NATIONAL QUALITY FORUM

Meeting Summary

Perinatal and Reproductive Health 2017 Off-Cycle Quarterly Webinar

The National Quality Forum (NQF) convened a public webinar for the Perinatal and Reproductive Health Standing Committee on September 11, 2017. An archived recording of the webinar is available for playback.

Welcome, Introductions, and Overview of Topic

Suzanne Theberge, Senior Project Manager with NQF, began by welcoming participants to the webinar and providing a brief overview of the agenda and NQF's off-cycle work. Ms. Theberge stated that there would be several presentations on the use of NQF-endorsed measures in improving reproductive and perinatal health care.

Setting a Target and Lowering Episiotomy Rates

Missy Danforth, Vice President for Hospital Ratings at Leapfrog Group provided a brief overview on the work of the Leapfrog Group, which is a national non-profit organization that collects and publicly reports information about the safety and quality of inpatient hospital care. Leapfrog conducts an annual survey, which almost 2,000 hospitals participate in, to determine the ratings for hospitals. National health plans, many regional health plans, and several transparency vendors use the ratings for both payment and public reporting purposes. One of Leapfrog's reporting domains is maternity care, which includes several measures, such as elective deliveries, cesarean births, episiotomy, deep vein thrombosis (DVT) prophylaxis for women undergoing cesarean section, bilirubin screening for newborns, and a high-risk deliveries composite measure.

The NQF-endorsed episiotomy measure (#0470: *Incidence of Episiotomy*) was first added to the survey in 2012. An episiotomy is a surgical incision of the perineum to enlarge the vaginal opening for delivery. In the last five years, Leapfrog has noted a number of improvements as it relates to measure #0470. Ms. Danforth noted the number of hospitals reporting on this data has nearly doubled (from 833 in 2012 to 1,321 in 2016) and the overall rates of episiotomy have decreased each year, from 13% in 2012 to 9.7% in 2016. From 2012-2014, the target rate was 12%, and the percent of hospitals reaching this target grew each year. In 2015, the target rate was lowered to 5%, and the corresponding rate of hospitals meeting this target rate decreased, but more hospitals have been meeting the target rate each year since.

Ms. Danforth shared some examples of how hospitals, purchasers and consumers are using the information provided by Leapfrog. She noted a recent *Journal for Obstetrics & Gynecology* article reviewing one hospital's experience in reducing rates. The hospital noted having a "stretch goal" (meeting Leapfrog's new target rate for a greatly reduced rate of episiotomies) to strive for motivated improvement. While the American College of Obstetrics and Gynecologists (ACOG) guidelines align with the Leapfrog goals, which was a helpful factor as well, the hospital also noted the importance of public

reporting via the Leapfrog reports in helping drive improvement. Additionally, the hospital stated that individualized monitoring and feedback for physicians to compare themselves to their colleagues was helpful. Ms. Danforth also explained that various purchaser groups, such as the Pacific Business Group on Health, HealthCare 21 in Tennessee, and the South Carolina Business Coalition on Health are highlighting the data on episiotomy rates. Consumer groups such as Childbirth Connection are also using and reporting on the episiotomy rates. Transparency groups also use the data; Leapfrog has partnered with Castlight, a transparency group, to publish annual reports on hospital performance in maternity care, which include the episiotomy measure.

Committee Discussion

Committee co-chair Dr. Carol Sakala questioned why more hospitals report on clinical areas other than maternity care, and what, if anything, the Committee could do to encourage more hospitals to report on maternity care. Ms. Danforth noted that not all hospitals provide maternity services, particularly those in large systems. Additionally, Leapfrog requires a minimum sample size for deliveries and as a result, some hospitals do not have enough volume to report on the measures. She encouraged the participants to contact their Leapfrog regional leaders if they are interested in collaborating with Leapfrog to encourage more participation.

Another Committee member, Dr. Mambarambath Jaleel, requested more information about whether Leapfrog had tracked the rate of severe lacerations. As Ms. Danforth was no longer on the call when this question was asked, Dr. Elliott Main from the California Maternal Quality Care Collaborative was able to answer the question. He noted that reduced episiotomy is generally associated with reduced third and fourth degree lacerations. He also stated that using the rate of third and fourth degree lacerations as a measure on its own is not advisable, as it can lead to the unintended consequence of more cesarean sections.

California: Reduction in Cesarean Section Rates

Elliott Main, MD, the Medical Director of the California Maternal Quality Care Collaborative (CMQCC), presented on California's reduction in C-section rates. Dr. Main provided a brief background on the work of the CMQCC and some of their projects to improve maternity care. The CMQCC is a multi-stakeholder organization that engages state health agencies, hospital systems, purchasers, hospital associations, and payers to focus on improving maternity care. The CMQCC has developed an initiative to reduce early elective deliveries. The CMQCC created a toolkit and provided technical assistance to various entities throughout the state of California. From 2009-2014, there was an 8% increase in full term births, which translates to 25,000-30,000 fewer births before 39 weeks per year, and 120,000 fewer early births overall since the project began.

The CMQCC created another initiative that focused on hemorrhage and pre-eclampsia and used a mentor model (a nurse and a physician) to lead the quality improvement project at several hospitals simultaneously. As a result of this initiative California's maternal mortality rate has decreased to 7.3 per 100,000 live births in 2013, while the overall US rate rose in 2013 (22 deaths per 100,000 live births). Dr. Main stated that the initiative also reduced severe maternal morbidity from hemorrhage.

The CMQCC used lessons learned from the two initiatives to address first-birth C-section rates. Dr. Main noted that C-section rates have been rising, and poor baby outcomes (namely, low APGAR scores and

seizures) were also increasing. One of the drivers for quality improvement is a variation in care. Dr. Main stated that there should be less variation in C-section rates among a more homogenous population, and the CMQCC decided to focus on nulliparous term singleton vertex (NTSV) births. Dr. Main noted that in California there was more variation in NTSV than the total C-section rate; he stated that the rates of NTSV births range from 12%-70%. He also noted that 40% of hospitals in the state were already achieving the Healthy People 2020 NTSV target rate of 23.9%.

Dr. Main underscored the importance of reducing the primary C-section rate to reduce poor health outcomes, both at the primary C-section and at later births. He stated that it is a cause of one of the biggest catastrophes in obstetrics, placenta accreta, a serious complication where the placenta grows in or past the uterine wall. He also noted that unnecessary C-sections and the associated risk is a topic that is increasingly being covered in the media, including in *People* and *Cosmopolitan* magazines.

The CMQCC learned from their previous initiatives that in order to change practices, they needed a multidimensional approach, including changing hospital culture and attitudes, addressing physician autonomy, and public reporting. Dr. Main also noted the importance of having strong professional leadership from organizations such as the American College of Obstetricians and Gynecologists (ACOG) and engaging other stakeholders, including health plans and pregnant women. In collaboration with a multidisciplinary team, CMQCC developed a toolkit of resources and evidence-based best practices to reduce C-sections, as well as a companion implantation guide. The CMQCC has a rapid cycle data center, in which they can retrieve performance data from the State Department of Health on a monthly basis and send the data to the hospitals via an automated system. The CMQCC has the ability to use the data to find the key drivers for the primary C-section rate for each hospital in the state and identify the training needs of each individual facility and provider. The CMQCC uses this data to focus their quality improvement efforts on hospitals with rates over 24%, which is above the target rate of 23.9%. The primary focus of the quality improvement effort is on labor practices that lead to C-section indication. The CMQCC divided the hospitals into small groups (6-8 per group) using the mentor pair model of a nurse and a physician. Using classic Institute for Healthcare Improvement techniques, each group meets monthly to discuss their progress, share best practices, and review data reports from the data center. Of the 25 hospitals who participated in the first wave of the effort, 17 had a significant reduction in C-sections, and 11 of those 17 are now below the target rate of 23.9%, within a year of participating in the program and before the program's end. Three more waves of hospitals have since started similar quality improvement efforts.

Dr. Main then spoke briefly about the potential downsides of reducing the C-section rate. He noted the need for using balancing measures to ensure that there are no negative impacts from reducing the C-section rate. Thus far, the hospitals participating in the project have had a decrease in patients with third and fourth degree lacerations (tears of the perineum that can be caused by delivery). Most importantly, there has not been an increase in poor newborn outcomes – rates of unexpected complications during birth or the neonatal period have been either flat or fallen significantly.

Cal Hospital Compare publically reports the rate of C-sections for every hospital in the state of California, and the Secretary of Health issues an annual honor roll for hospitals meeting the target rate. Cal Hospital Compare has also worked with Yelp to provide information about hospital C-section rates on their website along with the subjective consumer ratings; this part of the project is still under development, but has shown some promise.

Committee Discussion

Committee member Cynthia Pellegrini requested more background from Dr. Main about a chart in his slide deck showing the national rate of maternal mortality climbing while California's rate was dropping and asked if that correlated with the onset of the CMQCC's work. Dr. Main explained the Collaborative's work began in 2009, and improved maternal outcomes were noticed as early as 2010, but they were not statistically significant until 2012. He noted that while his presentation had focused on C-section rates, the Collaborative also had programs on hemorrhage and preeclampsia, concurrently. Dr. Main explained that California also has other factors that help influence maternal mortality, including a very high rate of prenatal care (only 1-2% of mothers, at most, have had no prenatal care at delivery).

Committee member Karen Shea asked about how financial levers can be effective in improving quality, whether as incentives or withholding payments. Dr. Main stated that California's work with incentives is still in progress, but that he personally felt that public reporting alone is not sufficient. Dr. Main explained that the goal in California is to have all of the health plans working with the same measure, even if they are using different ways to achieve the goal (education, incentives, blended payment rates, etc.). Dr. Main also noted that Texas recently passed a law in which providers are not paid for early elective deliveries. He also noted that a recent *Health Affairs* article studied the effectiveness of this law and determined that it may be an effective way to improve quality. Dr. Main raised some concerns with legislating how medicine is practiced, but thought this type of work may be effective when paired with other quality improvement initiatives, such as the state Quality Collaboratives in Ohio and California, as having resources to draw on, such other facilities' experience and published work, can assist hospitals that need to improve. Dr. Kimberly Gregory, the Committee co-chair, agreed, and mentioned that California Care had threatened to not contract with hospitals that were not working to improve their NTSV rates. She noted that this was an effective mechanism to encourage some late adaptors to join the NTSV collaborative.

Ohio: Dissemination of Early Elective Delivery Quality Improvement

Michael Marcotte, MD, of the Ohio Perinatal Quality Collaborative (OPQC), presented on work to reduce early elective deliveries in Ohio. Dr. Marcotte provided the history of the collaborative, which started in 2008 by obstetricians and pediatricians focused on improving newborn outcomes addressing both maternal and neonatal complications that lead to poor outcomes. OPQC was first asked by the state to assess why there was so much variation in the delivery of antenatal steroids to patients delivering babies before 34 weeks. One of the key factors, the OPQC discovered, was accuracy of the birth registry and birth certificate data. The OPQC was able to implement trainings to ensure birth registry and birth certificate data was entered accurately. These trainings allowed the OPQC to focus on how to measure improvement in other areas without putting major burdens on hospitals. The OPQC developed other initiatives, including developing highly reliable ways to maintain sterility in lines that were placed in premature babies to reduce bloodstream infection rates, and examining the benefits of human milk for all babies born very pre-term, to improve immunity. The OPQC is currently working on the following initiatives: standardizing diagnosis and care for babies born with neonatal abstinence syndrome related to prenatal opioid exposure; 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; and progesterone treatment to prevent preterm birth. Ohio has 107 maternity hospitals, 54 Level II and III neonatal ICUs,

and five children's neonatal ICUs. For all of their initiatives, the OPQC partners with Ohio Department of Health, the Ohio Department of Medicaid, MedTAPP, and CDC, and the trainings are available to providers working in a range of facilities, from outpatient obstetric clinics to federally qualified health centers.

Dr. Marcotte discussed an early elective delivery project that began in 2008 and consisted of three phases: pilot, testing expansion, and full implementation. The pilot focused on 20 hospitals accounting for 49% of Ohio births. The lessons learned were then implemented in 2012 in 15 pilot sites accounting for about 17% of births in Ohio. The second phase, testing expansion, also focused on accuracy of the data in the birth registry. The implementation phase began in 2013, with 70 of the 72 remaining hospitals in the state (two hospitals chose not to participate), covering the remaining 32% of births in Ohio. Several techniques, such as coaching and mentoring for providers, and monthly webinars for participating facilities, were used to reduce the rate of early elective deliveries. Dr. Marcotte noted that throughout all phases of the project there was a statistically significant reduction in early elective deliveries.

Committee Discussion

The Committee did not have any questions or discussion on this presentation.

Hospital Accreditation and Perinatal Care Certification

Susan Yendro, RN, MSN, spoke about The Joint Commission's hospital accreditation and Perinatal Care Certification programs. The Joint Commission has been working with perinatal measures since the early 2000s. In 2009, they selected a new measure set based in part on the measures endorsed in NQF's 2009 Perinatal endorsement maintenance project. Hospitals began to collect data on the measures in 2010, and in 2012, The Joint Commission began retooling the measures as electronic measures, or eCQMs. The five measures in the measure set were re-endorsed by NQF in 2016, with two of those measures endorsed as both eMeasures and paper measures.

For accreditation, all hospitals who have 300 or more live births per year collect and submit all five of the chart-based perinatal care measures; this threshold was lowered on January 1, 2016, from 1,100 live births or more. In addition to the hospital accreditation program, The Joint Commission also began to certify hospitals for perinatal care in 2015. In order to receive certification for a specific topic area, hospitals have to submit data on all five of the measures. The Joint Commission also offers training and technical assistance to hospitals that are implementing the measures to improve quality. The Joint Commission's accreditation and certification programs not only require that hospitals collect and analyze performance data, but that they also require hospitals to use the performance data to improve the services they provide. These measures are publically reported on the Quality Check website, and via an annual report, released publically, that shows the rates and trends in performance on 29 measures, including on the perinatal care measures, for over 3,300 hospitals accredited by The Joint Commission.

Committee Discussion

Dr. Gregory asked The Joint Commission whether they plan to extend the mandated reporting threshold to hospitals with less than 300 births, and if they plan to publically report NTSV rates. Ms. Yendro explained that at this time, The Joint Commission plans to maintain the threshold of 300 births. She

indicated that The Joint Commission is currently assessing whether to publically report outcome measures, such as the NTSV measure, and welcomes feedback in this area.

Dr. Gregory noted that the performance for some of the perinatal measures is very high. She stated that previous Joint Commission annual reports have noted that performance is declining on some measures when they lose NQF endorsement due to being topped out (no more room for improvement). Dr. Gregory wanted to know if that was potentially a concern that performance rates for perinatal measures would start to decline as well, especially as one of the measures was recently removed from the Medicaid Core Set for this reason. Ms. Yendro agreed this is a challenge, but since the threshold for reporting was lowered in 2016, performance rates may decline as more facilities are reporting. She also explained The Joint Commission has added some topped out measures to their certification programs to ensure continued high performance and may be able to do so for the perinatal care measures.

Development Update on a Contraceptive Counseling Patient Reported Outcome Performance Measure

Christine Dehlendorf, MD, MAS, of the University of California, San Francisco, presented an overview of the development and testing of a new patient reported outcome measure (PRO-PM) on patient-centered contraceptive counseling. The Office of Population Affairs (OPA), a division within HHS, recently developed a set of measures (endorsed by NQF in 2016 and discussed in the next presentation) on contraceptive uptake and method used. Dr. Dehlendorf noted that the new measure her group is developing is related to those recently endorsed measures developed by OPA. Dr. Dehlendorf explained that the PRO-PM measure they are developing focuses on the patient experience of counseling. To develop the PRO-PM measure, the measure development team began with the research-based Interpersonal Quality of Family Planning Care scale, an 11-item scale that had previously been demonstrated to be reliable and valid. To develop a PRO-PM measure based on this scale, the team reduced the eleven items to four using an iterative process with both qualitative and quantitative methods. After extensive testing, they were able to refine the survey to the following four items:

- 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

These items echo what had previously been found to be the most important domains in a patient's experience of contraceptive counseling: interpersonal connection, information sharing, and decision support. Dr. Dehlendorf noted that the team is currently defining how to determine who receives the survey at a given clinic or system when the measure is implemented. While there is a need to have a relatively standardized target population, the measure should also be flexible enough to be implemented in a real-world setting.

The measure has completed face validity testing with patients, providers, and administrators. In a few months, 10 clinics across the country will begin testing the measure. It will be distributed to 15,000 patients with a response rate goal of 20%, or 2,400 responses, across 30 providers. Data from this sample will be used to analyze reliability, validity, and implementation costs and processes. The

measure will be distributed both on paper and electronically and will be available in English and Spanish. Dr. Dehlendorf also noted they do not plan to risk adjust the measure for conceptual reasons; however, stratification by patient demographics will be analyzed to assess whether there is statistical evidence for stratification. The team hopes to submit the measure to NQF for endorsement consideration in 2019.

Committee Discussion

The Committee did not have any questions or discussion on this presentation.

Implementation of Contraceptive Measures

Brittni Frederiksen, MPH, PhD, of the Office of Population Affairs (OPA), provided the final presentation of the webinar which was focused on the implementation of three recently NQF endorsed contraceptive measures: #2902: *Contraceptive Care – Postpartum*, #2903: *Contraceptive Care – Most and Moderately Effective Methods*, and #2904: *Contraceptive Care – Access to LARC;* OPA is the steward for all three measures. Dr. Frederiksen noted that the measures are already in use in a number of places, including Healthy People 2020 (measure #2903); the Medicaid Adult and Child Core Set (measure #2902); CMS's Maternal and Infant Health Initiative (all three measures); and Infant Mortality COIIN (all three measures). The Association of State and Territorial Health Officials is working with 26 states and one territory as part of a learning community to increase access to contraception and will use these measures as part of their outcome evaluation. Planned Parenthood Federation of America use measures #2903 and #2904 as quality improvement measures, and the state of Oregon is using measure #2903 as part of a pay-for-performance measure set and their accountable care model for Medicaid. Bayer Pharmaceuticals has published trends and regional variations for all three measures using commercial sector data. Title X is also using an adapted version of the measures that allows them to calculate performance data without claims data.

Dr. Frederiksen noted the stewardship team had received a lot of feedback on challenges with the denominator of all three measures, as it can be difficult to find women at risk of unintended pregnancy or who are already using long activing reversible contraceptives (LARCs) or are sterilized, using claims data. To address this challenge, Dr. Frederiksen recommended using the National Survey of Family Growth Data, which does collect information on these variables, and using that data to adjust the denominator to assess the percentage of women whose contraceptive needs are likely not met. In order to fully address these issues, the measure steward is working on eMeasure versions of the measures since the data is available in electronic health records. OPA plans to submit the eMeasures for endorsement in 2019. Dr. Frederiksen noted another major issue regarding the measures, around communication on proper use. In response, OPA has created an interpretation guide, which is publically available, that highlights the importance of ensuring the measure is used in a patient-centered manner. In addition, OPA provides resources for providers on how to provide quality contraceptive care. OPA is working with the National Family Planning and Reproductive Health Association, which has created a Contraceptive Quality Measure Implementation Subgroup. This subgroup has been working on developing communication products and a stratification guide for measure implementation for the three contraceptive measures.

One of the other challenges has been the question of benchmarks or expected rates of performance. Dr. Frederiksen reiterated there is no benchmark for measure #2903, and the performance rate is not

expected to reach 100%, as some women will make informed decisions to use methods in the lower tier of efficacy. She noted that experts generally do not want this measure to be benchmarked, but that OPA is interested in input on how to effectively use the measure to improve care without a goal of achieving a 100% performance rate. The measure is not looking for a high percentage of LARC provision, but is focused on finding where there is less than 2% LARC provision, which may indicate access issues. Conversely, Dr. Frederiksen noted that OPA is also discussing how to handle the opposite end of the spectrum, sites with very high rates of LARC use, which could potentially indicate that the measures were not being used in a patient-centered manner. The PRO-PM on patient-centered contraceptive counseling, discussed by Dr. Dehlendorf in the previous presentation, should address issues with potential misuse of the measures since it is intended to be a balancing measure for the access measures.

Committee Discussion

Dr. Gregory asked what the level of analysis is for the contraceptive measures. Dr. Frederiksen explained the endorsed measures are at the health plan, facility, and public health region levels, and Dr. Dehlendorf noted the PRO-PM on patient centered contraceptive counseling will be at the provider level. Committee member, Dr. Tracy Flanagan highlighted the importance of the contraceptive measures in providing quality care, and stated that Kaiser Permanente has calculated their rates for Northern California and is very interested in using them to improve the quality of their care.

Dr. Marcotte noted that Ohio recently passed a law requiring counseling and offering of LARCs to post-partum women before they leave the hospital. While this is not being enforced (and there is no way to enforce it), it was part of an effort to reduce infant mortality. Dr. Main asked how the law is applied to Catholic hospitals and Dr. Marcotte explained they have a religious exemption.

Opportunity for Public Comment

Following the presentations and Committee discussion, Ms. Theberge opened the call for public comment. Two public comments/questions were received and were discussed by the Committee. Chris Pettker of the Society for Maternal-Fetal Medicine indicated some of their organizations do not participate in Leapfrog because of concerns about possible data integrity issues in some of the areas outside of obstetrics. He encouraged The Joint Commission and Leapfrog to collaborate on making the perinatal core measures publically available. Mr. Pettker asked Dr. Main whether the expectation is that all hospitals should be below the Healthy People 2020 goal of 23.9% for NTSV, or whether that should be the national average, and the focus should be on reducing variability and the standard deviations. Dr. Main explained that they are currently learning more about this as the program continues, but many facilities in California are at 20% already, including some of the largest university high risk centers. Dr. Main added that he did not think it was realistic for every facility to be at 20% but thought all should be no higher than the mid-20s; currently some facilities are showing 50% or even higher rates. Dr. Main also noted some states have average rates below 20%.

Dr. Gustavo San Roman asked Ms. Yendro whether the performance rates for measure #0471: *PC-02: Cesarean Birth* from 2011-2015 represent the unadjusted rate or the age adjusted with the direct standardization rate. Ms. Yendro did not have the data available but offered to follow up with Dr. San Roman. Dr. San Roman noted that data from 2010-2016 may not be comparable to future data since the age risk adjustment was removed in 2016.

Ms. Theberge adjourned the call by stating the meeting summary and transcript would be posted to the project webpage next week, and thanked the presenters, the Committee, and the attendees for their participation.