perinatal Quality Collaborative Writing Committee

AJOG 2010



20 hospitals = 47% of Ohio births
18,384 births between 36^0 → 38^6
4780 (26%) scheduled
13,604 (74%) unscheduled

%

HAND COLLECTED DATA

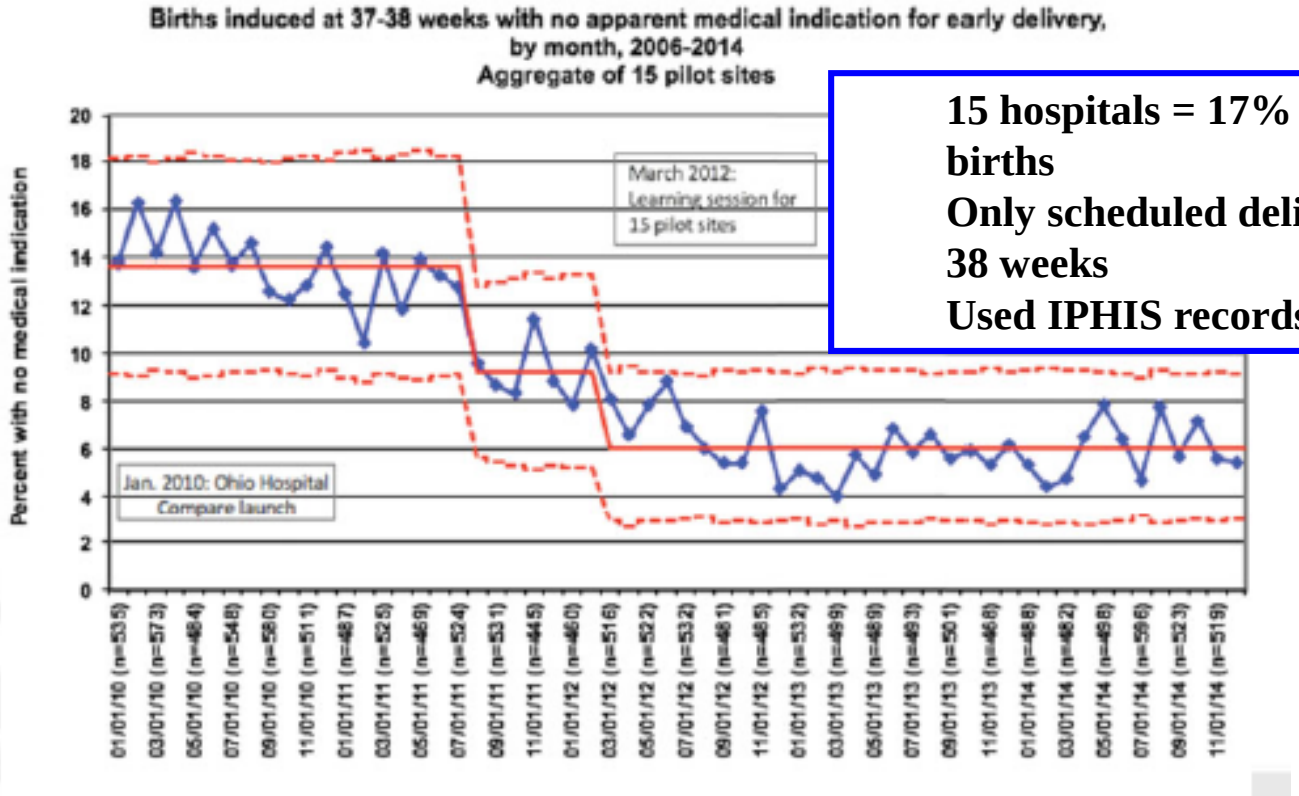
Observe X 2 Months

Project ran 9-1-08 → → 11-30-09

American J of Perinatology August 2017

Using a State Birth Registry as a Quality Improvement Tool

Carole Lannon, MD, MPH[1] Heather C. Kaplan, MD, MSc[1] Kelly Friar, MHA[2] Sandra Fuller, MEd[1]
Susan Ford, BSN, MSN[3] Beth White, MSN[4] John Besl, BS[1] John Paulson, MS[5] Michael Marcotte, MD[6]
Michael Krew, MD, MS[7] Jennifer Bailit, MD, MPH[8] Jay Iams, MD[9]



15 hospitals = 17% of Ohio births
Only scheduled deliveries 37 & 38 weeks
Used IPHIS records for data

OPQC Ohio Perinatal Quality Collaborative

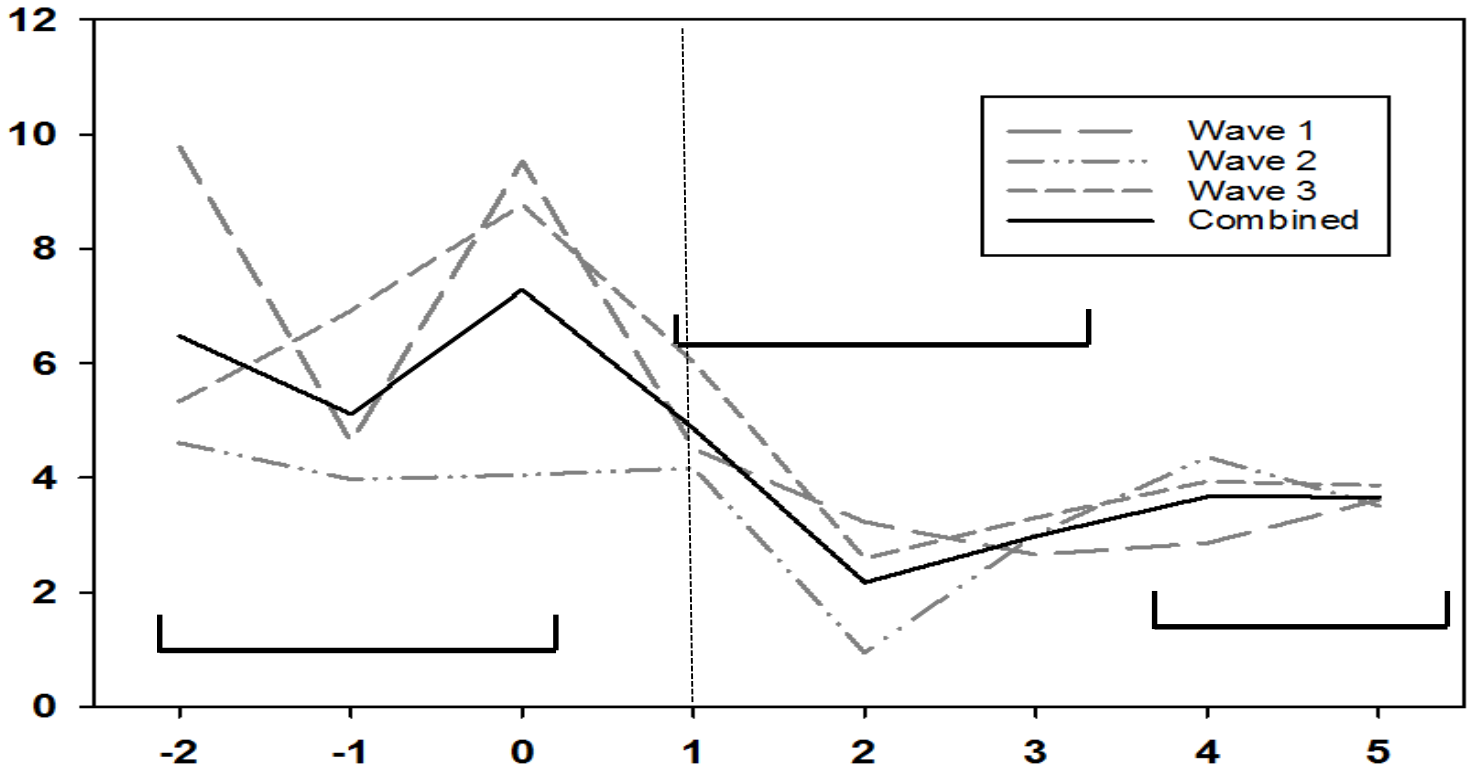
Using Quality Improvement to Reduce Early Elective Deliveries and Improve Birth Registry Accuracy

soon to be submitted to Obstetrics & Gynecology

- 70 remaining Maternity hospitals

(32 % of births)

- Three waves
- Staggered starts



OPQC Ohio Perinatal Quality Collaborative

Thank You!

Web: www.OPQC.net

Email: info@OPQC.net

OPQC Ohio Perinatal Quality Collaborative

Hospital Accreditation & Perinatal Care Certification

Susan Yendro, RN, MSN, Project Director, Department of Quality Measurement

The Joint Commission

Perinatal Care (PC) Performance Measures

Susan Yendro, RN, MSN
Project Director
Department of Quality Measurement
The Joint Commission
September 11, 2017

The Joint Commission

Perinatal Care (PC) Measures Chart Based

- PC-01 Elective Delivery
- PC-02 Cesarean Birth
- PC-03 Antenatal Steroids
- PC-04 Health Care-Associated Bloodstream Infections in Newborns
- PC-05 Exclusive Breast Milk Feeding

The Joint Commission

Electronic Perinatal Care Measures (ePC)

- ePC-01 Elective Delivery
- ePC-05 Exclusive Breast Milk Feeding

The Joint Commission

Perinatal Care Project History

- 2007 – Board of Commissioners recommended updating measures
- 2008 – National Quality Forum project
- 2009 – TAP/TJC identified new measures, Measure specifications released
- 2010 – Data Collection began
- 2012 – PC-01 and PC-05 specified as eCQMs
- 2015 – Perinatal Certification program launched

The Joint Commission

PC Project Updates

- PC measures review for NQF endorsement
  - All 5 chart based and 2 eCQMs passed through process and received continued endorsement in Fall of 2016
- PC-02 is being reengineered into an electronic Clinical Quality Measure (eCQM)

The Joint Commission

Joint Commission Requirements

- For **accreditation** ORYX: 5 PC measures mandatory for hospitals with 300 or more births per year (effective January 1, 2016)
- For **certification**: No minimum number of births required - all participants must report the 5 PC measures

The Joint Commission

2017 CMS Requirements

- For the Hospital Inpatient Quality Reporting (IQR)
  - required to report chart-abstracted measure PC-01
- For IQR and EHR Incentive Programs
  - eCQM requirements to report eCQMs
  - Included in 15 available eCQMs:
    - ePC-01 and ePC-05

The Joint Commission

Accreditation and Certification

- Accreditation Surveys
  - Organization-wide evaluation of care processes and functions
- Certification Reviews
  - Product or service-specific evaluation of care and outcomes

The Joint Commission

Performance Improvement Standards

- Implements an organized, comprehensive approach to performance improvement
- Collects & analyzes PI data
- Uses this data and information to improve or validate care, treatment, or services provided

The Joint Commission

Quality Check

- https://www.qualitycheck.org/

The Joint Commission

The Joint Commission's Annual Report on Quality and Safety

Table 8: Perinatal care measure results

As in the other measure sets, high rates are preferred in this measure set for two of the measures. However, a lower score reflects better performance on the Cesarean section, elective delivery, and newborn bloodstream infections measures.

PERFORMANCE MEASURE	2011	2012	2013	2014	2015	2011-2015 DIFFERENCE (% POINTS)
Perinatal care composite	**53.2%**	**57.6%**	**74.1%**	**96.3%**	**97.6%**	**44.4%**
Antenatal steroids	73.6%	81.8%	89.7%	91.8%	97.2%	23.6%
Cesarean section*	26.3%	26.3%	25.9%	26.8%	26.2%	-0.1%
Elective delivery*	13.6%	8.2%	4.3%	3.3%	2.3%	-11.3%
Exclusive breast milk feeding**	46.2%	50.8%	53.6%	49.4%	51.8%	5.6%
Newborn bloodstream infections*	N/A	N/A	2.5%	3.2%	2.4%	-0.1%

Since implementation in 2011, the average number of hospitals reporting data was 724 and ranged from 151 to 1,756.
* For this measure, a decrease in the rate is desired, so a negative percentage point difference is favorable.
** This measure was included in the composite for 2011 and 2012, but not subsequently.
This measure is an outcome measure and is not included in the composite. Only proportion process measures are included in the composite.

The Joint Commission

The Joint Commission PC Measure Resources

- Access the Annual Report at: https://www.jointcommission.org/annualreport.aspx
- View the manual and post questions at: http://manual.jointcommission.org
- Pioneers in Quality: Expert to Expert Series, eCQM Measure of Focus: ePC – 1 & 5 https://www.jointcommission.org/piq_expert_to_expert_series/

The Joint Commission

Questions

The Joint Commission

The Joint Commission Disclaimer

- These slides are current as of (8/28/2017). The Joint Commission reserves the right to change the content of the information, as appropriate.

The Joint Commission

Update on Development of Contraceptive PRO-PM Measures

Christine Dehlendorf, MD, MAS, Director, Program in Woman-Centered Contraception, University of California, San Francisco

A performance measure of patient-centered contraceptive counseling

Christine Dehlendorf, MD MAS
University of California, San Francisco

PWCC
Program in Woman-Centered Contraception

Background

- Concern that claims-based measures could incentivize non-patient centered counseling towards specific methods
- Measure of client experience is also of interest in general as one component of the Triple Aim
- Goal to validate a patient-reported outcome performance measure (PRO-PM) that may be used to measure the client-centeredness of contraceptive counseling delivered by providers

PWCC
Program in Woman-Centered Contraception

Validation of IQFP

- Construct validity - associated with:
  - Global visit satisfaction (100% vs. 51%)
  - Satisfaction with process of method selection (77% vs. 30%)
- Convergent validity – associated with audio recording derived measures of patient centered care
- Predictive validity – associated with contraceptive continuation and use of an effective method
- Discriminant validity - Not associated with minutes in counseling

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Program in Woman-Centered Contraception

Adaptation as a PRO-PM

- Reduce items in order to have parsimonious tool for non-research setting, while retaining psychometric characteristics
- Define target population for measure
- Test face validity as performance measure with patients, providers and clinic administrators
- Test validity and reliability as a performance measure

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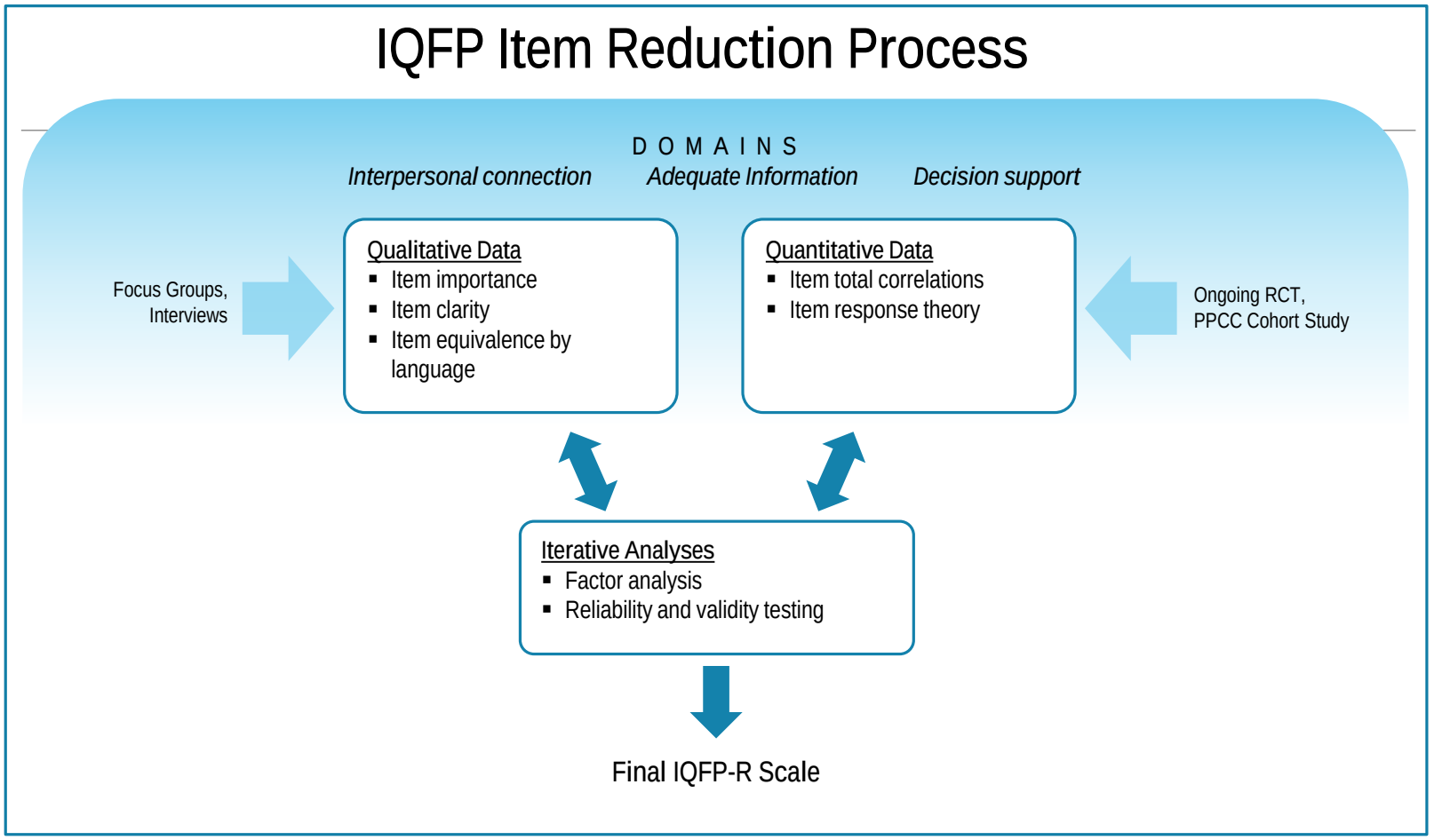
Program in Woman-Centered Contraception

IQFP Item Reduction Process



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Final Four Item Scale

Think about your visit with [provider] at [site] on [date of visit]. How do you think they did? Please rate them on each of the following by circling a number.	Poor	Fair	Good	Very good	Excellent
Respecting me as a person	1	2	3	4	5
Letting me say what mattered to me about my birth control method	1	2	3	4	5
Taking my preferences about my birth control seriously	1	2	3	4	5
Giving me enough information to make the best decision about my birth control method	1	2	3	4	5

PWCC

Program in Woman-Centered Contraception

Defining Target Population

- Goal to define target population for use of IQFP-R
  - Who gets the survey?
- Balance between standardization and flexibility/real world feasibility
- Two pronged approach:
  - Use clinic-based, same day identification when feasible
  - Otherwise, develop algorithm to identify target population to receive survey

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Program in Woman-Centered Contraception

Pilot Testing

Pilot test the IQFP-R to measure face validity and optimize administration

- Modified Delphi Process with up to 30 providers and administrators; integrate results with those from patient interviews
  - Face validity
  - Administration
- 20 semi-structured interviews and 3 focus groups of patients
  - Face validity
  - Feedback on administration of PRO-PM
  - Assess equivalence of paper and tablet versions of the IQFP-R

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Program in Woman-Centered Contraception

Real World Testing

- Work with 10 clinics for real-world testing
- Plan to send survey to 15,000 patients
- Obtain responses from 2,400 (20% response rate) within one month of clinical encounter
- Complete analysis of bias, validity, reliability and implementation cost
- Create dissemination materials
- Hold meetings with administrators and providers for feedback of real world implementation

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Risk Adjustment

- Consider it unlikely will be necessary, as quality counseling generally applicable
- IQFP scores not correlated with patient demographics
- Risk adjustment generally not considered necessary in Delphi Process with providers and clinic administrators
- Will also evaluate statistically at PRO-PM level, including related to language and mode of administration

PWCC
Program in Woman-Centered Contraception

Implementation of Contraceptive Measures

Brittni Frederiksen, MPH, PhD, Health Scientist,
Office of Population Affairs (OPA)

Implementation of Contraceptive Measures

Brittni Frederiksen, MPH, PhD, Health Scientist
Office of Population Affairs (OPA)

Three contraceptive measures endorsed by NQF

- **2902 Contraceptive Care – Postpartum:**

Among women ages 15 through 44 who had a live birth, the percentage that is provided:

1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraceptive within 3 and 60 days of delivery.
2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Intermediate Clinical Outcome

- **2903 Contraceptive Care – Most & Moderately Effective Methods:**

The percentage of women aged 15-44 years at risk of unintended pregnant that is provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception.

Intermediate Clinical Outcome

- **2904 Contraceptive Care – Access to LARC:**

Percentage of women aged 15-44 years at risk of unintended pregnant that is provided a long-acting reversible method of contraception (i.e., implants, intrauterine devices or systems (IUD/IUS).

Structure

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Entities currently using the measures

- Healthy People 2020 Objectives: Objectives FP-16.1 and FP-16.2 use National Survey of Family Growth Data to calculate #2903
- 2017 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) and Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) incorporated NQF # 2902 Contraceptive Care – Postpartum Women Ages 21-44 and Ages 15-20
- CMCS Maternal and Infant Health Initiative: 13 states and 1 US territory have reported on all three contraceptive care measures for the past two years and are funded to continue reporting on the measures for two more years (2014-2017)
- Collaborative Improvement and Innovation Network to Reduce Infant Mortality (IM CoIIN): 3 states reporting on the contraceptive care measures and 6 states working on establishing the measures in their state
- Association of State and Territorial Health Officials (ASTHO) Increasing Access to Contraception Learning Community: 26 states and 1 territory using the contraceptive care measures as part of their outcome evaluation
- Planned Parenthood Federation of American (PPFA) reports on #2903 and #2904 with their clinical quality improvement (CQI) affiliate cohort in their quality dashboards and in a CQI Learning Collaborative
- Oregon is using #2903 as part of a pay-for-performance measure set in their accountable care model for Medicaid
- Bayer HealthCare Pharmaceuticals recently published trends and regional variations in all of the contraceptive care measures in the commercial sector using the Truven Health MarketScan Commercial Claims Database
- Title X is using an adaptation of measures in Performance Measure Learning Collaboratives (PMLCs) based on the Institute for Healthcare Improvement's Breakthrough Series model

OPA | OFFICE OF POPULATION AFFAIRS

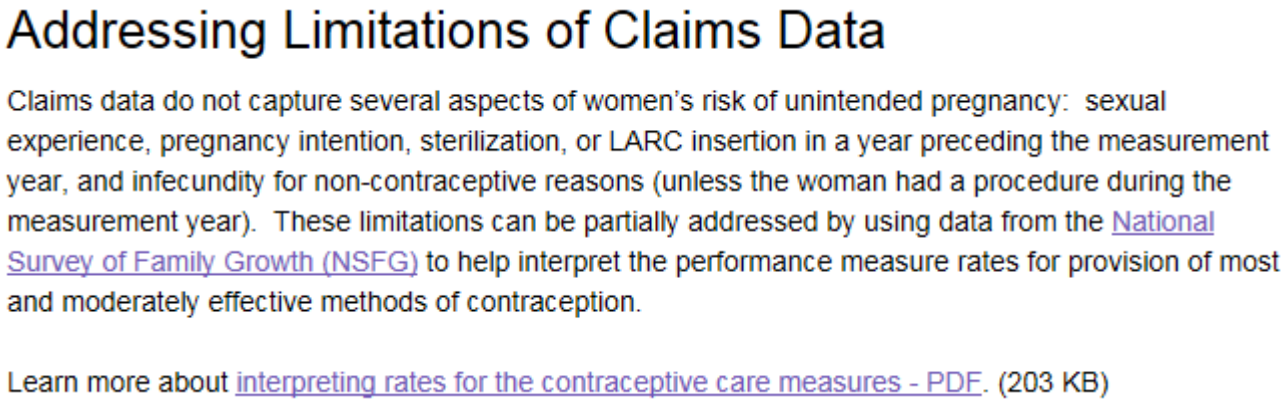
Lessons Learned: Communication is Key

- Adjusting the denominator using National Quality Forum data
- Ensuring measures are used in a patient-centered manner
- Benchmarking

OPA | OFFICE OF POPULATION AFFAIRS

Addressing Limitations of Claims Data for Denominator

- Difficult to capture a denominator of women at risk of unintended pregnancy using claims data
- Developing eMeasures for submission to NQF in 2019 to address the limitations of claims data
- Created an interpretation guide posted on OPA's website to help with interpretation of each of the measures



Addressing Limitations of Claims Data

Claims data do not capture several aspects of women's risk of unintended pregnancy: sexual experience, pregnancy intention, sterilization, or LARC insertion in a year preceding the measurement year, and infecundity for non-contraceptive reasons (unless the woman had a procedure during the measurement year). These limitations can be partially addressed by using data from the National Survey of Family Growth (NSFG) to help interpret the performance measure rates for provision of most and moderately effective methods of contraception.

Learn more about interpreting rates for the contraceptive care measures - PDF. (203 KB)

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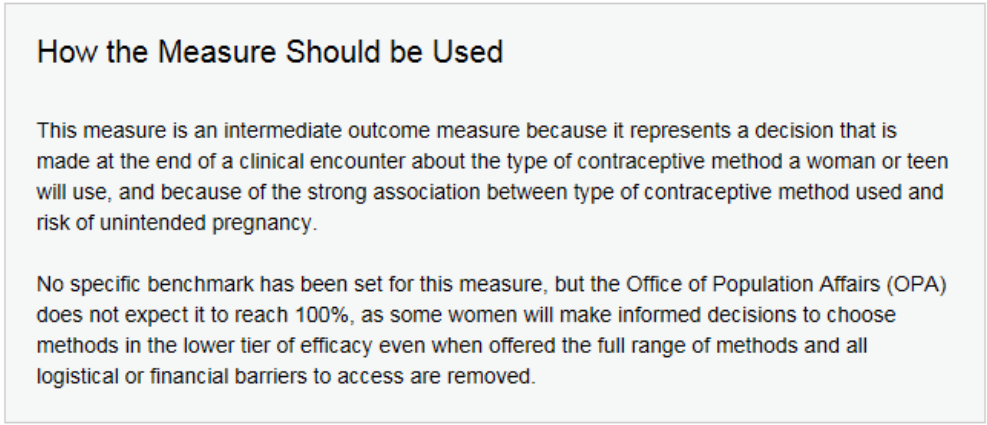
Ensuring Patient-centeredness

- Included a section on the OPA website on how the measures should be used

https://www.hhs.gov/opa/performance-measures/index.html



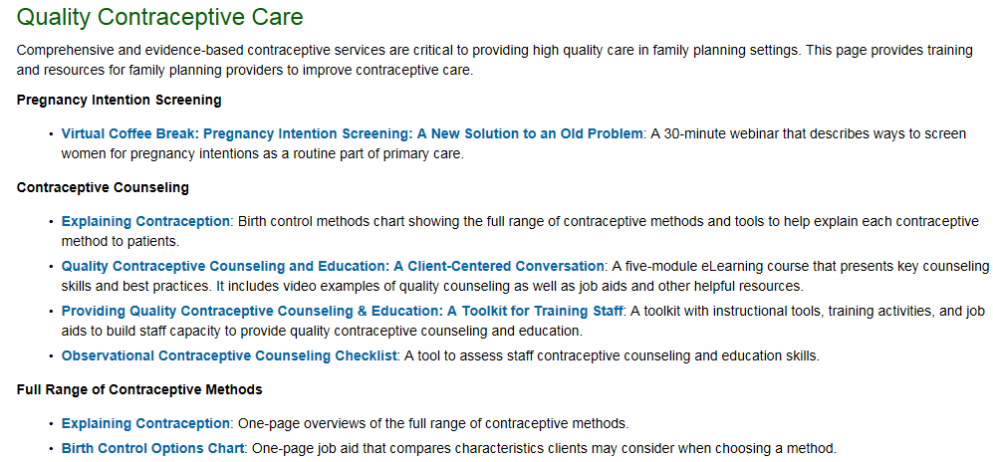
How the Measure Should be Used

This measure is an intermediate outcome measure because it represents a decision that is made at the end of a clinical encounter about the type of contraceptive method a woman or teen will use, and because of the strong association between type of contraceptive method used and risk of unintended pregnancy.

No specific benchmark has been set for this measure, but the Office of Population Affairs (OPA) does not expect it to reach 100%, as some women will make informed decisions to choose methods in the lower tier of efficacy even when offered the full range of methods and all logistical or financial barriers to access are removed.

- Extensive training on FPNTCs website

https://www.fpntc.org/quality-contraceptive-care



Quality Contraceptive Care

Comprehensive and evidence-based contraceptive services are critical to providing high quality care in family planning settings. This page provides training and resources for family planning providers to improve contraceptive care.

Pregnancy Intention Screening

- **Virtual Coffee Break: Pregnancy Intention Screening: A New Solution to an Old Problem**: A 30-minute webinar that describes ways to screen women for pregnancy intentions as a routine part of primary care.

Contraceptive Counseling

- **Explaining Contraception**: Birth control methods chart showing the full range of contraceptive methods and tools to help explain each contraceptive method to patients.
- **Quality Contraceptive Counseling and Education: A Client-Centered Conversation**: A five-module eLearning course that presents key counseling skills and best practices. It includes video examples of quality counseling as well as job aids and other helpful resources.
- **Providing Quality Contraceptive Counseling & Education: A Toolkit for Training Staff**: A toolkit with instructional tools, training activities, and job aids to build staff capacity to provide quality contraceptive counseling and education.
- **Observational Contraceptive Counseling Checklist**: A tool to assess staff contraceptive counseling and education skills.

Full Range of Contraceptive Methods

- **Explaining Contraception**: One-page overviews of the full range of contraceptive methods.
- **Birth Control Options Chart**: One-page job aid that compares characteristics clients may consider when choosing a method.

- Maintaining national standard of care through *Providing Quality Family Planning Services: Recommendations of CDC and U.S. Office of Population Affairs*

qfp

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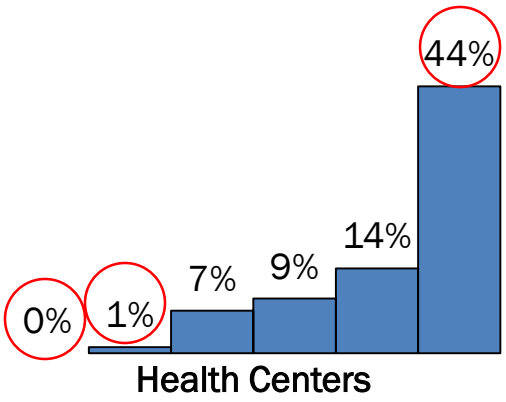
Benchmarking

- OPA is taking steps to obtain expert input on these issues:
  - Considering whether to recommend a specific benchmark for most/mod
  - Communicating that the LARC measure is an access measure and we should be focusing on the left end of the distribution
  - Is there a need to focus on the right end of the distribution as well?



How the Measure Should be Used

This measure should be used as an access measure to identify very low rates of LARC use (less than 1-2% use); very low rates may signal barriers to LARC provision that should be addressed through training, changes in reimbursement practices, quality improvement processes, or other steps. The barriers to obtaining LARC are well documented, and include client physician lack of knowledge, financial constraints, and logistical issues. The *Contraceptive Care – Access to LARC* measure should not be used to encourage high rates of use as this may lead to coercive practices. This is especially important given the historical context of coercive practices related to contraception. For the same reason, it is not appropriate to use the *Contraceptive Care – Access to LARC* measure in a pay-for-performance context.

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Communicating about the Contraceptive Care Measures

- Office of Population Affair's website
- Family Planning National Training Center
  - Resources on client-centered counseling
  - IHE Breakthrough Learning Collaborative model
- Four manuscripts and commentary by NFPRHA on the contraceptive care measures in the September 2017 issue of Contraception
- National Family Planning & Reproductive Health Association's (NFPRHA) Contraceptive Quality Measures Implementation Subgroup's communication products

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Moving Forward

- Many organizations are using the measures and we have set up systems to capture that experience
- We will be submitting the claims-based measures for maintenance in 2019
- Planning on submitting eMeasures for NQF endorsement in 2019
- Collaborating with PRO-PM to use these measures synergistically

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Committee Discussion / Q&A

Public Comment

Next Steps

- Staff will draft and share a summary of today's call

Project Contact Info

- Email: Perinatal@qualityforum.org
- NQF Phone: 202-783-1300
- Project page:
http://www.qualityforum.org/Perinatal_Project_2015_2016.aspx
- SharePoint site:
http://share.qualityforum.org/Projects/Perinatal/SitePages/Home.aspx

Thank you!