# Maternity Action Team Public Webinar

April 21, 2014
3:30-5pm ET

NATIONAL QUALITY FORUM

# Welcome and Roll Call

| | |
|---|---|
| **Maureen Corry (Co-Chair),** Childbirth Connection Programs, National Partnership for Women & Families | **David Hopkins**, Pacific Business Group on Health |
| **Elliott Main (Co-Chair**), California Maternal Quality Care Collaborative | **Christine Hunter**, US Office of Personnel Management |
| **Amy Bell**, Carolina's HealthCare System | **Paul Jarris**, Association of State and Territorial Health Officials |
| **Jesse Bushman,** American College of Nurse Midwives | **Maulik Joshi**, American Hospital Association |
| **Divya Cantor**, WellPoint, Inc. | **Kate Menard,** Society for Maternal Fetal Medicine |
| **Dean Coonrod**, Maricopa Integrated Health System | **Erica Mobley**, The Leapfrog Group |
| **Karen Gandy**, BlueCare of Tennessee (Blue Cross Blue Shield Tennessee) | **Cynthia Pellegrini,** March of Dimes |
| **Melanie "BZ" Giese**, South Carolina Department of Health and Human Services | **M. Michael Shabot**, Memorial Hermann Health System |
| **Susan Gullo**, Institute for Healthcare Improvement | **Kathleen Simpson**, Association of Women's Health, Obstetric and Neonatal Nurses |
| **Keisher Highsmith**, Health Resources and Services Administration | |

# Webinar Objectives

- Provide an update on the Maternity Action Team's efforts to-date
- Share and seek input on a perinatal measure set 'playbook' idea to help late adopters with data and measurement challenges
- Feature successes and lessons learned—including barriers and strategies to overcome them—from the efforts of three groups to achieve the goals of reducing early elective deliveries

# NQF 2014 Maternity Action Team

**<u>Goal:</u> Promote healthy mothers and babies by further reducing early elective delivery (EED) rates**

- Multistakeholder action team includes providers, consumers, health plans, purchasers, measurement experts and others committed to aligning efforts to reduce EEDs
- Team members building on and leveraging previous EED successes and commitments in support of HHS' Partnership for Patients initiative

# Maternity Action Plan

## Promoting Healthy Mothers and Babies

# ‘Playbook’ Update and Input

# Measurement Strategy

- 2012 MAT emphasized the important role of performance measurement
- Mandatory reporting of The Joint Commission perinatal measure set now in effect
- 2014 MAT identified that there is a need for standardized data collection, reporting, and improvement tools

# ‘Playbook’ Idea

- Purpose: Help “late adopters” address challenges and barriers to collection and reporting of the PC-01 EED measure
  - “Late adopters” = hospitals/ health systems with high EED rates for a variety of reasons
- Key considerations:
  - Will be concise and not duplicate existing resources (e.g., March of Dimes toolkit)
  - Will be developed in a timely manner so it can be put to use ASAP

# Proposed 'Playbook' Contents

- Rationale for why late adopters need to catch up
- Key barriers that late adopters encounter, may include:
  - Scheduling in rural hospitals
  - "Non-commitment"
  - Measurement and data collection issues
- Strategies to address barriers, may include:
  - Measurement/data collection guidance
  - Clinical and quality staff work together—both collect and compare, agree before submission of data
  - Peer-review opportunities

# Proposed 'Playbook' Contents

- Measurement guidance
  - Data abstraction/collection tools for hospitals that collect data by hand
  - Clarification of data in public reports, especially Hospital Compare (e.g., N/A, insufficient data, etc.)
  - Clarification of why data is different across different reports
  - Tips for working with vendors on any of the above
  - Educational tools and resources from TJC, Leapfrog, others
  - Meaningful use specifications

# Opportunity for Public Comment

# EED Barriers and Strategies: Successes and Lessons Learned


# Carolinas HealthCare System

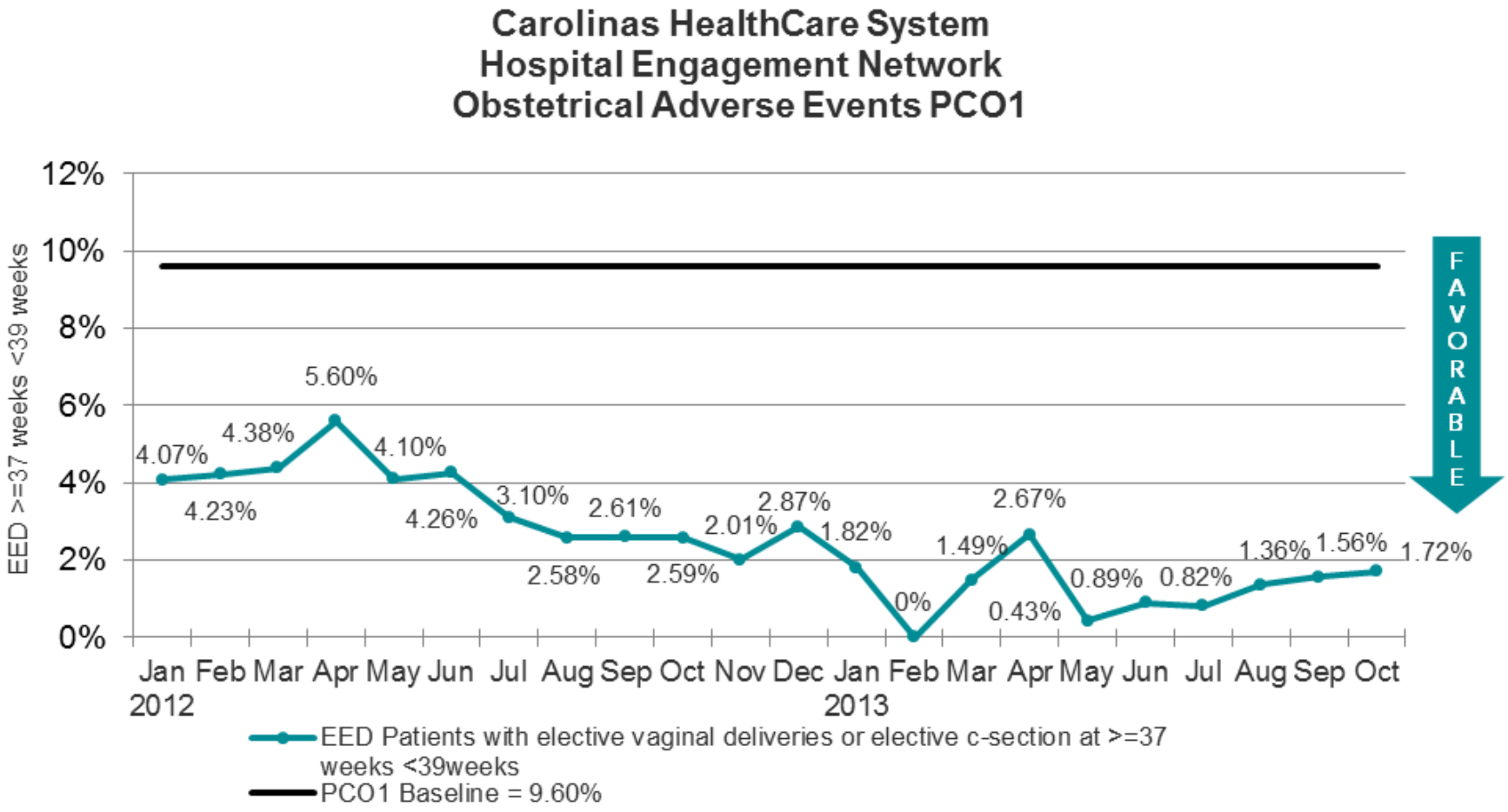
Amy Bell, RNC, MSN, NEA-BC

Outcomes Specialist—Obstetrics

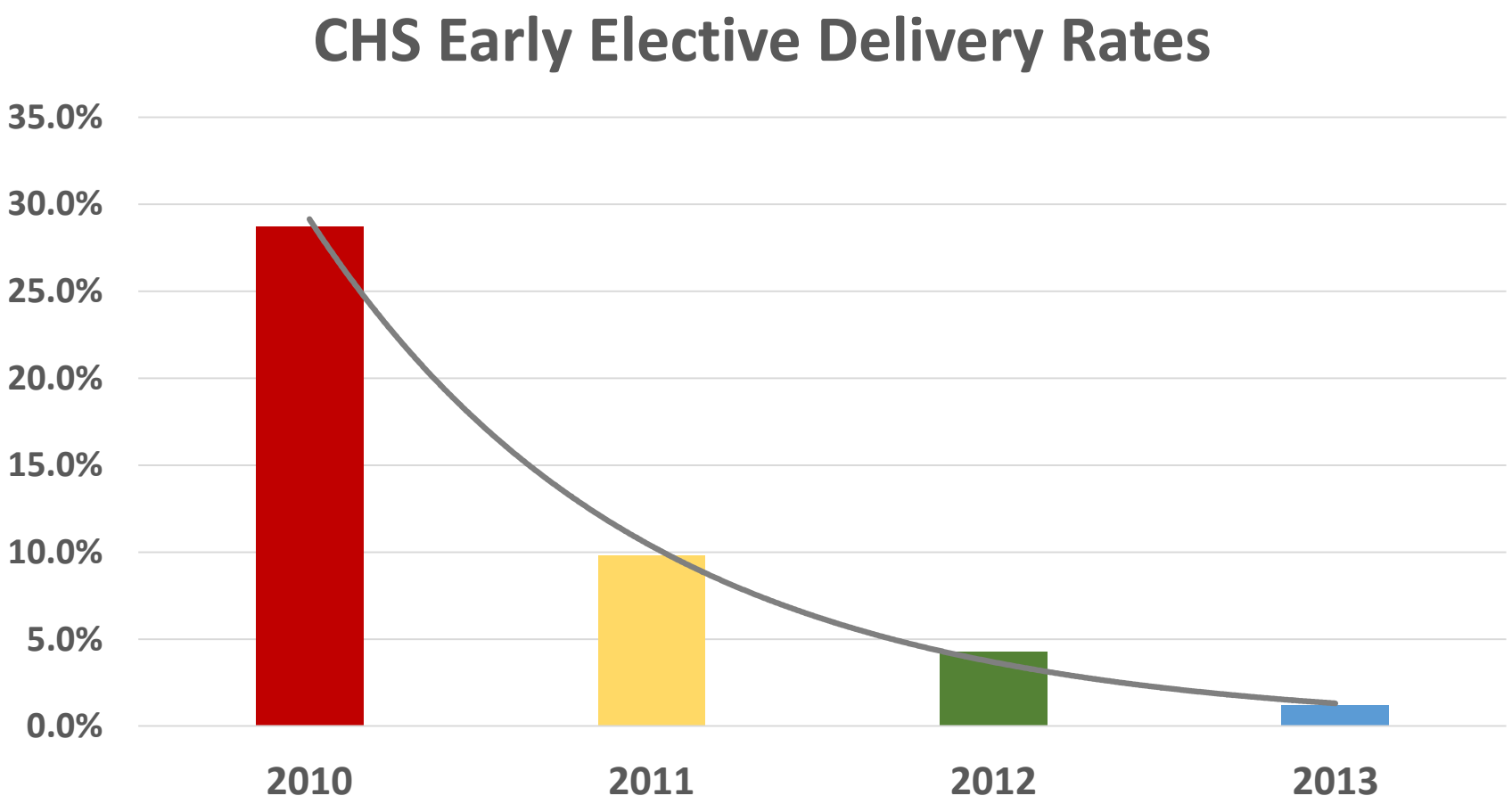
# EARLY ELECTIVE DELIVERY

*The Journey for Carolinas HealthCare System*

# 71.1% Reduction in EED (2012-2013)



# The bigger story……



# Engagement of Facilities

- Communication to providers, facility leaders, and OB nursing staff of importance of initiative—explain the why?
- Importance of building relationships with OB leaders/data collectors in each facility
- OB providers and OB nursing leaders are members of Corporate Quality Committees/Collaboratives

# Strategies for EED Rate Reduction

- Concerted effort to educate data collectors on Perinatal Core Measure abstraction
  - 1:1 face-to-face education sessions
  - Data validation for chart abstraction
  - Data re-validation sessions

- 100% of patient charts were abstracted (did not sample)
  - Understanding processes at each facility
  - Assisted with identifying systemic opportunities
  - Deep dive reviews for cases that were EEDs

# Strategies for EED Rate Reduction (cont.)

- Review data monthly in system-wide collaboratives
- Highlight facilities with lower rates and share best practices
- Implement a Hard Stop policy
  - Maternal-Fetal Medicine consult for any case not meeting approved criteria for delivering before 39 weeks; MFM can support the decision to proceed with the early delivery

# Strategies for EED Rate Reduction (cont.)

- Patient education about expectations is key
  - Adopt AWHONN's *"Go the Full 40"* campaign
  - Provide education materials from AWHONN to patients in the following arenas:
    - Ambulatory office setting at 28 weeks
    - Discharge from OB triage
    - Childbirth Education classes

- Celebrate successes

# External Factors Contributing to EED Rate Reduction

- North Carolina Hospital Association
  - Publicly reporting EED rates per facility across NC
  - All NC facility CEOs signed a pledge not permitting EEDs
- South Carolina BCBS and Medicaid
  - Refusing to pay claims for patients with an EED starting 1/1/13
- AWHONN
  - Go the Full 40 campaign
- March of Dimes
  - 39 week campaign

# Questions??

# CONTACT INFORMATION

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Florida Perinatal Quality Collaborative

AT THE LAWTON AND RHEA CHILES CENTER FOR HEALTHY MOTHERS AND BABIES

Partnering to Improve Health Care Quality for Mothers and Babies

# Florida's Efforts to Reduce Early Term Elective Deliveries


## William M. Sappenfield, MD, MPH

FPQC Research and Data Director
Chairman, Department of Community and Family Health
Director, Lawton and Rhea Chiles Center for Healthy Mothers and Babies
USF College of Public Health

## Linda A. Detman, Ph.D.

FPQC Program Manager
Research Associate, Lawton and Rhea Chiles Center for Healthy Mothers and Babies
USF College of Public Health

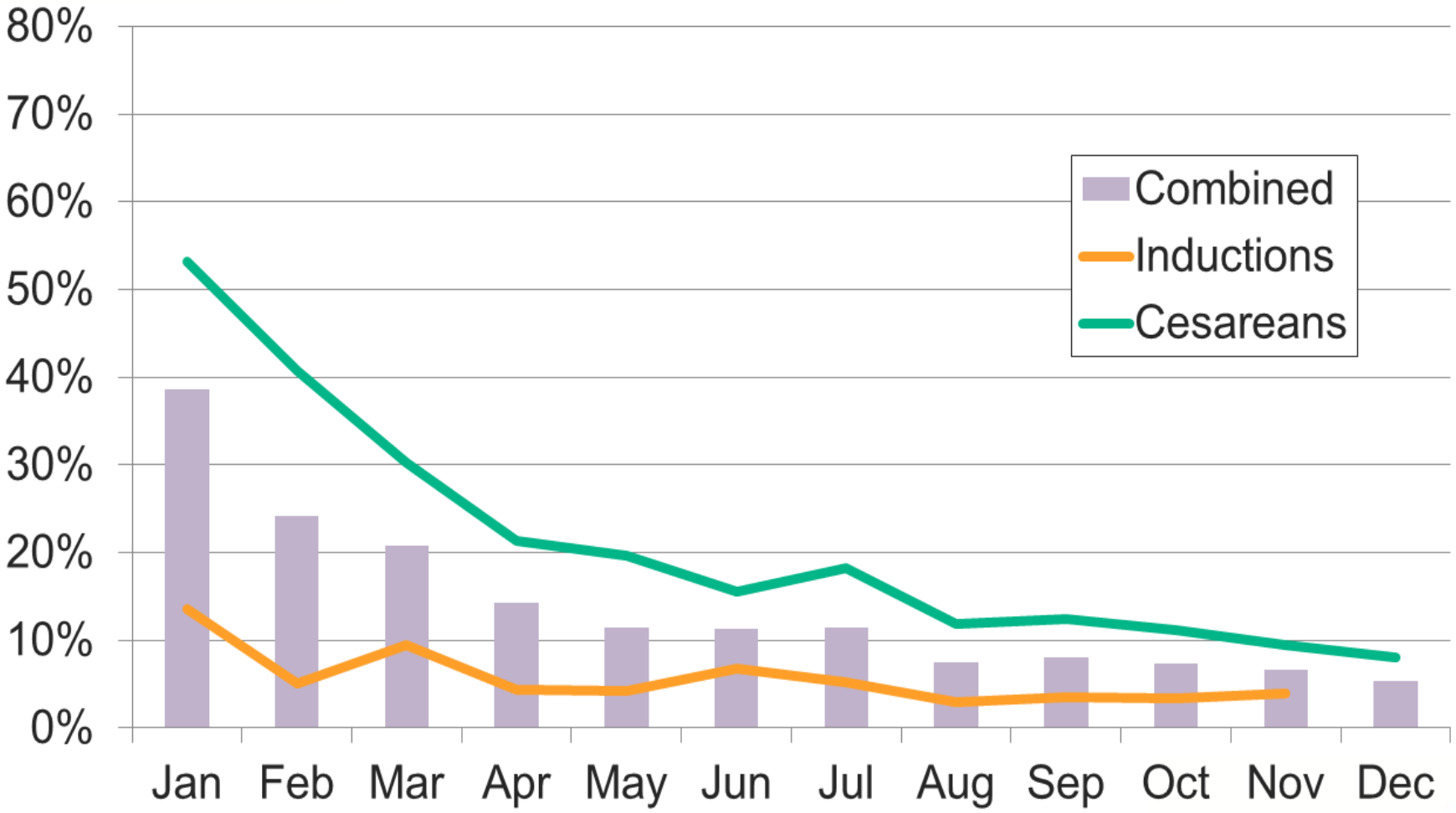
# FPQC Background

- Started in 2010 at the USF Chiles Center
- Collaborative of providers, partners & funders
- Initial QI initiative on reducing **early elective deliveries** & **neonatal catheter infections**
- New QI initiatives on **obstetric hemorrhage** & **neonatal resuscitation**
- Developing a new QI initiative on **antenatal steroid use** with MOD Big 5 (CA, IL, NY, TX & FL)
- Piloting a **QI indicator** project using timely birth certificates & hospital discharge data

# Florida Context

- De-regionalization of perinatal care statewide
- Pro-business regulatory environment
- Delivery hospitals not part of one organization
- No provider organization has routine communication/leadership mechanisms with providers in all delivery hospitals
- FPQC efforts are completely voluntary

# Florida/"Big 5" Pilot Hospitals Reduction of NMI Deliveries <39 Weeks by Delivery Type 2011




**Published in *Obstetrics & Gynecology*: "A Multistate Quality Improvement Program to Decrease Elective Deliveries Before 39 Weeks Gestation"**

# Expanded Florida Efforts to Reduce Non-Medically Indicated Deliveries <39 Weeks

- Partnered with Florida Hospital Association to assist their OB HEN hospitals
- Recruited additional Florida hospitals to use toolkit approach through MOD service package
- Offered provider outreach & education, including Grand Rounds, education packets, and literature bulletins
- Partnership with District XII ACOG to expand the NMID/EED program to hospitals with high rates in specific regions
- Florida Healthy Start Coalitions offered pregnant woman education through a MOD grant

# Hospital A, 2006 — 2011

## Non-Medically Indicated (NMI) Deliveries Prior to 39 Weeks

Non-medically indicated (NMI) deliveries are labor induced or cesarean deliveries performed without a maternal or fetal medical condition requiring pregnancy intervention under routine conditions. NMI deliveries prior to 39 weeks increase the risk of admissions to neonatal intensive care units, prolonged hospitalizations and increased costs, respiratory morbidity and support, and other neonatal and infant morbidities.[1-6]

## March of Dimes Big 5 Prematurity Collaborative

The March of Dimes Big 5 State Prematurity Collaborative partnered with Florida, Texas, Illinois, New York, and California teams to implement in pilot hospitals a new toolkit aimed at eliminating NMI deliveries <39 weeks gestational age.[7] The toolkit outlines the best practices on NMI deliveries and provides support and evidence-based materials for implementing a quality improvement project incorporating policies and tools used successfully at multiple hospitals in the United States. Six hospitals in Florida were chosen to participate as pilot hospitals. When looking at individually collected clinical data, all six hospitals effectively implemented practices and policies that substantially reduced their percentage of NMI deliveries prior to 39 weeks.

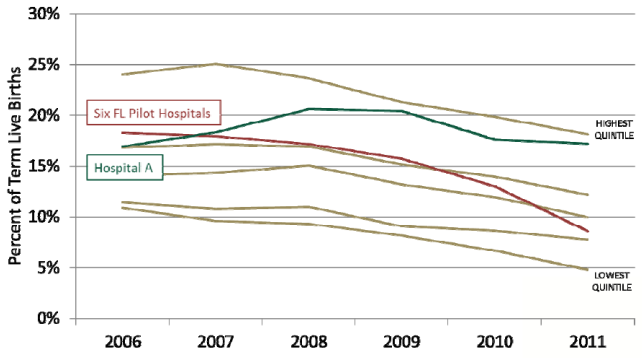
## Measuring NMI Deliveries Prior to 39 Weeks

Birth certificate data are used to calculate a surrogate measure in order to assess and monitor NMI deliveries prior to 39 weeks completed weeks of gestation. Gestational age is defined using the clinical estimate of gestational age from the birth certificate.

NMI deliveries prior to 39 weeks are classified by birth certificate reporting using The Joint Commission's (TJC) list of Conditions Possibly Justifying Elective Delivery prior to 39 Weeks Gestation.[8] The measure is restricted to live births to women presumed to be at risk for a NMI term delivery prior to 39 weeks. Therefore, live births occurring prior to 37 weeks gestation and live births with mothers or infants having medical conditions present prior to pregnancy or prior to labor and delivery are not included as these births were also not at risk for a NMI delivery.

◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆

**Percent of NMI Singleton Liveborn Babies Prior to 39 Weeks Gestation for Hospital A Compared with the Six Big 5 Pilot Hospitals and the Average Florida Hospitals by Quintile**




Data Source: Florida Live Birth Certificate

# Florida Perinatal Quality Collaborative

AT THE LAWTON AND RHEA CHILES CENTER FOR HEALTHY MOTHERS AND BABIES

Partnering to Improve Health Care Quality for Mothers and Babies

## TOOLS FOR DIALOGUE ON EARLY ELECTIVE DELIVERIES

### Making an Impact:

- **Discuss the importance of a full-term pregnancy.**
  - Begin dialogue at the first prenatal visit.
  - Use MOD Brain Card for visual example of developing organs and provide clients with information to take home.
  - Explain the definition of "full-term", which is 39-40 weeks.
  - Include the father and other family members in the conversation.

- **Discuss birth plans and the value of letting labor begin on its own.**
  - Encourage clients to discuss with family and friends the value of spontaneous labor and the length of a normal pregnancy.
  - Suggest strategies for "end-of-pregnancy" discomforts, such as: drinking plenty of water, stretching, and using gentle heat for pain.



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## Literature E-Bulletin on Non-Medically Indicated Deliveries <39 Weeks Gestation

Dear Perinatal Care Providers: Below is a list of recent literature on the issue of non-medically indicated deliveries <39 weeks gestational age. These references are provided to you by the Florida Perinatal Quality Collaborative through the generous support of a grant from the March of Dimes. You can click on the reference and go directly to the PubMed abstract for the article and access available full text articles. If you have any questions, please contact us at fpqc@health.usf.edu or by phone at 813-974-8888.

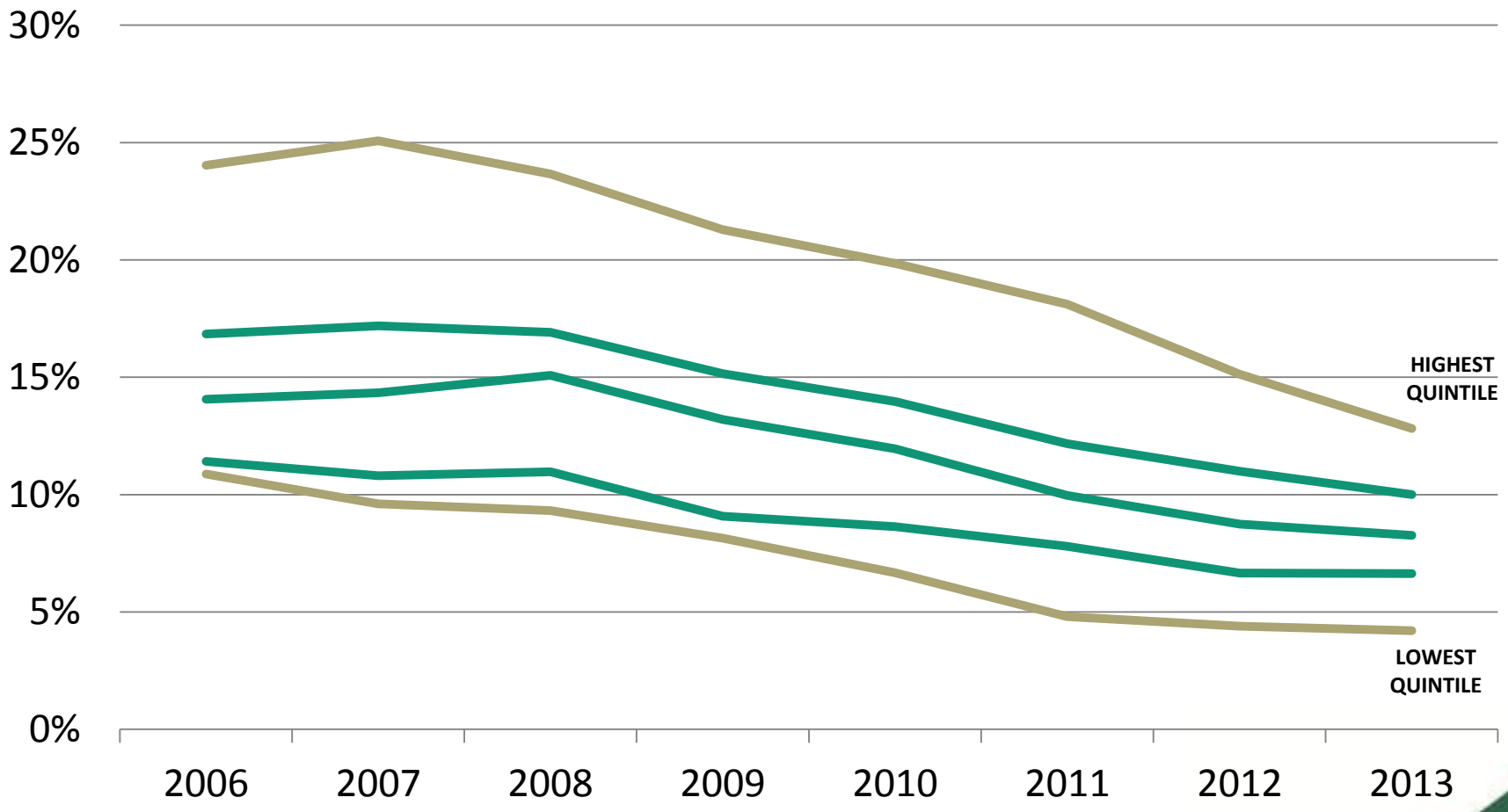
Doyle JL, Kenny TH, von Gruenigen VE, Butz AM, Burkett AM. Implementing an induction scheduling procedure and consent form to improve quality of care. *Journal of Obstetrics, Gynecology, and Neonatal Nurses.* 2012; 41:462-473.

A quality improvement initiative was implemented in a level III hospital, with 3,000 births annually, to align with ACOG guidelines and eliminate elective deliveries before 39 weeks gestation. A multidisciplinary Perinatal Safety Team was established with representatives from nursing, medicine, administration, and scheduling, to implement an induction scheduling procedure and consent form. Since implementation, elective deliveries before 39 weeks gestation have decreased from a baseline of 5.6 per month to 0.7 per month; of the 28 months post-implementation, 25 of these had zero elective inductions and 17 of 28 months had zero elective inductions and elective cesareans. The authors address issues with hard and soft stops and conclude that "the hard stop is essential for ultimate success as patient safety must be the number one concern." They also note the top reason for elective induction of labor was discomfort and as such, providers can support parents by reminding them that discomfort at the end of pregnancy is expected and normal, that babies take 40 weeks to fully develop, and due dates have an accuracy window of two weeks.

Simpson KR, Newman G, & Chirino OR. Patients' perspectives on the role of prepared childbirth education in decision making regarding elective labor induction. *Journal of Perinatal Education.* 2010; 19(3):21-32.

This study was conducted to evaluate the reasons why nulliparous women choose an elective induction of labor and to

# Percent of NMI Single Live Births <39 Weeks Among Term Births for Florida Hospitals by Quintile




Data Source: Florida Live Birth Certificate Data

# Challenges with EED Expansion

Sustainability in participating hospitals

- Funding streams
- Intensity of QI efforts
- Move from 1º data reporting to 2º data reporting
- Continued participation preventing recidivism:
  - Enthusiasm of OB Champion and L&D staff
  - Adherence to established protocols and systems
  - Willingness to assess variations from protocol

# Challenges with Expansion

Expanding to “Late Adopters”

- Using accurate hospital data to define the issue
- Finding entry into deliveries hospitals to assist
- Having the opportunity for making the case
- Motivating hospital efforts to address the issue

# Proposed EED Efforts

- Focus strategies on “Late Adopters” in Florida
- Recruit FPQC participation
- Continue promotional activities
  - Grand Rounds/hospital consultations
  - E-Bulletins
  - Provider education packets
  - Community campaigns
- New promotional activities
  - MOD and ACOG Banner Program
  - EED focused newsletter
  - Special EED videos by state ACOG leaders
  - Focus outreach to high rate hospitals

# Banner Opportunity

Many hospitals have implemented hard stops for Early Elective Delivery – for those who have successfully reduced their rate below 5%, the March of Dimes offers recognition through their Banner program.


march of dimes

# Making It to 39 Weeks:

## Florida's Campaign to Reduce Early Elective Deliveries

# EED Newsletter

http://health.usf.edu/publichealth/chiles/fpqc/eed

# Making It to 39 Weeks:

## Florida's Campaign to Reduce Early Elective Deliveries

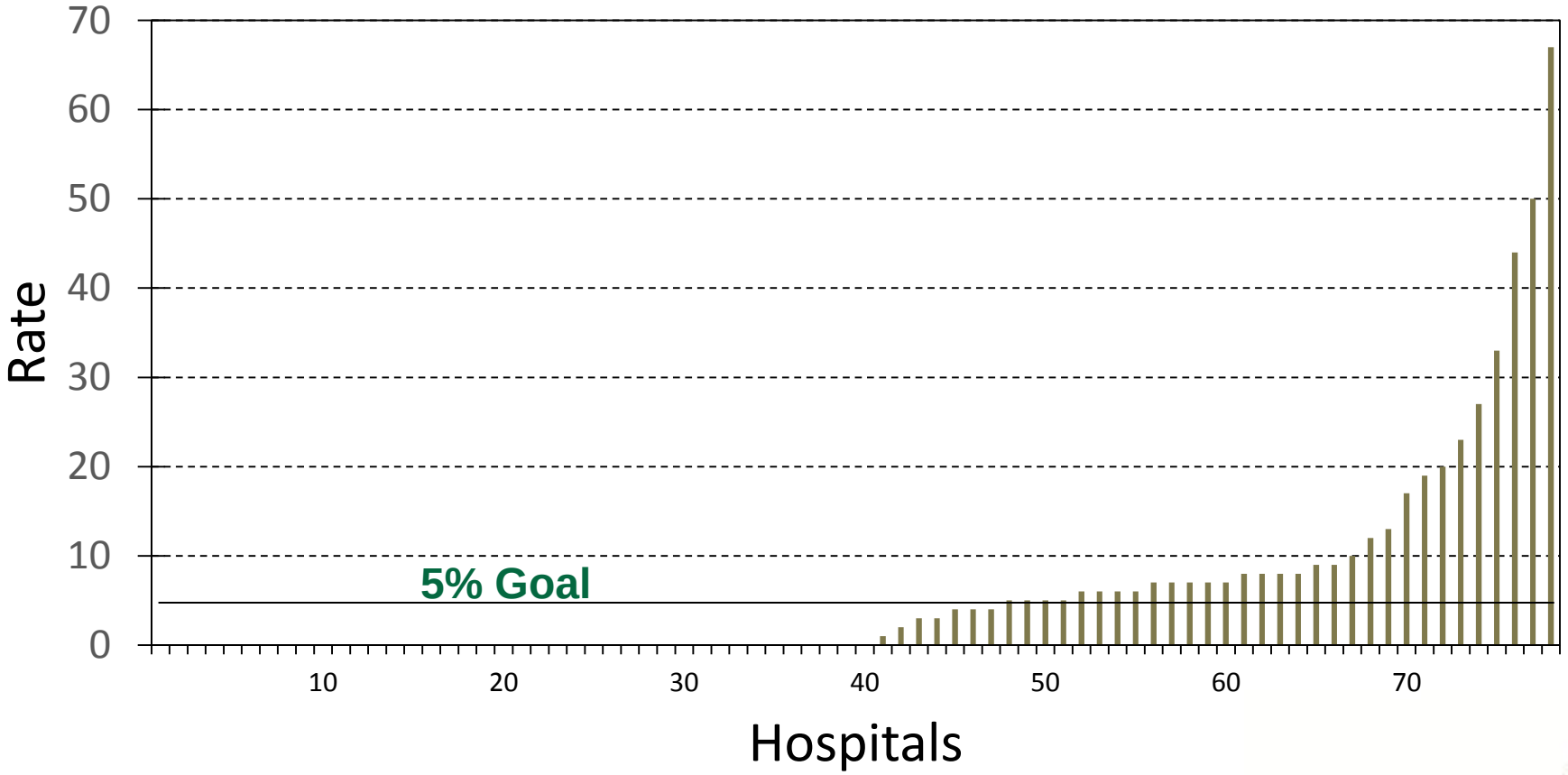
**Robert W. Yelverton, MD**
**Chair, District XII ACOG**

**Karen E. Harris, MD, MPH**
**Vice-Chair, District XII ACOG**

# EED Video

http://health.usf.edu/publichealth/chiles/fpqc/eed

# Medicaid Early Elective Delivery Rates by Hospital Florida, January to March Quarter, 2013 (N=78)




Data Source: CMS Website March 2014

# Questions?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FPQC
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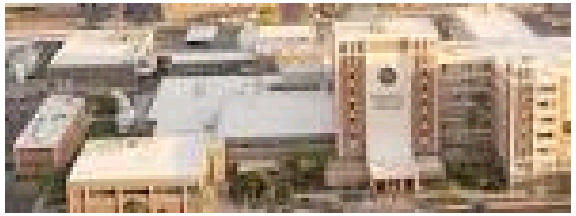
# DELIVERING HEALTHY BABIES AT MIHS

## Elimination of Early Elective Delivery

Dean Coonrod, MD-MPH, FACOG
Maria Manriquez, M.D. FACOG
Mary Bachhuber, RN
Maricopa Integrated Health System, District Medical Group, University of Arizona College of Medicine - Phoenix

# Maricopa Integrated Health System (MIHS)

- Arizona's only Public Health Care System
- Maricopa Medical Center
  - 522 Licensed beds
  - 2013 Deliveries = 2,600
  - Level 3 Nursery
  - Serves 11 Family Health Centers
- Maricopa Health Plan
  - >60,000 members
- Most Affordable Comprehensive Maternity Plan in the Valley (Maternity Package Plan Agreement)



# MIHS Women's Care Clinicians

- All employed by one group
- 13 - obstetrician gynecologist
- 10 - certified nurse midwives / nurse practitioners
- 6 - maternal fetal medicine (MFM) specialist
- Contract with other ObGyn subspecialists
- Family Practice providers of prenatal care (FHC)

# Maricopa Medical Center L&D

- Clinicians
  - 24/7 in house:
    - Attending ob/gyn
    - Senior and Junior residents
    - 1-2 interns
    - On call MFM
- Educating
  - ObGyn residents, rotating interns, medical students, nurses
  - Educating physicians for over 50 years
  - Major affiliate hospital for University of Arizona, College of Medicine - Phoenix
- Research
  - Clinical research in all departments

# Our Patient Population

- Ethnicity
  - Hispanic 76%
  - Caucasian 7%
  - African American 7%
  - Native American 4%
  - Asian <1%
  - Other/Unknown 5% (we have a large refugee population)
- Primary language our patients speak
  - English 62%
  - Spanish 29%
  - Spanish/English 7%
  - Other 2% (Burmese, Somali, Arabic, Chinese, Vietnamese, Karen, Kirundi, Sign Language)
- Payor Mix  inpatient / clinics
  - AHCCCS (Medicaid) 64%/49%
  - Self Pay 12%/29%
  - Medicare 10%/12%
  - Private insured 10%/6%
  - Other 4%/4%

# MIHS Tradition of Conservative Evidence Based Management

- Cesarean Section rate of average 23%
  - Primary Cesarean rate of 10%
  - NTSV about 17%
  - Repeat Cesarean rate of 13%
- VBAC rate of 37% (January-June 2013)
  - VBAC success rate of 72%
- Elective induction rate of 0.4% (January-June 2013)
  - At any gestational age
- Required best gestational age dating (ACOG criteria)
  - Dating ultrasound if unsure LMP

# Commitment to Quality Indicators

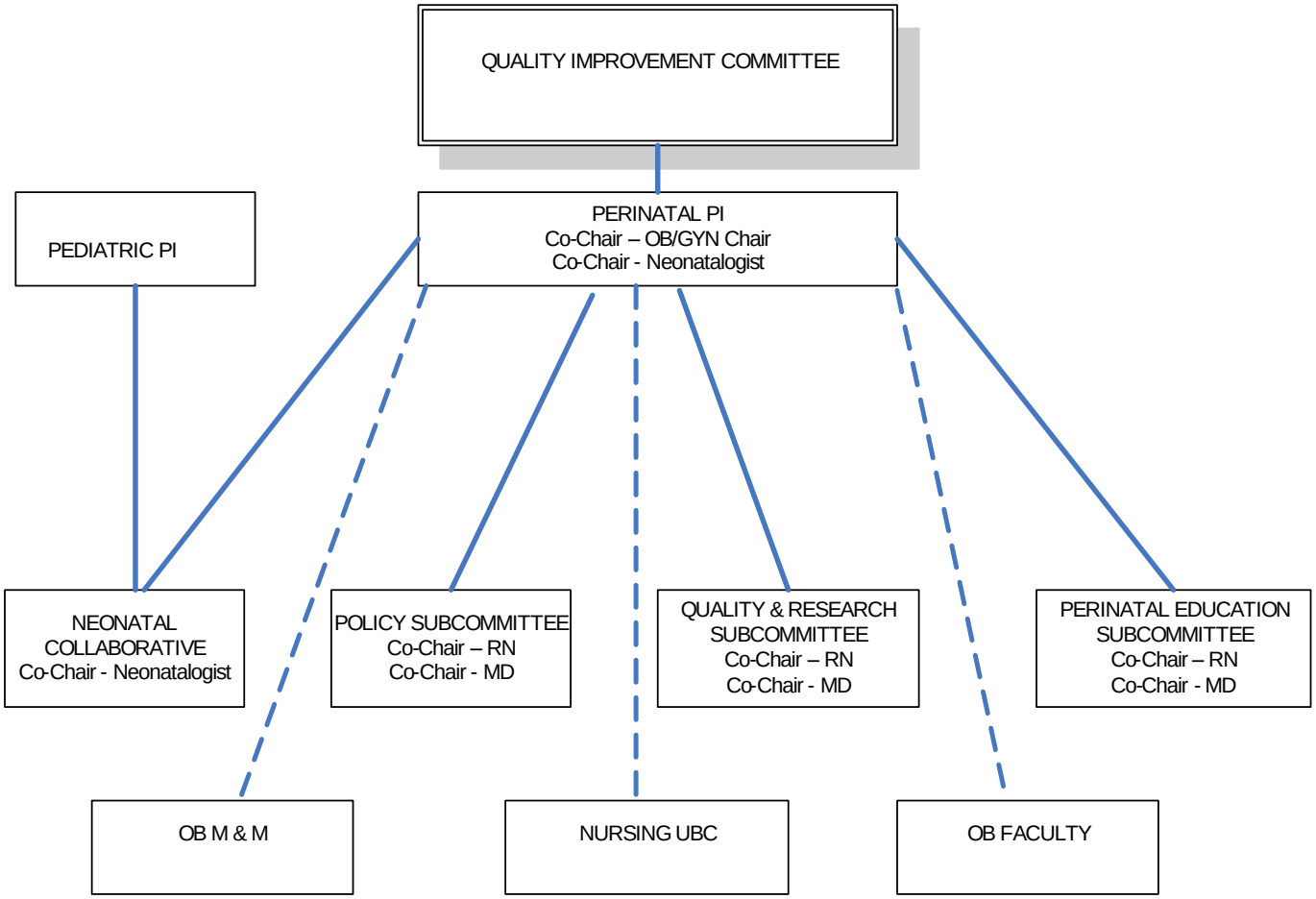
- Perinatal Performance Improvement (PI)
  - OB Policy Subcommittee
  - OB Quality Research Subcommittee
  - Perinatal Education Subcommittee
  - Neonatal Collaborative
- Committee Structure
  - Co Chairs - Chair of Obstetrics and Medical Director of Neonatology
  - Representative Members
    - Assistant Director of OB, MFM, Midwifery, Neonatology, OB anesthesiology, Maternal Child Quality Analyst, Manager L&D, Manager Postpartum, Directors – Women's Outpt clinics, Women's and Infants, Family Health Clinics

# Perinatal Quality & Research

- Interdisciplinary group of clinical and research staff aimed to facilitate and coordinate maternal and infant quality and research projects
- Activities include
  - MIHS Obstetrical Statistics (APT)
  - Pregnancy Related Core Measures
  - National Quality Forum Perinatal Indicators
  - MIHS Department/Division Dashboards
  - MIHS Patient Safety Indicators
  - Press Ganey Patient Satisfaction
  - CMQCC Participant
    - Hemorrhage
    - Hypertension

CMQCC
CALIFORNIA MATERNAL
QUALITY CARE COLLABORATIVE

# WOMEN & INFANTS COMMITTEE STRUCTURE



# Arizona Elective Delivery Rates

- Results of Reporting Hospitals in 2010
- Target of 12%
  - Only Maricopa Medical Center and Chandler Regional Medical Center were below the target rate

# Elimination of Elective Deliveries before 39 weeks Gestation

- California Maternal Quality Care Collaborative (CMQCC), March of Dimes (MOD) and other California Health entities release the **Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age** in July 2010
- First presented to PQRS in December of 2010
- Our department began work in March 2011
- Perinatal Quality and Research Subcommittee developed MIHS policy and scheduling form
- Women's Care Clinic and Family Health Care Clinics were notified of policy and scheduling form and asked to implement

# PDCA process initiated

- Review of current status
- Determined outcome measures and data collection process (**RN,MD)**
- Determined process measure(s) and data collection process (**MD)**
- Align scheduling process with process  and develop or adopt scheduling form (**RN L&D Manager)**
- Aim for consensus on key concepts (**MD Co-Chair)**
- Develop departmental policy (**RN educator)**
- Physician/Nursing Education on common language, definitions and documentation (**RN L&D members**)
- Patient Education (**Postpartum RN manager, PPRN**)
- Support above members as needed, Data Analysis (**Nursing Admin)**

# The Details

- Policy development
- Scheduling form development
- Patient education materials
- Utilized the PowerPoint available from CMQCC / MOD
- October 2011 Rollout
  - Staff meetings
  - Child Family Health Fair
  - Family Health Clinics notified of implementation

- **1. Confirmation of gestational age using one of the ACOG criteria**
  - Ultrasound measurement at less than 20 weeks supporting a gestational age >39wks
  - Fetal heart tones have been documented as present for 30 weeks by Doppler
  - It has been > 36 weeks since a positive serum or urine HCG test
- **2. Scheduling**
  - Provider or designee contacts the L&D scheduler with the Schedule Form for
  - Induction and Cesarean Section, this may be phoned followed by a fax of the form to L&D
  - All components of the form must be completed
  - If the induction is felt not to be indicated as suggested by the form, the scheduler will inform provider is not authorized to schedule the procedure without documented permission from the OB/Gyn department chair or designee
  - Women who have medical indications for delivery have priority over women **having** elective cesarean sections or inductions of labor. These decisions are at the discretion of the L&D unit charge nurse in consultation with the designated physician leader.
- **3. Informed Consent All patients scheduled non-medically indicated (elective) delivery prior to 39 weeks will have an informed consent discussion. The informed consent discussion must be documented in the medical record by the provider. The informed consent discussion will include the risks and benefits of induction of labor or cesarean section and will include a discussion of risks to the baby of being born electively prior to 39 weeks gestation.**

Maricopa Integrated Health Systems

Scheduling Form for Inductions and Cesarean Sections

Patient Name_____Phone_____

Provider requesting _____ G/P_____

☐ Induction ☐ C/Section Desired Date/Time_____

**Dating** EDC: _____ Gestational age at date requested _____ (week + day)

EDC based on ☐ US 10-20 weeks;* ☐Doppler FHT+ for 30weeks;* or ☐ +hCG for 36 weeks* ☐ Other dating criteria_____ (*details)*

***By ACOG Guidelines, women should be 39wks or greater before initiating an elective delivery. ACOG also states that a mature fetal lung test in the absences of clinical indication is NOT considered an indication for delivery.***

☐ Fetal Lung Maturity test result: _____ Date:_____

**INDICATION for Delivery**

**Obstetric and Medical Conditions (approved for <39wks)**

- ☐ Abruption
- ☐ Previa
- ☐ Preeclampsia
- ☐ Gestational HTN
- ☐ GDM with insulin
- ☐ ≥ 41+0 weeks
- ☐ PROM
- ☐ IUGR
- ☐ Non-reassuring fetal status

_____

**Scheduled C/S (>39 weeks)**

- ☐ Prior C/S*
- ☐ Prior classical C/S (may be earlier with FLM or per MFM)
- ☐ Prior myomectomy (*may be earlier with FLM or per MFM)*
- ☐ Breech
- ☐ Other malpresentation (*may be earlier with FLM or per MFM)*
- ☐
- ☐ Twin w/o complication (*ok ≥38wks)**
- ☐ Other: _____

- ☐ Isoimmunization
- ☐ Fetal malformation
- ☐ Maternal HIV infection
- ☐ Maternal CHTN
- ☐ Maternal Heart or Liver or Pulmonary disease
- ☐ Thrombophilia/Coagulopathy
- ☐ Maternal Fetal Medicine (MFM) consult recommendation, name of MFM _____

_____

- ☐ Patient choice

**Elective Induction >>39weeks**

- ☐ Patient choice/social*
- ☐ Macrosomnia*
- ☐ Distance*
- ☐ Other*: _____

***ACOG criteria which must be met in order to be scheduled or with +FLM and criteria not met**

_____

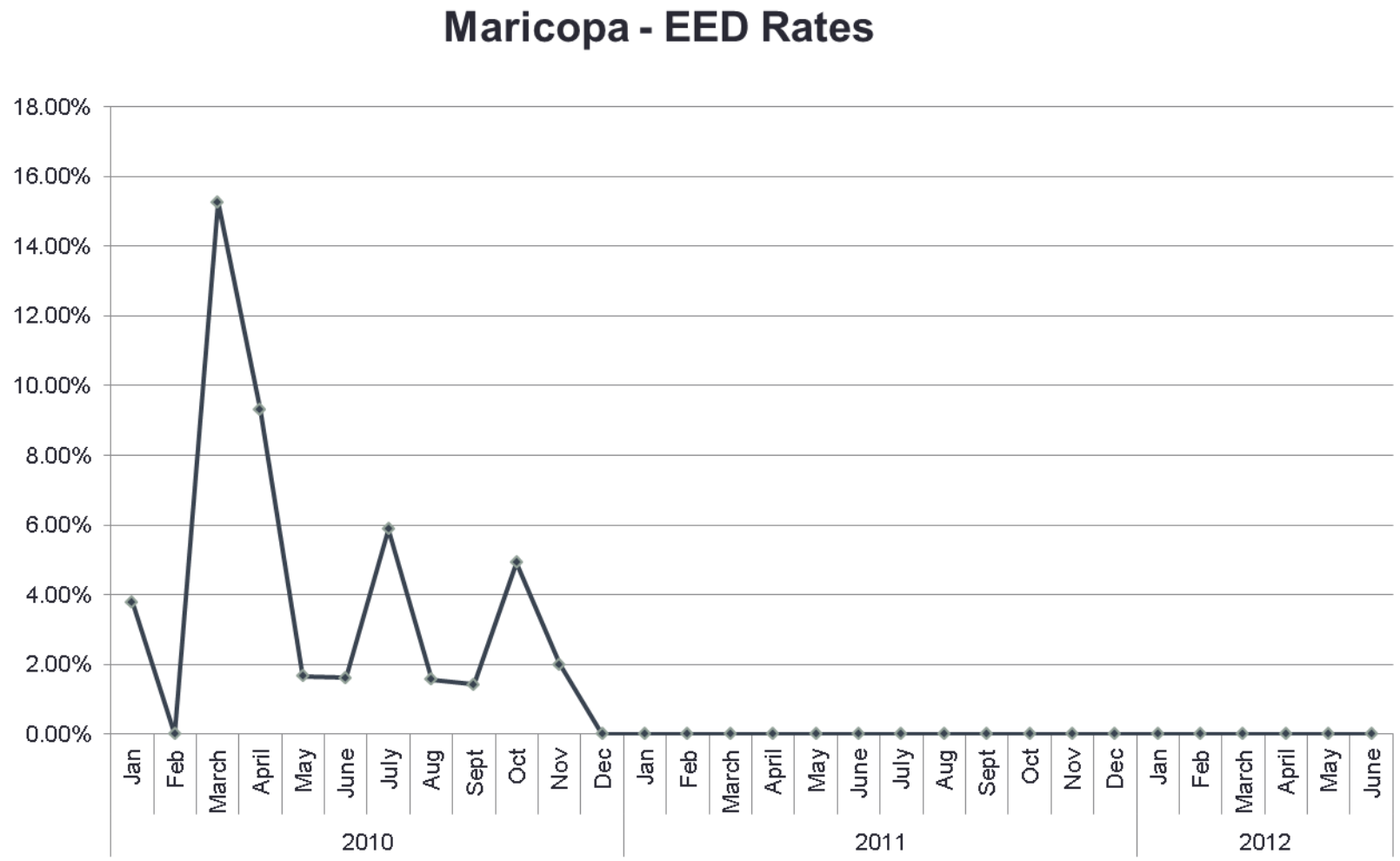
**Cervical Exam** (for inductions) _____

Date of Exam (within 7 days of date of induction) _____

Bishop Score: *circle each element of the below and add:* **Total Score**_____

| Score | Dilation | Effacement | Station | Consistency | Position |
|---|---|---|---|---|---|
| 0 | Closed | 0-30% | -3 | Firm | Posterior |
| 1 | 1-2 | 40-50% | -2 | Medium | Midposition |
| 2 | 3-4 | 60-70% | -1, 0 | Soft | Anterior |
| 3 | 5-6 | 80% | +1,+2 | ------ | ------ |

To be completed by Labor and Delivery Staff after receiving above fax/information
Procedure Scheduled ☐by_____ Confirm date/Time_____Procedure NOT Scheduled ☐
Please FAX completed form to # 5594




0% 2013
0% through
March 2014

# Why?

- Low baseline rate
  - Tradition
  - Not much consumer demand
- One medical group
  - Challenge to education providers at other remote sites / other specialties.
  - Education and Re-education
- Committee / Sub-committee structure
- Empowered nursing staff to say “no”
- Elective deliveries < 39 weeks a criteria for peer review
  - Only one case reviewed
- Wanting to be ahead in the innovation curve
  - Early innovators
  - CMQCC, Committee structure, educators
- Continued tracking
- Right people

# Opportunity for Public Comment

# Next Steps

- Summary of key takeaways from today's webinar
- Stay tuned for 'Playbook' updates
- Next MAT monthly call – May 19, 4pm ET

# For More Information

***Go to the Project Page on NQF's Website or the MAT's LinkedIn Group!***

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