NATIONAL QUALITY FORUM

Moderator: Suzanne Theberge
September 11, 2017
2:00 p.m. ET

OPERATOR: This is Conference #59915216

Operator: Welcome to the conference. Please note, today's call is being recorded. Please stand by.

Suzanne Theberge: Good afternoon, everyone, and welcome to the Perinatal and Reproductive Health Standing Committee Off-Cycle Webinar. This is Suzanne Theberge. I'm the Senior Project Manager on the team.

Next slide, please. We are just going to quickly go over the agenda and do a committee roll call and then we'll dive right into our series of presentation.

So, as you can see, we've got a great set of presentations today and then after we hear from our speakers, we will do a committee Q&A and discussion. Following that, we'll have a few minutes for public comment and then we'll close out with next steps.

All right. Next slide, please. And next slide please. I will do a quick roll call of the committee and if folks can just say here so we know you're on the line that would be great.

Matthew Austin? Jennifer Bailit?

Jennifer Bailit: I'm here.

Suzanne Theberge: Amy Bell.

Amy Bell: I'm here.

Suzanne Theberge: Tracy Flanagan?

Tracy Flanagan: Here.

Suzanne Theberge: Gregory Goyert? Kimberly Gregory?

Kimberly Gregory: Here.

Suzanne Theberge: Ashley Hirai?

Ashley Hirai: Here.

Suzanne Theberge: Mambarambath Jaleel? Diana Jolles?

Diana Jolles: Here.

Suzanne Theberge: John Keats? Deborah Kilday?

Deborah Kilday: Here.

Suzanne Theberge: Nancy Lowe? Sarah McNeil? Jennifer Moore? Kristi Nelson? Juliet Nevins? Sheila Owens-Collins?

Sheila Owens-Collins: Here.

Suzanne Theberge: Cynthia Pellegrini?

Cynthia Pellegrini: Here.

Suzanne Theberge: Diana Ramos? Carol Sakala?

Carol Sakala: Here.

Suzanne Theberge: Naomi Schapiro? Karen Shea? Marisa Spalding? Sindhu Srinivas?

Sindhu Srinivas: Here.

Suzanne Theberge: Rajan Wadhawan? Carolyn Westhoff? And Janet Young? All right. Thanks, everybody. And I'd like to welcome all the folks that we have online as well. We have quite a few people who dialed in to hear the presentations today. So, welcome, everyone.

So, just very quickly, as you probably recall from our last webinar, NQF does hold this off-cycle conference call every quarter or so when the committees are not meaning to review measure and we do any number of topics on these webinars.

We can talk about what's going on at NQF. We might bring up an issue that was deferred from one of our in-person meetings during the CDP. We might talk about measure and science issue or we might do something today like what we're doing today which is a series of informational presentation on our use of NQF-endorsed measures.

So, very excited about today's topics and since we have such a full agenda, I'd like to just dive right in and get started. So, next slide, please. We are going to start with Missy Danforth who's the Vice President for Hospital Ratings at Leapfrog.

And we're actually going to do things a little bit differently from Missy's presentation. We are going to take committee questions, just a couple of minutes of committee questions directly after Missy's presentation before we do the rest of the presentations.

And then following that, we'll hold questions. Missy has (kind of with) a previous engagement and can't stay for the whole call. But we did want to give our committee members a chance to ask some questions. So, Missy, I'll turn it over to you. Thank you.

Missy Danforth: Thank you so much, everyone. Good afternoon and I'll be referencing few of the members of the standing committee who also participate on our Leapfrog Group, maternity care committee as well as we move through the presentation.

So, next slide. So, today, I'm going to talk about Leapfrog's use of NQF-endorsed measures specifically the episiotomy measure. Next slide.

So, just a little bit of background about the Leapfrog Group for those of you that may not be familiar with us. We are national, not-for-profit. We're actually located in downtown Washington, D.C. just a few blocks from the White House.

We were founded in 2000 by large purchasers of healthcare in response to the 1999 IOM Report to Err is Human. We have been collecting and publicly reporting information about the safety and quality of inpatient hospital care in particular now for over 15 years.

Our hospital ratings are used by all national health plans, many regional health plans and several transparency vendors, both in payment and for public reporting purposes.

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

We administer an annual, voluntary survey. It includes those measures that matter most to healthcare purchasers and consumers. All of our measures are evidence-based and when possible aligned with other national measurement organization.

The 23 national measures are divided into six different domains of hospital care, including inpatient care management. Medication safety, maternity care, which I'll focus on today, insuring and infections, pediatric care and inpatient surgery. And we actually use several NQF-endorsed measures through all six of these domains.

In 2016, over 1,850 hospitals submitted only for our hospital survey. Again, because our survey is voluntary, we're very impressed with this level of participation across the country. This number represents about 61 percent of all inpatient hospital bed and this year, we're actually expecting about 2,000 hospital surveys by the end of the year.

Our results are publicly reported for free on our website leapfrooggroup.org and you can get -- you can use this direct link to look up results for any hospital. We're actually publishing 2017 results right now. That survey opened on April 1st and it will close on December 31st.

Next slide. Our maternity care domain currently includes several measures, including elective deliveries, cesarean births, episiotomy, which I'm going to focus on today, DVT prophylaxis for women undergoing cesarean section, bilirubin screening for newborns and high risk deliveries composite.

The NQF-endorsed episiotomy measure was actually first added to the survey about five years ago in 2012. And as I mentioned, our maternity care section of our survey overseen by a national expert panel which is chaired by one of the presenters today, Dr. Elliott Main, and also includes two members of this committee, Jennifer Bailit and Kimberly Gregory.

Next slide. Well, what was (the emphasis) about for the past several years are really to two things related to episiotomy.

So, first is the increased number of hospitals willing to be transparent regarding their performance on this measure. As you can see in 2012, we had fewer than 850 hospitals that were publicly -- that were providing responses to the section of the survey.

The average rate at that time was 13 percent against Leapfrog's target rate of 12 percent. As you can see, as we've moved over time, we're now in 2017 and really only halfway through our survey cycle, we already have over 1,100 almost 1,200 hospitals that are reporting their performance on the episiotomy measure.

The average rate is down to 7.9 percent, again, from 13 percent in 2012. And as you can see, our expert panel has lowered the target for this particular measure from 12 percent in 2012, 2013 and 2014 to 5 percent.

And hospitals have really risen to that challenge. You can see the percentage of hospitals fully meeting our standard. It's 44 percent. So, you can see

there's a little decrease between 2014 and 2015 when we first lowered the target from 12 percent to 5 percent.

And now that percentage of hospitals fully meeting the standard, it's slowly creeping back up to where it was in 2012. We've been extremely pleased with this progress. Next slide.

I wanted to share with you some examples of how hospitals, purchasers and consumers are also supporting the information that Leapfrog presents on its website. So, first, I wanted to share this recent example that comes from Texas Children's Hospital Pavilion for Women in Houston, Texas.

This study was actually recently published in the Journal for Obstetrics & Gynecology just in July of 2017. What I really wanted to highlight from this article is three points from the discussion section which we found incredibly significant.

First is that the hospital credits their success in lowering their health system's episiotomy rate by having a stretch goal to strive for. They specifically know that Leapfrog's decision to change its target from 12 percent to 5 percent was a big motivator in helping this particular hospital achieve their low episiotomy rate.

The second point I make is that having professional society guidelines that support the desired practice was incredibly important.

ACOG product guidelines regarding routine episiotomy many years ago and this particular hospital notes in the study that even though those guidelines were available for over a decade really having the measure on a Leapfrog hospital survey, having the rate publicly reported to health plans, consumers and others and, again, having an aggressive target to strive for was also incredibly important to their success.

And lastly, knowing that their performance was being monitored, they provide their physicians with a great deal of feedback over the course of the study and found that giving physicians their individual feedback and allowing them to

compare their performance on the measure to their colleagues also help drove done these rates.

And lastly, one thing the study highlighted which I think is important because we do hear this from time to time, from physicians, hospitals and health systems is that as they were able to reduce their rate of episiotomy over time, they did not see an increase in third and fourth degree laceration, which is always a concern.

We certainly don't want to drive down rate for one outcome measure and potentially lead to harm somewhere else. Next slide.

But in addition to hospitals and health systems who are I think doing a great job in putting actionable processes and protocols in place to not only meet Leapfrog's target but also improve the care that they're delivering in their hospitals.

We also see that purchasers, our own purchaser members are very focused on the topic of improving maternity outcome. As I mentioned, Leapfrog has a handful of maternity care measures on our survey and our purchaser members are doing a great job in highlighting hospital performance on this measure to their employer members and also the beneficiaries covered by their employer-sponsored health plan.

This is an example from an annual report put out by HealthCare 21, a healthcare coalition in Tennessee. And as you can see here, they're highlighting not only their C-section and early elective delivery rates but also the episiotomy measure as well. You can see that in that right-hand column about halfway down in the section titled Not So, Helpful After All.

Next slide. Here's another example from the South Carolina Business Coalition on Health, also another member of Leapfrog. They themselves have many purchaser members in the South Carolina market.

And you can see here, this is a screenshot from their annual report where they're featuring many of the Leapfrog measures. If you go to the next slide, you'll see that they have -- I'm sorry, go back. Sorry.

They have a special -- they do have a special callout in this report specifically for the Leapfrog hospital survey maternity care measures. And I can send links to Suzanne for both of their reports in this presentation. I should have linked those.

Next slide. And lastly, we've been really pleased to see consumer groups pick up on this information. Obviously, Leapfrog being a purchaser-led organization, we do spend a lot of time making sure that our purchaser members are using this information with their health plan and, again, among their beneficiaries covered by their own employer-sponsored plans.

But we're also then pleased to see consumer groups like Childbirth Connection highlight the results of our survey and in particular our new report on episiotomy rate. As far as we know, Leapfrog is the only national organization using this measure on a national basis and publicly reporting episiotomy rate by hospital.

You can see this information in the screenshot here that includes a link to our website and at the bottom of this particular article, you can see a screenshot from the leapfroggroup.org website where consumers can go to to compare episiotomy rates and rates on all of our maternity care measures for about 2,000 hospitals across the country.

You can search for hospitals by location or by hospital name and compare them to hospitals within your state or across the country. We've been doing a lot to make sure that these results are widely distributed.

It was recently -- actually, about two years ago, we partnered with Castlight which is one of the largest transparency vendors in the United States to publish a series of reports every spring. We have been publishing maternity care reports for about the past three years now and each of those reports include summary level data about the episiotomy measure.

So, let me stop there and see if anyone has any questions. I do apologize for not being able to stay on the entire call today. But I'm grateful for having the opportunity to talk about the work that Leapfrog is doing.

Carol Sakala: So, Missy, hi, this is Carol Sakala and thanks so much for your work and your presentation. It looks as if hundreds more hospitals are voluntarily reporting to Leapfrog on measure in other clinical areas and I wonder two things.

One is do you understand why this might be and secondly, do you have any advice for what we might do with our various roles that we all play to increase maternity reporting hospitals?

Missy Danforth: Sure. So, we do have more hospital submitting a survey into -- submitting this on maternity care. There's a couple of reasons for that.

First is that not only hospitals that participate in our survey all from maternity care. Over the years particularly at hospitals consolidate with larger health systems in their market, we are seeing a consolidation of services as well.

In addition, because we do set minimum sample sizes for all of our maternity care measures, there are often critical access hospitals and some are rural hospitals who are providing labor and delivery services that may not have enough volume to be able to report on these measures.

And lastly, I will say that because of the way that our survey results were used, including by groups like Castlight and by the national health plans, we do have a number of health systems that purposely would hold their maternity care data because they do not want that information out there in the public.

In terms of getting all hospitals who do provide the services reporting to Leapfrog, what I can say is, you know, we have regional leaders. So, groups likes HealthCare 21 and the South Carolina Business Coalition on Health; in California, it's a Pacific Business Group on Health; in Massachusetts, it's The Group Insurance Commission.

So, we have these groups that we call regional leaders in about 45 of the 50 states and I'll be happy to share that list with you all. They're always looking for partners in their region and their state to help them encourage hospitals to participate.

They themselves send letters annually to hospital CEOs. A lot of them are going out and actually meeting with these hospitals. In addition, all four national health plans for the past two years have partnered together and sent out a single letter to all general acute care hospitals in the U.S. with signatures of all four national health plan asking them to report this information.

So, oftentimes, health plans in your state or health plans that you have relationships with were also excellent opportunities to really reinforce the message that you want this information through Leapfrog.

Carol Sakala: Thank you.

Suzanne Theberge: Are there any other committee members that have any questions or comments? OK. Well, if anybody thinks something later, we can -- just send it to me via e-mail and we can pass that along and get that question answered. Thank you so much for your time today, Missy.

Missy Danforth: Thank you all. Have a great afternoon.

Suzanne Theberge: All right. So, now, we would like to turn it over to our next speaker, Elliott Main of the California Maternal Quality Care Collaborative. Elliott.

Elliott Main: Good morning and good afternoon. I am very pleased to be able to present some of our activities at CMQCC. Next slide.

What I'm going to be focusing on today is our efforts -- our ongoing and current efforts on reducing the primary cesarean rate in California particularly focused on NQF 0471 or PC-02 low-risk first-birth C-section rate.

But first, next slide, I'm going to give a brief background about CMQCC and some of our prior projects because they have informed what we -- how we're approaching this effort here.

We are a multi-stakeholder organization. So, we engage and involve in this process multiple stake health agencies, hospital systems, purchasers, the hospital associations, the payers such as PBGH and other groups as well as public groups, all with a focus on maternity care and we are based at Stanford.

Our sister organization is CPQCC which is focused on improving NICU care. But we're really more holistic looking at all births and the care of mothers. We also host a Maternal Mortality Review Committee for the State of California. This has driven a number of our projects.

Next slide. Our very first project was early elective delivery. In this, we did a toolkit and help through statewide collaboratives and that led to an 8 percent increase in full term births.

This is a big deal in California, next slide, because 8 percent increase in full term births you California accounts for now the average of 25,000 to 30,000 fewer births before 39 weeks when we've analyzed.

You know, looking at the rates of under 39-week deliveries before 2009 when we started this project, there's now 120,000 fewer under 39 weeks prevented up to 2014. So, this has been a pretty exciting event and we're going to talk about how that was done.

Next slide. The second project that we did though is to focus and translated what we learned in maternal mortality to quality improvement efforts.

We focus on hemorrhage and pre-eclampsia and used -- we did this through what we call a mentor model where we have a nurse and physician who have experience in QI work with a smaller set of hospitals, six to eight hospitals at a time, in the context of a larger classical IHI QI project that may involve up to 100 hospitals.

And not only that maternal mortality had been lowered in California but we've actually recently published on reduction of severe maternal morbidity from hemorrhage.

So, in this study, we really have identified the tools that we use, next slide, and what we really wanted to do then was to apply this to a more difficult topic which was addressing first-birth C-section rates.

This is the classic slide from the National Center for Health Statics. They do both the total C-section rate and PC-02. They do the low-risk first-birth C-section rate as shown here by the blue line.

These in the last couple of years have levelled off which is a good thing but they still have been showing an increase of 50 percent from the late 1990s which was in turn 100 percent higher than 20 years prior.

This has been addressed a number of times and ways in the past, next slide, and this really developed a concept that OB QI for C-section is the third rail for obstetric quality programs. So, many people have touched this up and gotten burned in the past. And so we wanted to be very deliberate and precise as how we approach this. Next slide.

We did not the data that has been coming out about the lack of improvement in neonatal outcomes despite the 50 percent rise in C-section and then this was interesting which was the rates of low -- very low five in the APGARs and the rates of seizures in term singleton babies over the last eight years that had 50 percent C-section rise.

And you see how with rising C-sections, we certainly did not get a fall in more difficult baby outcomes and in fact, more difficult baby outcomes rose by 50 percent to 70 percent in this time period. Certainly not the outcomes we were hoping to see. Next slide.

So, the driver for a lot of QI is variation in care. People had published a lot and the total C-section rate being quite variable from place to place with as much as tenfold variation.

But then the question arise, if you do a risk stratified measure which is focusing on a more homogenous population, not perfectly homogenous but more homogenous and that is nulliparous term singleton vertex, you should have less variation.

And what we've seen in California and elsewhere is that the variation is still there and maybe even a little more variation than in total C-section rate.

But what we see here in California where the ranges from 12 percent to 70 percent in the NTSV C-section rates is that 40 percent of the hospitals when they started this project already were meeting the national target of 23.9 percent.

So, that's certainly said that 40 percent of hospitals and this included large, small university, non-university, HMO, non-HMO hospitals, if all of those hospitals could do that, there was less of an argument that the hospitals in the right side of the curve could.

And so, obviously, one of the mantras in QI is large variation equals opportunities for improvement. Next slide.

What we are focused on in terms of key outcomes is that the greater risk for a primary C-section is actually becoming a prior C-section. There are risks, of course, for that first C-section and you see in the green columns here that primary C-section risks are quite a bit higher than vaginal births.

But a lot of that risk is related to the indications for that primary C-section but some of it is certainly hemorrhage and other issues. But the two blue columns, the light blue and the dark blue are the risks in mothers who have had a prior C-section no matter who they're delivered.

Stronger blue is a VBAC and a lighter blue or purple is the repeat C-section and you can see that once you had a C-section, your risks are three to five times higher than if you had a vaginal delivery.

So, no matter if you had a successful VBAC or not, your risks are quite a bit higher for transfusion, for raptured uterus, for unplanned hysterectomy or for ICU admission. So, this is really telling and underscoring the importance of that prevention. Next slide.

Now -- next slide. Just to put a few faces on this. There's been a lot of publicity about repeat C-section just even in the last month. A case illustrated here presented at length in "People Magazine." It's a maternal death after a routine repeat C-section; otherwise, healthy lady.

Next slide, another case of severe hemorrhage and severe post-partum depression and ongoing issues in another repeat C-section and detailed in length in "Cosmopolitan" magazine.

So, it's not only in our medical literature but it's in the public eye now. And it's not just placenta accreta which is the worst of the worst and we see that, obviously, with increasing numbers of prior C-section at length.

But we had plenty of cases here in California after even a single C-section which is our biggest catastrophe in obstetrics which is a placenta accreta. Next slide.

So, we're learning from our work in reducing elective -- early elective delivery which did involve change in hospital culture and hospital attitudes and addressing physician autonomy by taking a multidimensional approach to QI.

And this having -- just starting in the lower left, performance measures and public reporting like we talked about with Leapfrog and Joint Commission and elsewhere.

Having a quality improvement toolkit. We'd developed one for early elective delivery with the March of Dimes. Having strong professional leadership from ACOG, (A1), and others.

To engage a driven QI, going around the circle here. Engage in health plans because they have pressure points to bring in payers such as Medicaid and our purchasers and pour employers. Public engagement and direct participation of pregnant women.

So, the next slide, we're taking this approach in a very similar way for our efforts to reduce primary C-sections. So, it's not just a single effort to transparency or it's not just a toolkit but it's really trying to bring all these pressure points to their -- at the very same time. Next slide.

So, the toolkit we developed with a multidisciplinary team is really a how-to guide with a lot of resources, best practices that we've collected from around

the country. It is an encyclopedia itself. It's 159 patients -- pages and it is use as a resource.

So, more to the point to say companion implementation guide which gives you some ideas of what might be useful to do first. All of these are available on our website that's all open source. This has been funded by foundations, by California Health Care Foundation to be exact.

Next slide. This -- the toolkit implementation guides have been as I said multidisciplinary with a lot of input from ACOG as well as from our nurse-midwife colleagues and our nursing colleagues and the public.

And ACOG came out with a very nice strong letter of support for the toolkit which has been very helpful as we work with obstetricians around our state. Next slide.

Also key for large scale quality improvement when we had 250 hospitals in California with over 500,000 births annually is having a rapid cycle data center and we're indebted to our State Department of Health for the provision of file records finding birth certificates every month that we're using for quality improvement.

Ohio has also been a leader in this area as you'll hear in one of our following presentations. This is very important and very useful. So, we can give feedback, automated feedback with very little effort on the hospital side. So, this low-burden high-value data that has been harnessed now for this project.

Next slide. We can do things like do analysis for each hospital in the state as to what are the key drivers for their primary C-section rate. It varies interestingly quite a bit from hospital to hospital.

Some hospitals as illustrated here in this what we call a demo hospital has very high rates of C-section spontaneous labor. Then drilling down we would learn further that we can distinguish between CPD C-sections or failure to progress and for fetal concern C-sections or no labor C-sections so we can really tailor the quality improvement efforts to meet the issue at the facility.

Next slide. Like Missy was describing last time, what we have found in many of our facilities is the provision of provider level rates internally to the hospital is quite instructive.

Here's the hospital, one of our earlier hospitals that had very huge -- had a fairly high rate as you see at the top. This is a screenshot from our datacenter. Not the highest rate is 27 percent over the course of the year for their NTSV rate.

But you look -- go down and look among the different providers in the hospital and you'll see rates as low as 15 percent or 18 percent. Another rates that are as high is 36 percent and 42 percent.

Clearly, there's different approaches and different attitudes among the providers in terms of what's happening with your patients. Next slide.

So, we're able to follow and give hospitals -- this is a control chart in one of our pilot hospitals before we started to be collaborative and could show that the hospital rates can change quite quickly when the physicians, nurses and the administrative leadership work together with incentives.

In this case, it was a datacenter and some quality improvement work and some discussions with local purchasers and employers actually. Those are quite significant incentives but disrupt the rate from 31 percent to 23 percent in a pretty short period of time. Next slide.

So, we're in the midst of four waves of 25 to 30 hospitals each -- 38 hospitals each, all with rates above the national target. This has been divided into groups of six to eight hospitals, each led by a mentor pair.

And this is classic IHI where we had monthly check-in calls and sharing best practices on conference calls supported by our staff and we do provide and structure and outcome measures shared to the datacenter.

We really focus on labor practices that lead to C-section indication. If you have a C-section indication, you should do a C-section. But there are a lot of

things you can do differently in labor that can avoid the development of that indication to begin with. Next slide.

We are -- Wave 1 launched in May. We have 12 months of results out of an 18-month collaborative. And here we have interesting preliminary data. We have eight hospitals that have not changed much at all, 17 hospitals that have a significant reduction and 11 of the 25 are not below 23.9 meeting the national target even if they started in the high 20s or mid-30s.

We have two -- three more waves that have started this year, January, September and November 2017, all slated to be 18 months.

I'm going to show you in the next slide a couple of examples of this because we wanted to focus on downsides. As Missy was talking for episiotomy rate, it's about are you worried that you're going to have more than third to fourth degree lacerations.

We're worried about that, too, because if you had more press -- more difficult vaginal deliveries, you could have third or fourth degree lacerations. We actually did not see an increase and actually we've seen a gradual reduction in all of our hospitals from the prior four-year baseline.

The most important outcome measure though for obstetrics involving C-sections having what I'd like to call a good take home baby, in here we used the other NQF measure that’s appropriate here which is the Healthy Term Newborns.

Just been recently reendorsed and reconfigured as unexpected newborn complications which is term babies without pre-existing conditions of any kind, they're term or singleton or have no birth defects or no fetal conditions. And asking whether they had major complications during or neonatal period. Next slide.

So, here we have in the next three slides three -- you know, six hospitals that have had major reductions in their C-section rate and then following their balancing measure in the bottom panels to see whether there are lows and increase in unexpected newborn complication.

So, first hospital fell from 31 percent to 24 percent. Going to the right, this is a Level III with 3,000 births fell from the mid-30s to 22 percent. In the bottom panel through state-wide rates, their unexpected newborn complications fell below the state-wide rate and this has been maintained for the course of the project so far.

Next slide. Another two hospitals showing a 28.5 percent to 21 percent fall and again another one from the high 20s to 20 percent. And again, in the new -- in the unexpected newborn rates, you see they're flat in the first case or significant fall in the second.

In the last -- next slide. In the last caring of hospitals so these are now some small hospitals, some big hospitals, university hospitals, they all having -- they're showing flat rates or improved neonatal outcomes with lower C-section rates. So, this is very reassuring even as you get down in the 20 percent range for primary C-section rates.

Next slide. So, there are other partners in this as we talk about the multiple lever piece. The Joint Commission mandate for reporting NTSV as processed to the attention of everyone.

Public reporting of state data on Cal Hospital Compare is now active in California. So, NTSV of C-section, episiotomy, VBAC and breastfeeding rates are publicly reported for every hospital in California.

The Secretary of Health issues an annual honor roll for NTSV section meeting the 2020 target. The last transparency piece is I really find it interesting which is Cal Hospital Compare taking the NTSV data and these others and working with Yelp to have this be more available to consumers who are supposed to go into a website.

If you go Yelp, next slide, you will see each hospital for each hospital in California, how they rank in terms of C-section rate, breastfeeding rate, an episiotomy rate on the right-hand side whereas the public comment or subjective nature on the left-hand side.

We and others are still working with Yelp to get the wording right now. You can see the rights. You have to follow the link to how hospital compare.

And we're doing some usability studies to see the best way to display the data. But this is an interesting next step for consumer interface of public release data. Next slide.

So, we think this is an important approach to bring these many levers to bare at the same time. We are currently in the midst of doing some interesting work with culture and attitude on units because I think that's what really separate the high units from the low units and that's going to be fed into this process as well. Next slide. Thank you for this and I'll be taking my questions at the end with the rest of the folks.

Suzanne Theberge: Thank you so much. OK. Next slide. We're going to be hearing from Michael Marcotte from the Ohio Perinatal (Quality Collaborative), and I will turn it, Mike, over to you.

Michael Marcotte: Thank you very much and it's really an honor to represent the Ohio Perinatal Quality Collaborative and Jennifer Bailit who's on your committee is one of our obstetric clinical content experts and has helped teach us all more and more about how to get best outcomes for our moms and babies.

And I also appreciate Elliott's presentation. Thank you very much for that. It's very helpful to learn from California every chance we get. So, next slide.

So, what I thought I would start with similar to what Dr. Main talked about was just to talk about the history of the Ohio Perinatal Quality Collaborative. We are a group of obstetricians and pediatricians working to try to improve the health of newborns as quickly as possible using quality improvement.

And we've been around since around 2008 and our first project which I'm going to talk about today really was working on the early elective deliveries and we call that the 39-week scheduled delivery without medical indication project.

And I will talk about that but I also wanted to speak just briefly about some of our other projects. We were asked by the state to really look at why there was so much variation in the delivery of antenatal steroids to patients who were delivering babies before 34 weeks.

And we were able -- that's really where we began to discover that one of the critical features for us to be able to demonstrate on a population level that there's a change just some way to measure that and our easiest way was to look at the birth registry or birth certificate.

And we found quite a bit of variation in terms of the personnel who entered the data into the birth registry and found a lot of opportunity and enthusiasm by them to learn how to do that more accurately.

And now was a critical learning for us as we begin to spread our work in looking at reducing early elective deliveries throughout our state because we use the birth registry to really focus in on how to measure improvement without putting a big burden on our hospital systems, many of which are community rural hospitals, critical access hospitals.

On the neonatal side, we started with blood stream infections and really focused in on developing highly reliable ways to maintain sterility in lines that were placed in our premature babies. We then took that to the next level of really looking at the benefits of human milk for all babies that were born in the very pre-term period to improve immunity.

And our most recent project for both the -- for the neonatal teams was working on standardizing our diagnosis and care for babies born with neonatal abstinence syndrome related to prenatal opioid exposure. Our other current project is working with babies that have chronic needs after their discharge from the NICU to improve ambulatory care for that select high risk group of children.

On the obstetric side, our current project that we are in the process of spreading is our progesterone treatment to prevent preterm birth. And we have completed and published our first paper on that which was really looking

at our pilot sites to show a significant reduction specifically in that group of at risk preterm births which occur before 32 weeks.

We showed a significant reduction in that across our state but more specifically in the 23 prenatal site practices that cared for our highest risk patients in Ohio, we showed a very significant reduction.

As we go back to our 39-week project, I'll go to the next slide and just point out some of the geographic realities that we face in Ohio. We're obviously not as large as California and we only have about less than a third of the deliveries that they have.

But we do have 107 maternity hospitals. We have 54 Level II and III neonatal ICUs, five children's neonatal ICUs. We've worked with 23 outpatient OB clinics in our progesterone project and nine of our total qualified -- federally qualified health centers to work on progesterone.

We partner with the Ohio Department of Health, the Ohio Department of Medicaid, MedTAPP, which is our data and research branch of all of our medical schools, the CDC to work with funding and resources.

And as you can see in Ohio, other than a few targeted large population counties, our population is spread out throughout our 88 counties and many of them only have one healthcare center that we're working with. Next slide.

So, these are some of our partners that we work with and as Dr. Main pointed out, we really couldn't do this work if we didn't have all of these partners, both from leadership, funding and advising. We really couldn't accomplished what we have been able to accomplish in Ohio and it's one of the things that we consider as essential element as you develop a state-wide perinatal collaborative. Next slide.

So, regarding our early elective delivery project, it really had three phases. The first, the pilot phase; the second was testing expansion; and then third was full implementation. And the project occurred across five years from 2008 to 2013. Next slide.

The first part of our project was really our pilot project which occurred in 20 of our charter hospitals. It accounted for about half of our births and it started in September of 2008.

The second part of our project was really learning about how to spread significant learnings that had occurred in our charter hospitals and we picked 15 pilot sites which accounted for about 17 percent of Ohio births and we really linked that to moving from hand collected data on this which was quite burdensome for our 20 charter hospitals to using birth registry or birth certificates to measure.

And coupled with that from our learning from the corticosteroid project, we learned that we needed to help our hospital systems do better at accurately documenting in the birth registry and that project started in 2012.

Our last project was a three-wave project similar to what Dr. Main talked about is currently going on around the PC-02 measure or the primary C-section measure and we started with waves, three waves and worked with 32 percent of our Ohio births in 70 of our remaining maternity hospitals. Two of our hospitals chose not to participate. Next slide.

First was our first project which looked at the project working with our 20 large referral hospitals which accounted for 50 percent of the births. We were able to show a significant impact in reduction in early elective deliveries from 36 weeks to 38 in sixth seven weeks.

As I mentioned, this was really our project in which we had quite a burden as we learned from our hospital systems to hand collect all of this information and our project went for about 14 months but we showed a significant reduction. We continue to follow this currently and have shown a maintenance of this reduction throughout Ohio.

Next slide. In our pilot project which actually was just recently published this month, we showed that in our 15 hospital sites that we were learning using the birth registry which we call the IPHIS record to document a reduction, we were able to show a similar reduction in the early elective deliveries now

focusing just on that 37 and 38-week population which is part of the PC-01 measure.

One -- some of the things to note about this is when we look at the birth registry, we realized that we really couldn't track cesarean section. So, we only picked cases in which there was an indication in the birth registry that this was a scheduled induction of labor.

Next slide. So, in our third component of our project which occurred in the 2014 -- excuse me, 2013 and 2014, we use dissemination project within accelerated IHI platform with 70 remaining maternity hospitals.

Again, we had already seen a significant reduction in the early elective deliveries. We use the IPHIS birth registry. We did coaching and mentoring and monthly webinars with these 70 maternity hospitals in three waves and again showed similar results to reduction and sustaining of the early elective delivery rate in scheduled deliveries looking at birth registries.

Next slide. So, I will also hold my question to the end but I appreciate the opportunity to share with you how Ohio has really worked to try to bring about culture shift within all of our maternity hospitals. Some of them that have very low resources but they all were able to show significant reductions in an early elective deliveries. So, thank you.

Suzanne Theberge: Great. Thank you so much. All right. Our next presenter is Susan Yendro from the Joint Commission. Susan?

Susan Yendro: Hi, everybody. Great to be with you this afternoon and just that I would tell you a little bit about what the Joint Commission is doing with the perinatal measures. Next slide, please.

So, the Joint Commission uses the measure set perinatal care and it includes the size measures that you see here and then chart-based measure set which is elective delivery, cesarean birth, antenatal steroids, healthcare-associated bloodstream infections in newborns and exclusive breast milk feeding. Next slide, please.

We have also worked on the retooling of several measures to be able to be electronically abstracted. So, the electronic or e-quality measures are elective delivery and exclusive breast mild feeding. Next slide, please.

So, the Joint Commission which has been around for quite a long time in working with hospitals and healthcare organizations to improve quality and safety has been involved with perinatal measures since the early 2000s. We had an initial measure set that looked at pregnancy and related conditions.

And in 2007, our Board of Commissioners recommended that these measures be updated. This was based on feedback from the field and research -- available research. So, we looked at the measures that were being endorsed through National Quality Forum project in 2008.

And we convene the TAP panel in 2009 and we identified a new set of measures and we specified those measures from five different or several different measure developers and specified them under the specification manual as one set.

Hospitals began to collect data on the measures in 2010 and it was in 2012 that we did the retooling of the measures as the eCQMs. The Joint Commission also began to certify hospitals for perinatal care and that program launched in 2015. Next slide, please.

So, the Joint Commission has continued to take the measures through NQF endorsement and all five measures were re-endorsed last year and as well as two of the ECQMs. I'm sure the Committee remembers that well.

And we're also working on retooling the PC-02 measure, the NTSV measure to be able to be collected as an eCQM as well. Next slide, please.

So, the Joint Commission provides both accreditation for hospitals as well as certification. For accreditation, we require that all hospitals who have 300 or more live births per year collect and submit all five of the chart-based PC measures and this was lowering of the threshold that used to be 1,100 live births or more and took effect on January 1st of 2016.

For our certification program, we require that all hospitals that wish to be certified has to participate in all of the five measures -- submit all five measures whether they have 300 live…

Operator: Hello? Hello?

Suzanne Theberge: Susan, I think we lost you. Operator, her line still joined? Operator?

Operator: I'm not showing her line. I do have a presenter dialing in now. I'm going to pick it up.

Suzanne Theberge: Thank you.

Operator: And Susan has rejoined.

Susan Yendro: Hi, this is Susan. Can you hear me?

Suzanne Theberge: Yes, we can hear you now.

Susan Yendro: Hi. I am so sorry. Something happened with my connection. Of course, right, when you're in the middle of speaking, couldn't have happened earlier. Do you want me to just continue where I left off?

Suzanne Theberge: Yes.

Susan Yendro: OK. So, I was talking -- OK. Talking about certification requirements for all hospitals that participate in the certification program. You can go to the next slide.

So, for CMS, we also has requirements for several of the perinatal measures. Hospitals are required to report on the chart based PC-01 measure, that's the early elective delivery as well as both the PC-01 and PC-05 are part of the EHR Incentive Programs. So, hospitals, have to choose a certain number of ECQMS to report and these are also part of that incentive program.

Next slide, please. So, as I've said, the joint commission provides both accreditation and certification of services for hospitals and healthcare organizations. With the accreditation program, it's a hospital wide or

organization-wide evaluation of care and processes and the functions that they perform.

And in the certification program, it's a more specific review of a specific product or service line and evaluation of the care and outcomes related to that specific topic area.

Next slide, please. So, the join commission requires a set of standards be followed by all of the hospitals that are certified or accredited.

And within those standards, it includes an entire chapter on the implementation of an organized comprehensive approach to performance improvement and that the organization collects and analyzes their performance improvement data and that they use the information to improve and validate care treatment or the services provided.

So, it's really a look to make sure that organizations are not only collecting data but that they're actually using it to help improve the care and safety for their patients that they serve.

So, during the survey process, the surveyors will actually look at the data that hospitals have submitted on the -- using the perinatal care specific example.

And then during their onsite survey, they will go through the hospitals performance improvement plans, review the data, how the hospital goes about analyzing the data, identifying where there's gaps and performance or areas that they want to improve and then the process that they've implemented to improve those gaps in care.

They also use a tracer methodology where they follow a patient. They'll interview the patient, interview the staff taking care of the patient.

So, if there are identified gaps using the performance measures as an example, if they notice a gap where perhaps the hospital has a very low breastfeeding rate, for example, they would observe to see our patients being supported in their choice to breastfeed or they'd been given education and opportunities to

learn about it. So, they actually use the measures as they go through the process of the tracers as well.

And then we also do intercycle monitoring throughout the accreditation or the certification cycle where the performance measures are also reviewed, again, with the hospital and to review their performance improvement plan based on any gaps or areas of improvement that are noted from the measures.

Next slide, please. So, the joint commission also publicly reports the quality measures on the site called Quality Check. The website is here in case anyone is interested in going out there and looking at that.

Currently, the join commission reports that the hospital level, the process measures for perinatal care and that's all available on this site.

Next slide, please. Another improvement product that the join commission provides using the quality measures is to produce an annual report. In the annual report, it shows the measure, the measure rates, the trends.

And here, you can see it for the perinatal care measures that for hospitals that has participated in these measures, there have been improvements in care based on the improved rates.

So, you see that for several of the measures, antenatal steroids and breastfeeding, a higher rate is desirable. And for cesarean section, earlier deliveries, and newborn bloodstream infections, a lower rate is desired.

This particular screenshot shows data up through 2015, the 2016 data will come out in the 2017 annual report which we anticipate will be out in fall. It usually comes out in November. So, anybody that's interested in seeing that.

On the next slide, we have access on the site location, the website location linked here for the annual report. We also have the detailed specifications manual available publicly at the website shown here, manual.jointcommission.org where organizations can go in and look at the specifications as well as post questions. And that's specifically related to the chart-based measures.

We also did a webinar series last year for electronic quality and clinical quality measures and the PC measures were featured on one of those and that webinar replay is also available on our website. Next slide. And I will also hold my questions till the end.

Suzanne Theberge: Great. Thank you so much. OK.

So, for our next presentation, next slide, please. We're going to just briefly switch gears a little bit and here's Christine Dehlendorf of the University of California, San Francisco. She's going to give us an update on the contraceptive PRO-PM measure that was under -- is under development and that was discussed briefly at the last committee meeting.

I know there's a lot of interest in that measure so we ask that team to give us a brief update. So, Christine.

Christine Dehlendorf: Thank you so much. Can I confirm you can hear me?

Suzanne Theberge: Yes. We can hear you.

Christine Dehlendorf: Great. So, I'm glad to be here. And this will be relatively a quick tour about our work on this performance measure on patient-centered counseling.

So, next slide. As I know you all are all aware, the newly endorsed measures on contraceptive uptake or contraceptive method used are focused on the effectiveness of the methods that are used both highly or moderately effective methods or LARC methods, specifically.

And while these are, obviously, very important measures to have, there has been some concern expressed about the possibility that the use of these measures, if it's done in unnuanced way could way could incentivize nonpatients that are counseling toward specific methods.

And, obviously, there's also a goal of providing quality patient-centered care regardless of this concern around incentivizing nonpatient-centered care just as a component of quality care in general and the Triple Aim.

So, our team has been working to validate a patient reported outcome performance measure to measure the client centeredness or patient centeredness of contraceptive counseling specifically as a unique health service because of it's personal and intimate characteristics, the choices of contraceptive method, obviously, is a very personal decision so we've been focusing on the patient experience of counseling around these decisions specifically.

And we initially received funding for this work from the office population affairs and more -- after that funding was terminated, we have now received private funding for this effort.

Next slide, please. So, we started with a research-based measure, patient reported outcome measure, the interpersonal call, your family planning scale, IQFP. And we had previously documented good construct, convergent, and predictive validity, predictive validity that it was associated with contraceptive continuation and use of an effective method at six months.

And we also found discriminant validity. So, we started with that scale which is an 11-item scale and wanted to adapt that to the performance measure context.

Next slide. So, in order to adapt it as a PRO-PM, we -- our goal was to reduce the number of items from 11 to be able to have it be feasible to use in a performance measure quality improvement context while retaining its psychometric characteristics.

We also wanted to define who should receive the measure and also test face validity and then finally do validity and reliability testing for it as a performance measure, specifically.

Next slide. So, first, in order to reduce our 11-item IQFP scale, we use an iterative process using both qualitative and quantitative data. And qualitatively, we talked to patients about item importance and item clarity and also work to ensure that the items were equivalent across Spanish and English.

And then we combine that with quantitative data from almost a thousand patients that we hit had collected data on to assess item total correlations and did factor analysis and assessed using an iterative process, assessed what items were most essential to keep in a more parsimonious scale.

And we also paid attention to the domains you see across the top to make sure they were all represented.

Next slide. So, our final scale that we achieved to this process that retained all of the psychometric validity characteristics of the original 11-item scale are here and they're respecting me as a person, letting me say what mattered to me about my birth control method, taking my preferences about my birth control seriously, giving me enough information to make the best decision about my birth control method.

So, this includes both interpersonal connection domain, the information sharing domain, and the decision support domain that are previous qualitative work that's found to be important to patients in their experience of contraceptive counseling.

Next slide. So, in terms of next steps, what we're doing with this scale is we are currently in the process of working to define how we will determine who receives the survey when a given clinic or health system is using this as a performance measure.

And so, we are trying to figure out how to, given the challenges of implementing patient-reported outcome measures, we're trying to strike a balance between standardization of the target population and flexibility and how clinics can actually do it in the real world.

So, this requires a longer conversation. But just in brief, we're planning on using a two-pronged approach. One is to allow clinics who can identify patients who receive contraceptive counseling on the same day to allow them to give the survey to the patient on that same day and for clinics (wherein) that's not possible using a ICD-10 and other code-based algorithm to allow them to identify in a weekly basis their target population to whom they can send the survey.

Next slide. We also have pilot tested this four-item survey as a -- and its implementation as a performance measure specifically with both assess face validity with both providers and administrators using a modified Delphi Process.

And also with patients -- and doing this both assess face validity, as I've said, and also to optimize administration and to make sure that we have equivalence across different modes of administrations, specifically both electronic and paper versions, we're planning on using both text, e-mail, and paper versions of the survey depending on patient preferences for communication.

Next slide. So, our real-world testing is where we're going to start in the next few months, where we're going to test this survey as a PRO-PM in 10 clinics across the country.

We're planning to send the survey to 15,000 patients or to distribute it in clinic, as I've said, and estimating a 20 percent response rate. Our goal is 2,400 responses and that's in order to be able to assess reliability and validity on a provider level and we're anticipating having approximately 30 providers on our sample.

We are going to use that sample to analyze validity, reliability, and also understand implementation cost of this patient reported measure and also understand the process of implementation of the measure using interviews with the providers and administrators, so to understand better how to maximize implementation in the real world.

Next slide. Briefly, about risk adjustment, we're not anticipating risk-adjustment will be necessary based on both conceptual grounds, like, quality of contraceptive counseling shouldn't be different across different populations based on the fact that our IQFP scores did not vary by patient demographics and based on our Delphi process and the fact that providers and administrators did not think that it was appropriate but we are going to analyze statistically whether there is evidence for stratification by patient demographics.

Next slide. All right. Then I'll just briefly -- so our plan is to submit -- before handing it to Brittni -- our plan is to submit for endorsement in June or July of 2019. Thank you very much.

Suzanne Theberge: Great. Thank you. And now, we will turn to our last presentation. Brittni Frederiksen of OPA will be presenting on the implementation of the contraceptive measures that this committee recently endorsed.

Brittni Frederiksen: Awesome. Thanks, Suzanne.

Thanks for having me on this call today. I'm excited to present about measures. So, I'm a Health Scientist at the Office of Population Affairs and we are the steward of the three new contraceptive care measures.

Next slide, please. Just as a reminder, we have the three -- for those that aren't on the Committee and are on the call, we have three new contraceptive care measures. These are the first contraceptive care measures to be endorsed and we're very excited about this.

The 2903 is Most & Moderately Effective Methods in all women of reproductive age, ages 15-44. Can we go back one slide? Sorry.

And that's looking at most effective contraception and moderately effective contraception. So, that's sterilization, implants, IUDs, and then injectables, oral pills, patch ring, or diaphragm.

The second measure, how we think of them, 2904, is access to LARCs. Long-acting reversible contraceptives, implants and IUDs. And that, again, is an all women.

And then both those measures are incorporated into a postpartum measure, NQF 2902, that looks at most and moderately effective method within three and 60 days of delivery of a live birth and that's to look at the immediate postpartum period. And then the postpartum period where a woman has likely received through a postpartum visit and contraception.

So, the most mod measures are intermediate clinical outcome measures because they occur between when a woman is counseled by her provider and provided a method and then a long-term outcome of unintended pregnancies with the goal of reducing unintended pregnancies.

And then the LARCs measure is a structural measure and we have had to communicate this very strongly as an access measure. We're very interested in understanding or knowing that all women have access to LARCs. And so, we're just interested in that last end of the distribution, very low rates of LARCs use.

Next slide, please. So, not presenting any data. I'm very impressed by the other presenter's presentations and we're excited to have data at some point because these are new measures. We're really working with people to use the measures and, again, to calculate them.

So, I've listed a number of entities that are currently using the measures and just putting this list together. I was really excited to see all the work that's been done since they've been endorsed.

So, I'll just go over a few of these quickly. A version of the measures using National Survey of Family Growth Data was incorporated into the Health People 2020 Objectives, and that's just the most mod measures, 2903.

The postpartum measures, 2902, were incorporated into the Core Set, Medicaid's Core Set for the Adult and Child Core Set.

And then we're really excited to be working with CMS on their Maternal and Infant Health Initiative where 13 states and 1 territory has been reporting on all three contraceptive care measures as they were being developed and then for the next two years.

The Infant Mortality COIIN, three states are reporting on the measures and six states are working on establishing the measures in their states.

The Association of State and Territorial Health Officials has -- is working with 26 states and one territory as part of a learning community to increase

access to contraception and they'll be using these measures as part of their outcome evaluation.

And then our colleagues at Planned Parenthood Federation of America report on 2903 and 2904 within their clinical quality improvement affiliate cohort. And they're using these in quality dashboards and a CQI learning environment -- learning collaborative.

Our colleagues in Oregon are using 2903 as part of a pay-for-performance measure set and their accountable care model for Medicaid which is really exciting.

And then we know that Bayer has published trends and regional variations on all of the measures using commercial sector data, using the Truven Health MarketScan Commercial Claims Database.

And then in Title X, we're using the measures but it is an adaptation of the measures. Many of our grantees report aggregate level data as part of the family planning annual report and it's not claims level data but we've conducted two Performance Measure Learning Collaboratives within our grantees and use the Institute for Healthcare Improvement's Breakthrough Series model with that.

So, we're excited that even though they don't have claims data, they can calculate similar measures. Next slide, please. So, some of the things I wanted to talk about on today's call or some of the lesson's we've learned in this early implementation and, really, it's around communication and communicating about the measures, talking to people about them and how to use them appropriately.

So, I'll touch on three things. We get a lot of feedback on the denominator. It's very difficult to get a denomination of women at risk of unintended pregnancies using claims data.

We have suggested adjusting the denominator using the National Survey of Family Growth Data and I'll talk a little bit about that. We also have been

very adamant about insuring that the measures are used in a patient-centered manner. And then I'll talk a little bit about benchmarking.

Next slide, please. So, addressing the limitations of claims data for the denominator. Because we can't get sexual activity intention using claims data, as well as previous sterilization and LARCs use when we're only focused on one measurement here, we have recommended the use of National Survey of Family Growth Data that collects information on those variables and then you can adjust your denominator to get at a percentage of women whose contraceptive needs are presumably not met.

But recognizing these limitation with the claims-based measures, we have begun to develop eMeasures for submission to NQF in 2019 because EHR data has the pregnancy intention and sexual activity questions in it. So, we're excited to pilot those this fall.

We've also created an interpretation guide that we've posted on our website. As OPA is the steward, we have dedicated a webpage on our website to help with understanding the measures and interpreting them, so I put little of that text below.

Next slide, please. The other piece of this is just ensuring that these measures are being used in a patient-centered manner. And we have included sections on our website on how the measures should be used.

And most importantly, that there has no -- been no benchmark set for the most and moderately effective method measure, 2903, and that we wouldn't expect it to reach 100 percent because some women will make informed decisions to choose methods in the lower tier of efficacy even when they have access to the full range of methods and they don’t have any barriers to those methods.

The other piece of that is communicating about the LARCs measure that we are not looking for a high percentage of LARCs provision but we're really interested in looking at the left end of the distribution entities with less than 2 percent LARCs provision.

We've also done a lot to enhance our Family Planning National Training Centers website to include resources around provider quality contraceptive care and there are a number of resources there that we direct people to if they want to use these measures in a client-centered way.

And then we are also maintaining the national standard of care through QFP guidelines, providing quality family planning services. And these were published in 2014 and maintained -- they remained the national standard for Providing Quality Family Planning Services.

Next slide, please. The other things that's been very interesting is benchmarking. We're taking steps to obtain expert input on benchmarking issues and we recently, just past week, held an expert users group around the measures which had a number of different colleagues from federal and state departments as well as different medical associations, health plans, academic researchers, to get their feedback on whether there should be a benchmark.

And currently, there's no benchmark. And I would say from the feedback that we got at this meeting, I don't think that people are wanting a benchmark because it could be used to provide nonclient-centered care. And so, we were excited to get that feedback but we also struggled at the same time with how to use the measure without a goal or a benchmark.

And so -- and knowing that this benchmark could be different in different context. So, we know that the percentages that we're seeing in Medicaid are much lower than we're seeing in dedicated reproductive health clinics. So, if people have insight on that, how they've used measures without benchmarks, we would love to hear your experience.

And then as far as the LARCs measure, we've definitely talked about only looking at the left end of the distribution, but then it becomes an issue, what if we're seeing very high rates of LARCs use?

So, we are very excited to use the PRO-PM as a balancing measure for this so that women can report on our contraceptive counseling experience and then we could potentially look at that by method.

Next slide, please. So, our efforts to communicate about the measures, we have the website dedicated to this that I talked about. Our family planning national training center, those resources on client-centered counseling as well as how to use these in an IHA -- (IHI) Breakthrough Learning Collaborative model.

We also published four manuscripts and there was a commentary by NFPRHA, the National Family Planning and Reproductive Health Association on the contraceptive care measures and these were just published on a September 2017 issue of contraception.

So, if anyone would like to look at those articles and doesn't have access, please feel free to contact me but I'd encourage you to check those out.

And then NFPRHA also developed a Contraceptive Quality Measure Implementation Subgroup and they've been working over the past year on developing communication products around key messages about using the measures, also a stratification guide that you can use to look at different populations within your use of the measures.

So, that's been really helpful and we hope to develop additional communication products where there's a need.

Next slide, please. So, moving forward, we're excited about the number of organizations that are using the measures and we've set up systems as far as this expert user group to capture that experience. We'll be submitting the claims-based measures for maintenance in 2019. And we're planning on submitting eMeasures for these three measures in 2019 as well.

And then we're collaborating with Christine and her group with the development of the PRO-PM and how to use these measure center synergistically so that the PRO-PM can be a balancing measure to these measures as well as its own measure for contraceptive counseling. And I'm happy to take any questions with the rest of the group.

Suzanne Theberge: Great. First, I just want to give a huge thank you to our presenters for an excellent set of presentations. We really appreciate your time and your speaking today.

So, now, I am going to turn it over to the Committee co-chairs, Kimberly Gregory and Carol Sakala to moderate the Committee Q&A and discussion portion of the call. Carol, Kim, are you ready to (start the discussion)?

Kimberly Gregory: Yes. Is there a way that we can see that they're raising their hands or we're just going to have to let people speak up as they choose?

Suzanne Theberge: I think you should be able…

Kimberly Gregory: Yes.

Suzanne Theberge: Yes.

Kimberly Gregory: We can see a hand.

OK. So, I'm going to start, actually, with a question, if that's OK, for the joint commission. One of the things that you had up when you were looking at the slide, that tracks by year, you had what you called the perinatal composite score and you actually had that as a percent. What is that and how do you calculate that?

Susan Yendro: Yes. Let me go back to my slide. There are a couple of caveats underneath of that graph when you look at the composite.

So, that composite includes the -- only the antenatal steroids and the -- looking on there -- what the statistician takes the rates for only -- there were three measures in the first few years and then it was reduced to two measures in the subsequent years to calculate the composite rate.

It doesn't include the…

Kimberly Gregory: You can get back to me, if you want.

Susan Yendro: Yes. Yes. I'm sorry. I had to look at the slide to remind myself which measures were includes. So, it doesn't include the breastfeeding measures in -- other than in '11 -- 2011 and 2012. And then the subsequent years it takes the composite rate of the rest of them. And I can get back to you with the specifics on how they were -- how that was calculated.

Kimberly Gregory: That would be great.

Cindy Pellegrini. I see your hand is raised.

Cindy Pellegrini: Yes. Thank you. I'd like to go back, if I could, all the way to Dr. Main's presentation and I don't know if we can flip back to the slide but I believe it was slide 21 with the grid of national versus California maternal mortality. Sorry, not the grid but the chart.

So, while we find that, there was a year at which the trends diverged dramatically where the national rate started climbing steadily and the California rates started dropping steadily.

And Elliot, thank you, to you and everyone for some excellent presentations. But I'm wondering if had any of the collaboratives efforts started that far back besides things like early delivery that might have impacted maternal mortality or do you have any hypothesis about what was going on there?

Elliot Main: So, we did start our toolkits and our regional lectures as far back as 2009, 2010 and our first collaboratives were 2011. So, we started seeing a decline in 2010 but it really wasn't statistically different until about 2012, you know, looking back at our baselines.

There -- and we ran a series of collaboratives for hemorrhage and preeclampsia and then ran them again in terms of sustainability. We are talking today about C-sections so I didn't get a lot of detail. But I wanted to give you a flavor of the types of collaboratives that we run in the scope of hospitals that are engaged.

California is also a little different. First of all, it's always hard with public health data to label cause and effects. And, you know, we'd like to have

corroborating data like severe maternal morbidity is one of ours here that's also going along in that same direction.

But there are other factors at play and we do have very good rates of prenatal care in California. Everyone is eligible for Medicaid or Medicaid agency whether you're documented or not.

So, we have very few people that don't have -- that have only one or two percent at the most have no prenatal care visit time to come to admission and that's not true, necessarily, in every state (in the union).

So, that's a factor. But we certainly do see increasing rates of hypertension, diabetes, obesity, that everyone else is seeing in the same time period. So, we are continuing to track on and we are -- our latest rates from our state partners also continue to be quite low. So, we're continuing to keep this on our agenda but we're quite pleased with the progress.

Kimberly Gregory: Christian Pettker?

Operator: Well, we need to open the lines for the public comment period to include that…

Suzanne Theberge: Yes…

Operator: …questions.

Suzanne Theberge: We can hold and take committee comments and then we'll open the lines for public questions and comments in just a couple minutes. We do have a question that came in via chat from one of our committee members. (Juliet) sent a question. The first speaker, the Leapfrog metrics about episiotomy. Do they collect balancing measures vial Leapfrog like increase in C-section rates or severe lacerations, et cetera?

Female: So, the first speaker is not with us now.

Suzanne Theberge: That's right. I'm sorry.

Female: But I believe she did comment that they actually had their severe laceration rates going down and that article that was presented. Elliot, did you want to go further on that?

Elliot Main: Yes. No, I think several studies have shown that reduced episiotomy is temporarily associated with reduced third and fourth degree lacerations by and large, you know. Not every single hospital every single time. But the aggregate that's been held very well.

Episiotomy rates have not, to my knowledge, every been associated with increase in C-section rates. Conversely, if you use third and fourth degree lacerations of quality measure, there's some evidence of that hospital leadership.

Administrative leadership can force or can push folks to do more C-sections to avoid third and fourth degree lacerations. So, that's one of the reasons it's not a popular quality measure.

Kimberly Gregory: Thank you. So, I'm not seeing any other committee hands at this moment. I'm going to jump in and -- yes?

And I ask Susan Yendro. Does the joint commission have plans to extend the mandated reporting to hospitals with less than 300 births or will it be stopping at that threshold? And also, does it have plans to publicly report NTSV rates?

And a little bit of my thinking behind that latter question is that there's a lot of confusion out there right now by what is meant by a Cesarean rate in the various groups that are reporting and I see a value in coalescing around the NTSV rate and having it be reliably available.

Susan Yendro: Hi, this is Susan. The first question regarding the threshold at 300 live births, there is -- we have not had any discussions about reducing that at this point. So that is -- that will remain at this point.

And then the public reporting of the NTSV, we hadn't previously reported the outcome measures. We've reported the process measures but it's something that we have taken under consideration and we're certainly open to feedback

such as this to help us in framing our decision for publicly reporting that on the future.

So, thank you, yes, for your feedback. And then I just wanted to get back on the other question regarding the calculation methodology.

It is listed on Page 32 of our annual report and it does go through how the composite -- it's a little bit more technical to go reading through it right now but you can refer to that on our website, the annual report, and from the 2016 annual report that's on Page 32.

Kimberly Gregory: Great. Thank you.

Susan Yendro: Sure.

Kimberly Gregory: Christian Pettker, you have your hand up? If you're still on mute, we can't hear you.

Suzanne Theberge: Kim, we need to wait till we open the public lines for beyond the Committee.

Kimberly Gregory: How do you tell?

Suzanne Theberge: Well, let us formally open up the comment period.

Kimberly Gregory: Got it. OK.

Suzanne Theberge: Yes. So, are there other questions from members of the Committee or comments?

Kimberly Gregory: One question for the…

Suzanne Theberge: Go ahead.

Kimberly Gregory: …contraception. Is that being measured at the provider level or the site level or the hospital level?

Brittni Frederiksen: Yes, it's not being measured at the provider level. It's at the health plan level, the facility level, some states are looking by public health region. So, higher levels than provider.

Christine Dehlendorf: The PRO-PM will be measured at the provider level.

Kimberly Gregory: Perfect. Thank you very much. The presentations were phenomenal.

Female: Tracy Flanagan?

Tracy Flanagan: Hi. I want to compliment OPA for putting for putting forward this measure. I think it's really important and in the entire landscape of quality measures is nothing really that has started this discussion about preventing unintended pregnancies.

Now speaking not as a Committee member but as a leader in Kaiser Permanente, I will say that we've actually calculated for Norther California all three of these measures and are very interested in trying to figure out how to use these for performance improvement.

We also have an additional measure that we're using that we know is flawed about insertions per hundred visits and we know it's flawed in all the ways you can possibly imagine.

So, please don't e-mail me or anything about that. But we're just -- we're trying to get it down to a provider level or a facility level, not all providers put in larcs.

And I also want to tell you that I appreciate the issues you brought up which is the denominator with patient centeredness and the benchmarking. And very much appreciated the PRO-PM from Christine. I think that is a piece that needs to come in to this discussion and balance all of this work.

Kimberly Gregory: Thank you. Other questions or comments from the Committee?

Karen Shea: Yes. Hi. This is Karen Shea. Can you hear me?

Kimberly Gregory: Yes. Hi, Karen.

Karen Shea: Yes. I have a quick question. The first two presenters were very effective in describing how public reporting has been successful in moving the measures.

But I'm wondering if you would also comment on financial levers and how effective they can be and also moving quality whether it's an incentive or whether it's a withhold of payment.

Suzanne Theberge: Did you want to direct that to any of the presenters who are still with us?

Karen Shea: Well, I'm wondering Elliot, you know, since you…

Elliot Main: Sure.

Karen Shea: …talked so much about public reporting, if you would comment on that?

Elliot Main: Well, I didn't show my slides on the incentive side because it's still a work in progress. The -- and indeed, I'm less sure that public reporting alone actually is very -- is necessarily very effective.

Virginia, for example, has a public website provider level C-section rates for the less 10 years yet hardly any patient traffic goes there and doctors aren't even aware that it exists but it's on the health department's website.

And it really is about traffic and about building awareness and building public confidence in the measures and understanding the measures. And being incented either financially or by their understanding to do something about it.

So, health plans are starting to reengage in employers are starting to reengage on this issue after feeling burnt in the VBAC dilemma of the managed care in the 1990s -- late '80s and '90s.

And they're exploring a variety of different ways to do these whether it's blended payments or ACOs or incentives or either quality incentives, primarily is the most common one or health plan directed educational efforts or health plan directed dissemination of hospital level rates.

And it still remains to be seen. One of those is going to be the most effective. I think what is probably our goal, certainly in California, is not to have all the different huge variety health plans and in our state, we have 50 different managed care medical groups.

So, our Medicaid is very diverse as well, is to not have them all do the same thing but I have them all do something around the same measure.

So, if one plan wants to do some education, another plan wants to do incentive, another plan is actually doing a blended rate or a bundled rate, those are a little different but gets the same point.

If they're all focusing on the same measure, then you can start getting more provider hospital engagement on it. So, that's what we're trying to do in California. It's not have everybody do the same thing but have everybody work on the same measures.

Karen Shea: Thank you.

Kimberly Gregory: Thank you. Is that good, Karen?

Karen Shea: Yes. Thank you.

Kimberly Gregory: So, I don't see any other hands right now. But is there anyone else that have a question or comment from the Committee?

Mike Marcotte: This is Mike Marcotte from Ohio and I just wanted to -- I'm intrigued by the contraceptive measures. We just had a law go into effect in July that requires counselling and then giving a woman who has delivered a baby a LARCs before they leave the hospital.

There's no way they're going to enforce that at this current time but it was a law that was passed as part of our attempts to reduce infant mortality. So, I just wanted to share that with the group.

Christine Dehlendorf: Just to clarify -- this is Christine Dehlendorf -- it's the law that you have to be able to provide postpartum LARCs at a given hospital?

Mike Marcotte: You have to counsel a patient and provide it if the patient desires it.

Christine Dehlendorf: Interesting. Thank you for sharing that.

Elliot Main: And Dr. Marcotte, there's a large number of catholic hospitals in your state. How do they get around that one?

Mike Marcotte: So, they are allowed to do the religious exemption. In our hospital system, we have two hospitals that are not catholic and one that is and so we have applied for it for the catholic hospital but the other hospital were in making efforts to try to make it available.

Again, the other interesting thing is we're going through our -- we have a state that has maternity licensure rules and they try to put those in to the rules to require that if you didn't have it, you could not get a maternal licensure but that was removed. But there -- so currently, there is no way to enforce the law but there is the law.

Elliot Main: So, this Elliot. Going back to the question about incentives versus laws and just raised it up, there was a recent Health Affairs article looking at the effectiveness of Texas approach to early elected delivery in which they basically passed the law saying we're not going to pay for it.

And they compared it to other states and suggested that it may be as effective, at least as effective as QI projects but I would probably say that that can work ideally when you've already had QI projects like they did in Ohio that were already published that showed great effectiveness.

It's only then that you could actually turn something into a law and have it be effective. So, that may be a good approach for -- I don't want to say laggards but latecomers to a QI project when there's already been a lot of work out there and experience that's been published.

And then you might be able to do that. But laws for practicing medicine is generally the last place we want to go but sometimes you have to go there.

Kimberly Gregory: And this is Kim. I think, Elliot, you would agree, though, that the threat of California Care not contracting with hospitals with a strong incentive for some of the late adapters to join into the collaborative for the NTSV.

Elliot Main: Yes. So, our ACA organization, their approach is that they really wanted everyone -- they gave a couple head start that by 2019, you should have your NTSV rate in line with the national target or they have a pretty generous view of doing QI projects (doing this) then you, you know, not that you've waived your hand out, but you're actually showing some progress. You may not have gotten all the way down to 23.9 but you're working on it.

And that -- you know, QI is not necessarily just about working with doctors and nurses or even (hospital) but it's really about engagement with hospital administrators as well because they provide resources to do these projects and incentives for their managers to become engaged. And so, you do sometimes have to do things that engage the C-suites as well as the provider level. Thanks, Kim.

Kimberly Gregory: Other questions from Committee members or from presenters to one another? So, I would just like to ask one more question to Susan.

I see that the performance is fairly high and some of the PC measures and I noted in a past Joint Commission Annual Report that performance became very high and then declined and the Join Commission attributed that to measures losing their endorsements because they had lost them because of the rational getting tapped out.

So, that's an issue that we may be facing and I know that the MAP -- one of the MAP Medicaid task forces recommended removal of one of your measures for that reason from one of the Medicaid core sets.

So, I wonder if you have any comments about that and whether you think it's a warning to us about removing a measure of being tapped out and then having performance decline afterwards?

Susan Yendro: I think it's something that everyone kind of struggles with. You know, we talked a little bit -- a bit ago about the Hawthorne effect of what gets measures gets managed. And I think it's not a concern that we would have.

The other thing in this measure set that I'm anxious to see is our results for 2016 since we lower the threshold. So, do we have more hospitals on the outliers ends of that that are -- will the rates comes down on some of those?

I think probably or specifically looking at one of them is the antenatal steroids measure. But those smaller hospitals may not have those early deliveries, (two of these). So, it may be a watch there. So, something definitely that we need to be watching out for.

The other thing that we've done. Some of the (tapped-out) measures, for example, the stroke measure set that were removed from the IQR program and that type of thing, is we've come to (monitor) our certification program because we thought that they were important measures for that specific topic area. So, we may be looking at doing something like that in the situation as well with the perinatal measures.

Kimberly Gregory: Right. So...

Elliot Main: This is Elliot. One example of that is with the VTE measure that has VTE screening prophylaxis for all hospital admissions, that’s been essentially retired.

But now we're interested in adding back into the (measure) pregnancy population which was explicitly excluded from that measure and we haven't done so well in screening -- risk factor screening in obstetrics because we've -- that's been excluded from the population. And now, that is no longer an active measure so it'd be hard to get them back in. So we're struggling with that one.

Kimberly Gregory: Good point. Thank you. So, we're hitting time and I think I speak for others on our committee that today's program has been very heartening to hear about the good uses to which our measures have been put. I'd like to thank the presenters, committee members, and Suzanne for organizing this.

And before she brings us up to next steps, I think we're going to move to public comment and hear what Dr. Pettker and maybe others have to say.

Suzanne Theberge: Yes. Thank you. Operator, can you open the lines for public comment, please?

Operator: Certainly. If you would like to ask a public comment at this time, press star one on your telephone keypad. Again, that is star one for any public comment. And your first comment comes from Christian Pettker.

Christian Pettker: Hi, everyone. Thanks for some great presentation. This is Chris Pettker, we're one of the organizational representatives from Society for Maternal-Fetal Medicine.

I had two questions. One is actually more of a comment than a question that extend on question earlier about the join commission working with Leapfrog to try to get the perinatal core measures more publicly available.

Some of our organizations don't participate in Leapfrog because of data -- perceptions of data integrity issues with -- and some of the areas outside of obstetrics. But some of us feel very strongly about our joint commission, perinatal core measure data and would love to have that publicly reported and available.

So, I think it would -- it's in everyone's best interest if we could initiate a conversation of the Joint Commission working with Leapfrog and making that the perinatal core measures publicly available. And our Leapfrog representative might not be on the call anymore, but maybe that's something that we could touch base with them in the future.

The other is a question for Dr. Main. Elliot, I'm just wondering, we use this healthy people 2020 goal of 23.9. Is your expectation that all hospitals will be below this average or that the national average is going to hover right around this and we'll just reduce the variability and make the standard deviations tighter?

Elliot Main: Well, I think we're going to learn a lot about it as people work on quality improvement. We have a lot of hospitals that, right now, are in the 20. I mean, two-zero rate right now in California. And they seem to be doing just fine with that and this includes some of the largest university high risk centers as well.

It's probably not realistic to have every single hospital blow up but I think everybody should be in the mid-20s, somewhere in the mid-20s, 25, 26, 27. IT's really not any good reason that anybody should be 30, 35, 40, 45 to 50 or even higher that we're seeing.

I think it's quite reasonable that we have -- a state average could definitely be below 23 points and there are state averages in the country right now that are below 20 percent, whole states.

So, you know, that's obviously an average of hospitals but it's kind of interesting when you start working on this, what people do and you have some hospitals in California that are between 16 percent and 18 percent that looked like they have very good baby outcomes.

You know, those aren't going to be your highest risk centers and there is some, you know, give or take, with case mix but it's only a couple percent at the most.

So, I would expect everyone should be able to be at below or near 24 percent, you know, plus or minus two, that kind of thing. But we're going to really learn to see what happens and I think some of our university or high acuity hospitals are surprising us of what they can do.

Christian Pettker: Thanks. I do think that a lot of hospitals do feel a little bit of pressure to get below the 23.9 without us having a lot of information on where these hospitals should be.

Should be, it's tough when some of the more publication-based ratings groups come out and say that hospitals aren't performing if they're not below this national average. Thank you.

Kimberly Gregory: Thank you. Dr. San Roman?

Operator: And your next comment comes from Gustavo San Roman with (birth risk).

Gustavo San Roman: …hear me?

Kimberly Gregory: Yes.

Gustavo San Roman: Hello? OK. Thank you very much for some great presentation. This is Dr. Gustavo San Roman. It was very good to be listening.

And I have a question, actually, for Susan from the Joint Commission. I was looking at the slide that you had the performance measures on where you listed the cesarean section rates from 2011 to 2015 and showing that number is pretty steady around 26 percent.

During that time period, you were applying a direct standardization age risk adjustment for that PC-02 measure. And I believe hospitals were reporting their measures already with the adjustments in place.

So, do those numbers through 2011 through 2015 represent the unadjusted PC-02 rate for NTSV or are those numbers representation the already risk, you know, age adjusted with the direct standardization through though four years?

Susan Yendro: Hi, this is Susan. I will have to check and get back to you on that.

Gustavo San Roman: All right. And just a followup. Because, as you know, the direct standardization was removed this year. It was removed in July of 2016 and I know our hospital only reported a risk-adjusted rate up through that period of time.

So, I think it's going to be a little confusing if those are the numbers that the Joint Commission has. If all those numbers were age risk adjustment and then starting in July of 2016, the age risk adjustment's been removed, we're not going to be able to compare apples to oranges anymore.

I mean, unfortunately, the data from 2010 through 2016 may actually has to be thrown away because you can't compare it if we lose that risk adjustment.

So, yes, I would love to -- if you could let us know, if those numbers that we're looking at, really, are apples to apples or apples to oranges because that will make quite a difference as we look at performance improvement throughout the upcoming years. So, I'd like to thank everybody again for some great presentation. Thank you.

Suzanne Theberge: All right. And I'm happy to -- this is Suzanne from NQF. I'm happy to facilitate any information exchange that's needed for followup for any questions.

So, we are out of time, but very briefly, next slide. Just to let you know, Committee members, I'll be sharing a summary of this call next week and we'll be posting that online towards the end of next week as well so folks can review and we'll be posting the call recording as well -- transcript rather, as well.

So, thank you, everyone, so much for your time today. Both our speakers, our committee members, and our audience members as well. This was a great call. And if you have any questions, any follow-up issues, please feel free to get in touch with me at this e-mail or phone number and we'd be happy to get any further questions answered.

So, thanks again, everybody. Thank you so much for your time and have a good rest of your afternoon.

Operator: This does conclude today's call. You may disconnect your phone lines.

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