Overview of National OB Quality Initiatives

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Objectives:

- Describe the national initiatives to improve safety and performance in OB
- Understand the power of perinatal collaboratives
- Describe California Maternal Data Center and how it can be used for benchmarking and driving maternal QI efforts.

Presenter Disclosure(s):

- None
CPQCC and CMQCC

Mission: Improving care for moms and newborns

California Perinatal Quality Care Collaborative (CPQCC)
- Expertise in data capture from hospitals
- Established Perinatal Data Center in 1996, works with VON
- Data use agreements in place with 130 hospitals with NICUs
- Model of working with state agencies to provide data of value

California Maternal Quality Care Collaborative (CMQCC)
- Expertise in maternal data analysis
- Developer of QI toolkits: Early Elective Delivery, OB Hemorrhage, Preeclampsia, Primary Cesarean
- Host of collaborative learning sessions
- Established Maternal Data Center in 2011

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CMQCC Key Partner/Stakeholders

State Agencies:
- MCAH, Dept Public Health
- OSHPD Healthcare Information Division
- Office of Vital Records (OVR)
- Regional Perinatal Programs of California (RPPC)
- DHCS, Medi-Cal

Public Groups
- California Hospital Accountability and Reporting Taskforce (CHART)
- Kaiser Family Foundation
- March of Dimes (MOD)
- Pacific Business Group on Health

Professional groups
- American College of Obstetrics and Gynecology (ACOG--District IX)
- Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN--California Section)
- American College of Nurse Midwives (ACNM-California Section),
- American Academy of Family Physicians (AAFP--CAFP)

Key Medical and Nursing Leaders
- University and Hospital Systems
- Kaisers, Sutter, Sharp, CHW, Scripps, Public hospitals,

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<<Considerations>>

- Importance of including as many stakeholders as possible in the collaborative
- Creating value for each stakeholder—thinking thru “what can the collaborative do for each stakeholder category?”
National Maternal QI Projects

- Quality/Performance Measures (examples)
  - Elimination of Elective Delivery <39 weeks (TJC, Leap Frog, CMS, HENs)
  - Low-risk First birth (NTSV) Cesarean Prevention (TJC, Leap Frog, CMS, HENs)
  - Increasing Antenatal Steroids for Fetal Maturation (TJC, Leap Frog, CMS)

- National Maternal Safety Bundles (examples)
  - Obstetric Hemorrhage (ACOG/ SMFM/ AWHONN)
  - Preeclampsia (ACOG/ SMFM/ AWHONN)

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<<Considerations>>

- Important for Quality Collaboratives to do BOTH performance and safety projects over time
- Maximize stakeholder engagement
- Builds recognition and respect
Early Elective Delivery- Accounting for the Success

- Strong evidence base (ACOG/ CMQCC-MOD)
- Data-driven QI capability (Quality Collab.)
- Professional leadership (ACOG)
- National Quality Measures (TJC, LF, CMS)
- Public Advocacy (March of Dimes)
- Transparency / Public reporting (CMS, LF, TJC)
- Payment reform to dis-incent activity (Various payers, CMS)
Success: Pressure From All Angles

- Public advocates
- Quality measures
- Public Reporting
- Data-driven QI
- Evidence
- Payment Reform

Final angle to complete initiative

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CMQCC Maternal Data Center: Data Flow

1. Links Birth Data to OSHPD file
2. Runs exclusions
3. Identifies CS and Inductions
4. Prints list of charts for review

Limited manual data entry for this measure

Calculates all the Measures

REPORTS
Benchmarks against other hospitals
Sub-measure reports

Mantra: “If you use it, they will improve it”
What are some of the features of the CMDC?

A low-cost, low-burden, web-based tool providing hospitals with:

- Overall hospital performance measures
- Drill-down statistics and case review worksheets to identify quality improvement opportunities—for both clinical quality and data quality
- Provider-level statistics—to assess variation within a hospital
- Benchmarking statistics—to compare your hospital to regional, statewide, and like-hospital peers
- Facilitating reporting to Leapfrog, Cal-HEN and PSF +
<<Considerations>>

- Important to move beyond reporting metrics to addressing WHY?
- Need to have timely data (months old rather than years old)
- Need a base of the entire population and then build projects requiring special data collection on that foundation
Maternal Mortality Rate, California and United States; 1999-2010

SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2010. Maternal mortality for California (deaths ≤ 42 days postpartum) was calculated using ICD-10 cause of death classification (codes A34, O00-O95,O98-O99) for 1999-2010. United States data and HP2020 Objective were calculated using the same methods. U.S. maternal mortality rates are published by the National Center for Health Statistics (NCHS) through 2007 only. Rates for 2008-2010 were calculated using NCHS Final Birth Data (denominator) and CDC Wonder Online Database for maternal deaths (numerator). Accessed at http://wonder.cdc.gov/ucd-icd10.html on Apr 17, 2013 8:00:39 PM. Produced by California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, April, 2013.

HP 2020 Objective – 11.4 Deaths per 100,000 Live Births
## Maternal Mortality and Severe Morbidity

Approximate distributions, compiled from multiple studies

<table>
<thead>
<tr>
<th>Cause</th>
<th>Mortality (1-2 per 10,000)</th>
<th>ICU Admit (1-2 per 1,000)</th>
<th>Severe Morbid (1-2 per 100)</th>
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</thead>
<tbody>
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<td>15%</td>
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National Maternal Health Initiative: Strategies to Improve Maternal Health And Safety

May 5<sup>th</sup> 2013
New Orleans, LA
“What every birthing facility in the US should have…”
Maternity Safety Bundles: “What every birthing facility should have…”

- Obstetric Hemorrhage Safety Bundle
- Severe Hypertension Safety Bundle
- VTE Prevention Safety Bundle
- Maternal Early Warning Criteria (triggers)
- Severe Maternal Morbidity Facility Review
- Patient, Family and Staff Support Bundle
Maternal Safety

Obstetricians (ACOG/SMFM/ACOOG)

Family Practice (AAFP)

OB Anesthesia (SOAP)

Blood Banks (AABC)

Hospitals (AHA, VHA)

Direct Providers

Nurses (AWHONN)

Midwives (ACNM)

Nurse Practitioners (NPWH)

Birthing Centers (AABC)

Safety, Credentials (TJC)

Federal (MCH-B, CDC, CMS/CMMI)

State (AMCHP, ASTHO, MCH)

Perinatal Quality Collaboratives (many)

Adopted July 2013
Maternity Safety Bundles: 4 Principles

1) Every hospital should have “A” safety bundle for these areas, we are not developing “THE” standard US bundle

2) “Plans are nothing; Planning is everything”. --Dwight D Eisenhower

3) Multi-disciplinary team work is key for the development, maintenance and daily use of the bundles

4) KISS is critical for success
Obstetric Hemorrhage Safety Bundle

- Readiness (every unit)
- Recognition & prevention (every patient)
- Response (every hemorrhage)
- Reporting / systems learning (every unit)
Obstetric Hemorrhage Key Elements

READINESS (every unit)

1. **Hemorrhage Cart** with procedural instructions
   - Balloons, compression stitches

2. Rapid access to **hemorrhage medications**
   - Medication kit or equivalent

3. Establish a **response team**: Blood Bank, Anesthesia, Advanced Gynecologic surgery, other support and tertiary services
   - Who to call when help is needed

4. Establish Massive and Emergency release **transfusion protocols**
   - O-negative/uncrossmatched

5. Unit **education** to protocols, regular unit-based **drills**
   - With post-drill debriefs
   - Include all relevant stakeholders
Obstetric Hemorrhage Key Elements

RECOGNITION & PREVENTION (every patient)

6. Assessment of hemorrhage risk
   - Prenatal
   - On admission
   - Other appropriate times

7. Measurement of Cumulative blood loss
   - Formal
   - As quantitative as possible

8. Universal active management of 3rd stage of labor
RESPONSE (every hemorrhage)

9. Unit-standard, stage-based OB Hemorrhage Emergency Management Plan with checklist

10. Support for patients, families and staff

For all significant hemorrhages
11. Establish a culture of:
   - Huddles: To anticipate and plan for high risk patients
   - Debriefs: Quick post-event reviews to identify successes and improvement opportunities

12. Multi-disciplinary review of serious hemorrhages
   - Stage 2 or 3 depending on frequency
   - To identify systems issues for improvement

13. Monitor outcomes & process metrics in perinatal QI committee
Committee on Patient Safety and Quality Improvement

ABSTRACT: The focus on patient safety and quality improvement has led to the development of standardized procedures and communication tools. A shared vision of patient safety is critical for minimizing errors and improving outcomes.

Committee on Patient Safety and Quality Improvement

ABSTRACT: Preparing for clinical emergencies in obstetrics and gynecology is crucial. It is essential for obstetrician-gynecologists to be prepared for potential emergencies through active engagement in emergency drills, training, and post-events debriefing.

Preparing for Clinical Emergencies in Obstetrics and Gynecology

ABSTRACT: Patient care emergencies may occur at any time in any setting, particularly in the inpatient setting. It is important that obstetrician-gynecologists prepare themselves by assessing potential emergencies, establishing early warning systems, designating specialized first responders, conducting emergency drills, and debriefing staff after actual events to identify strengths and opportunities for improvement. Having such systems in place may reduce or prevent the severity of medical emergencies.
Key OB Hemorrhage QI Toolkits: Full of Resources

www.CMQCC.org

www.pphproject.org

A COG District II Website
(ACOG website)

More resources are coming on-line especially from state Perinatal Collaboratives. Later in the year, the NPMS Bundle will be published with an index to resources.
Key Partner: Hospital Engagement Networks (HEN’s)

- 27 HENs with over 3,700 participating hospitals focused on making hospital care safer, more reliable, and less costly.
- 10 core patient safety areas, one is reduction of obstetrical adverse events with an initial primary focus: Early Elective Deliveries.
- New for 2014, reduction of “OB harm” from – Obstetric Hemorrhage
  – Preeclampsia

• Intended not be punitive but educational
• Identify cases to review carefully for systems improvement opportunities
• For Obstetrics, they define severe maternal morbidity:
  – All cases with ≥4 units of blood products
  – All cases admitted to an ICU
• These cases would have a mini-RCA. ACOG has developed a package to aid reviews
A model for Rapid-cycle Improvement

- Maternity care has unusually large variation in care, even after risk adjustment
- Examine the drivers for successful projects:
  - multi-organization collaboration
  - alignment of goals
- Central role for data-driven QI / State-wide data system
  - Not just reporting hospital rates and provider rates
  - Multiple tools to allow intelligent analysis to allow providers to answer why their rate is high
Success: Pressure From Many Angles

- OB QI Project
- Leaders
- Quality measures
- Public advocates
- Data-driven QI
- Evidence
- Public Reporting
- Payment Reform

May not need ALL angles for ALL projects

Transforming Maternity Care

CMQCC: California Maternal Quality Care Collaborative
Thank You!

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