Maternity Action Team Web Meeting

August 18, 2014
3:30pm-5:00pm ET

NATIONAL QUALITY FORUM

Webinar Objectives

- Publicly launch the *Playbook for the Successful Elimination of Early Elective Deliveries* ("Playbook")
- Learn how several hospitals and hospital systems have used strategies in the Playbook to successfully reduce early elective deliveries

NQF 2014 Maternity Action Team

Goal: 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 Team Roster

Maureen Corry (Co-Chair), Childbirth Connection Programs, National Partnership for Women & Families	**Christine Hunter,** US Office of Personnel Management
Elliott Main (Co-Chair), California Maternal Quality Care Collaborative	**Paul Jarris**, Association of State and Territorial Health Officials
Amy Bell, Carolina's HealthCare System	**Maulik Joshi**, American Hospital Association
Kate Berrien, Community Care of North Carolina	**Kate Menard,** Society for Maternal Fetal Medicine
Jesse Bushman, American College of Nurse Midwives	**Erica Mobley**, The Leapfrog Group
Divya Cantor, WellPoint, Inc.	**Barbara O'Brien**, University of Oklahoma Health Sciences Center
Dean Coonrod, Maricopa Integrated Health System	**Cynthia Pellegrini,** March of Dimes
Linda Detman, University of South Florida College of Public Health	**Brynn Rubinstein, MPH**, Pacific Business Group on Health
Karen Gandy, BlueCare of Tennessee (Blue Cross Blue Shield Tennessee)	**William Sappenfield,** University of South Florida, College of Public Health
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	**Kim Werkmeister**, Cynosure Health Solutions

Maternity Action Pathway

Promoting Healthy Mothers and Babies

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Playbook Overview

To access the Playbook, go to the Links tab on the webinar platform or go to NQF's website

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Playbook Purpose and Overview

- **Purpose:** To provide guidance and strategies to help those struggling to reduce their rates of early elective delivery
- Supports all who are practicing and delivering care, and provides specific guidance for hospitals and hospital systems/networks facing various barriers and challenges in their quality improvement (QI) efforts

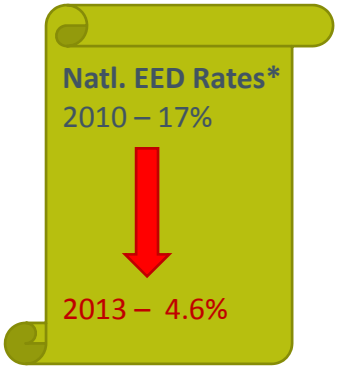
Playbook Contents

- Section I. Current Landscape for Eliminating Early Elective Delivery
- Section II. Barriers to Reducing EED and Strategies to Overcome Them
- Section III. Challenges and Barriers to Monitoring Performance and Progress Towards Eliminating Early Elective Deliveries
- Section IV. Key Strategies to Promote "Readiness" for Early Elective Delivery Reduction Activities
- Section V. Measurement Guidance
- Section VI. Educational Tools, Resources, And Exemplars to Support Early Elective Delivery Elimination Efforts

Section I. Current Landscape for Eliminating EED

- Widespread momentum in recent years to curb EED rates through partnerships and perinatal collaboratives, patient and provider education, measurement and public reporting, and "hard stop" policies

- Yet despite significant progress, there are still areas in the country finding it difficult to achieve results



* The Leapfrog Group website. Dramatic decline in dangerous early elective deliveries; The Leapfrog Group cautions against babies being born too soon, hits national target. March 2014. Available at http://www.leapfroggroup.org/policy_leadership/leapfrog_news/5164214.

Making the Case to Eliminate EED (Exhibit 1)

- Strong medical evidence for reduction of neonatal and maternal harm
- Strong support from professional organizations
- Transparency: public reporting
- Quality Improvement tools and help available
- Part of Pay-for-Performance models
- Established ongoing national project

Section II. Barriers to Reducing EED and Strategies for Overcoming Them

- Describes common barriers that medical leaders, hospitals, and health systems may encounter in their EED reduction efforts and offers a range of strategies to address these barriers
- Example drivers and strategies from Playbook are provided here

Section II. Barriers to Reducing EED and Strategies for Overcoming Them

Provider-Initiated Early Elective Deliveries – Example Drivers/Strategies

Barrier 1. Lack of Effective Policies For Elective Labor Induction or C-Section	
Drivers:	**Strategies:**
Absence of policies or guidelines for scheduling deliveries	Establish hard-stop policy requiring OB quality committee chair or OB department chair approval to schedule cases <39 weeks without evidence of medical indication on approved list (TJC PC-01 and ACOG resources).
Barrier 2. Provider Resistance to Change/Lack of Accountability	
Provider perception that EED does not result in worse outcomes	Provider Education: Hold Grand Rounds with a combination of respected outside leaders combined with local champions. The MOD/CMQCC Toolkit has a great slide set.
Barrier 3. Provider Concerns Regarding Financial Impact of Eliminating EED	
Provider concerns that patients will change practices if requests for EED are not accommodated by their prenatal care provider	Work with all local delivery facilities to implement hard stop policies for EED to ensure no competitors continue to offer EED (it is now the exception).

Section II. Barriers to Reducing EED and Strategies for Overcoming Them

Infrastructure- or Capacity-Initiated Early Elective Deliveries – Example Drivers/Strategies

Barrier 4. Lack of Standardized Scheduling operating room (OR) cases	
Drivers:	**Strategies:**
OR schedule is managed by a central scheduler responsible for posting all OR cases, with no mechanism to confirm the appropriateness of the timing of scheduled c-sections.	Standardize gestational age determination and include with all scheduled deliveries in the hospital's scheduling system (the method of standardization should be approved by the hospital's OB/GYN committee).
Barrier 5. Lack of 24-hour Anesthesia Coverage	
Hospitals without 24-hour anesthesia coverage or dedicated obstetric anesthesia teams have concerns about the potential for an increase in unscheduled, emergent, or after-hours c-sections/epidurals and decreased flexibility in scheduling cases.	• Explore options for expanding obstetric anesthesia coverage such as through the use of CRNAs. (Good for all OB emergencies!). • Define unintended consequences and establish a measurement system to monitor over time and a feedback loop to the OB stakeholders.

Section II. Barriers to Reducing EED and Strategies for Overcoming Them

Barrier 6. Lack of Institutional Support and/or Competing Demands Across Multiple Service Lines	
Drivers:	**Strategies:**
Complexity of system and/or competing priorities	Space out large quality initiatives and plan for intense parts of improvement activities to occur at different times for different initiatives.
Barrier 7. Lack of Awareness of Among Women of Risks Associated with EED	
Lack of general awareness among women of risks associated with early elective delivery and benefits of spontaneous labor in healthy women and fetuses	Utilize March of Dimes, ACNM, and AWHONN patient education materials on EED, and Childbirth Connection resources on induction and cesarean section (see Section IV for specific resources).

Section III. Challenges and Barriers to Monitoring Performance and Progress Towards Eliminating Early Elective Deliveries

- Describes challenges, barriers and strategies related to data collection
- Three primary barriers described in this section:
  - Multiple demands on staff resources
  - Disconnect between clinical team and quality department
  - Issues related to data accuracy

Section III. Challenges and Barriers to Monitoring Performance and Progress Towards Eliminating Early Elective Deliveries

Challenges Related to Data Collection – Example Drivers/Strategies

Barrier 8. Multiple Demands on Staff Resources	
Drivers:	**Strategies:**
Data collection is time consuming	Develop streamlined tool for manual data collection.
Barrier 9. Disconnect Between Clinical Team and Quality Department	
Obstetricians and OB nursing staff may not have experience with quality initiatives or measurement	Promote collaboration between clinical and quality staff through regular team meetings for education, training and development/review of data collection plans.
Barrier 10. Issues Related to Accuracy of Data	
Lack of provider awareness of documentation requirements for coding	Provide education to providers on coding requirements to improve accuracy.

Section IV. Key Strategies to Promote "Readiness" for EED Reduction Activities

- **Strategies to Engage and Activate Senior Leadership**
  - Engage a physician champion to support the project
  - Empower nurses to enforce a Hard-Stop policy and procedure
- **Policy and Payment Strategies (see Exhibit 2)**
  - Initiate a state-wide hospital collaborative for reducing EED
  - Offer modest bonuses to hospitals that meet quality targets
  - Initiate a hybrid approach of collaboratives and legislation
  - Develop payment legislation around EED reduction

Section V. Measurement Guidance

- **Calculating the PC-01 Measure**
  - Data Abstraction/Collection Guidance
  - Case Review Using Algorithm
  - Measure Calculation Considerations for Meaningful Use Program
  - "Cheat-Sheet" for Hospitals to Use
- **Interpretation of PC-01 Measure Results**
  - The Leapfrog Group Data
  - Hospital Compare Data

Section VI. Educational Tools, Resources, and Exemplars to Support EED Elimination Efforts

- A compilation of resources for:
  - Patients
  - Quality improvement
  - Clinicians
  - Measurement
- References exemplar strategies and case studies
- Includes contact information for various Maternity Action Team members to obtain further information/guidance

Opportunity for Public Comment

Playbook Strategies Put to the Test

Eliminating 39wk Elective Deliveries

Tami Michele, DO, FACOOG
Obstetrician/Gynecologist
Spectrum Health Gerber Memorial
Fremont, Michigan

Michigan Keystone OB Project:

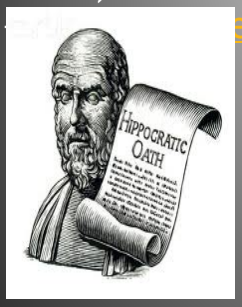
- Created a 'Culture of Safety'
  - Improved communication
- No Elective Inductions or Scheduled Cesareans <39wks
  - Revised our clinical practice
- Safe Use of Pitocin
  - High alert medication
- *De*–Management of 2nd Stage Labor
  - More time
- Electronic Fetal Monitoring Standards
  - Appropriate and timely response

Spectrum Health System Synergy Award Winner for Sustained Performance: No Elective Delivery <39 wks after 2 yrs (Now 4 yrs) of data collection

- Coordinated effo

OB Providers
Office Staff
L&D Nurses
Surgical Dept.
Surgeons
Administration
Scheduling Dept.

Primum non nocerum. (First do no harm)"



- Or, in other words……

"*What is best for the Patient?"*

The OB Providers took it one step further….

- Productivity vs. Teamwork
- We changed our payment contracts to focus on teamwork
- Eliminated productivity bonus
- Reduces elective inductions and drives down the C/S rate when physicians have no incentive for # of Births
- Sharing of OR Block Time for C/S scheduling

Our Results in one year

- **Induction rate** ⇩ by 13.5% (currently 13.2%)
- **Total C/S rate** ⇩ by 3.8% (currently 25.8%)
- **Primary C/S rate** ⇩ by 2.6% (currently 12.8%)
- **Epidural Rate** ⇩ ⇩ ⇩ (currently 18-27%)

Spectrum Health Induction Policy:

- No use of cervical ripening agents for elective induction <41 wks.
- Cervical ripening is used according to Bishop score recommendations in the ACOG practice bulletin for medically indicated inductions or >41 wks.

Michigan Keystone OB:

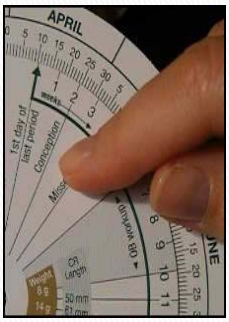
- Safe use of Pitocin

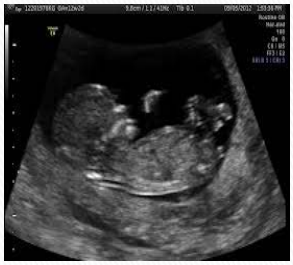
Pitocin (Oxytocin)

- **Black Box Warnings**
- Elective induction of labor is defined as the initiation of labor in a pregnant individual who has no medical indications for induction.
- Because the available data are inadequate to evaluate the benefits-to-risks considerations, oxytocin is not indicated for elective induction of labor.

How can we use less Pitocin?

Inductions and Planned C/S in Our Office





*Start educating women at the 1st prenatal visit of elective induction risk

*Repeat C/S at 39-40wks

*Confirm date with a <12 wk ultrasound

Postdates

- If no medical indications for induction, NST and AFI are ordered at 41 wks to confirm fetal well-being
- We plan scheduled induction before 42 wks.

Spontaneous Labor is Cost Effective

- More efficient, usually faster labors
- Less nursing staff required
- Less intervention
- Patient is lower risk than when using pitocin
- Decreased C-Sections
- Shorter postpartum stay if vaginal delivery (24 hrs vs 48 hrs for C/S)
- Less paperwork too!

Question…..

With the outcomes of the project showing a benefit to the patient, how did the staff feel about the changes in the obstetrical departme

Participating physicians, nurses and staff experienced an increase in:

1. job satisfaction
2. working conditions
3. perceptions of hospital management
4. As a result of their efforts, clinical staff ***enjoyed*** providing safe, quality, evidence-based care that is good for mothers and babies!

April Adams, RNC-OB
Clinical Team Supervisor
Duncan Regional Hospital, OK

Rosemary Blackmon
Executive VP/COO
Alabama Hospital Association

Shelly Lanagan, RN

Perinatal Clinical Care Specialist

Summit Healthcare Regional Medical Center, AZ

Opportunity for Public Comment

Wrap-Up and Next Steps

- Summary of key takeaways from today's webinar
- Access the Playbook: posted on the NQF website
- Let us know how you plan to use the Playbook – we want to know!
  - Send input or comments to jfeldman@qualityforum.org

For More Information

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

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2014

JOHN M. EISENBERG
PATIENT SAFETY & QUALITY AWARDS

Submissions will be accepted
August 1, 2014 – September 30, 2014

EisenbergAwards@qualityforum.org

Thank You!