SQAC Quality Priority Proposal

Proposed Priority Area: Maternity

Description of the priority area: Maternity care includes pre-natal management visits with Obstetrics and Gynecology specialists, midwives and doulas before the delivery of a child, the delivery of a child either in a hospital setting or in another setting and then follow up with the mother within 6 weeks after delivery.

Reasons it is being highlighted: Maternity care is a high cost service area that impacts a large group of citizens and directly impacts the next generation. Massachusetts' statewide C-section rate of 32%[1] is significantly higher than the World Health Organization's recommended rate of between 10-15%.[2] Expectant parents have many choices from whom and where to receive their care and are particularly focused on receiving the highest quality care. Public reporting of quality data has the potential to provide consumers with relevant and actionable information as they consider their obstetric care options.

While there is a clear, defined course of maternity services, gaps in care continue to persist. Recent reductions in early elective deliveries either by C-section or induction without medical indication in Massachusetts demonstrate that effective stakeholder engagement can lead to improved quality. Massachusetts Health Quality Partners (MHQP) Practice Pattern Variation Analysis (PPVA) found significant variation among providers in the number of prenatal ultrasounds performed for uncomplicated pregnancies.

Ways that quality may be improved: There are several areas for improvement in the area of maternity care including:

- Reduction of C-section rates
- Increased rate of women having a vaginal birth after cesarean (VBAC)
- Reduced provider variation, through increased use of best practices.

Ways that quality could be measured: CHIA previously conducted research on this quality priority and has published the results on their findings.[3] CHIA asked Massachusetts stakeholders to review a list of 63 measures and identify those used by their organization. The 14 most commonly used and referenced measures are included in the following table.

[1] Massachusetts Department of Public Health, 2012 C-Section Rates. See http://www.cesareanrates.com/2015/02/Massachusettscesareanrates.html
[2] World Health Organization Statement on C-Section Rates; Executive Summary. See http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/
[3] http://www.chiamass.gov/assets/docs/r/SQAC-Final-OB-Brief-6-26-15.pdf

	Included in SQMS	Massachusetts affiliate of ACOG endorsed
Obstetrics Measures		
PC-01 Elective Delivery (elective vaginal deliveries or elective cesarean sections at >=37 and <39weeks of gestation completed)		X
PC-02 Cesarean Section: percentage of nulliparous (first-time pregnancy) women with a term, singleton baby in a vertex position delivered by cesarean section	X	X
Appropriate Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision – Cesarean section		
Maternity care: vaginal birth after Cesarean (VBAC) delivery rate, uncomplicated		
Obstetric Trauma Rate - Vaginal Delivery with Instrument: 3rd and 4th degree obstetric lacerations: rate per 1,000 instrument-assisted vaginal deliveries (PSI 18)	X	
Obstetric Trauma Rate - Vaginal Delivery with Instrument: 3rd and 4th degree obstetric lacerations: rate per 1,000 vaginal deliveries without instrument assistance (PSI 19)	X	
Under 1500g infant Not Delivered at Appropriate Level of Care : The number per 1,000 live births weighing less than 1500g delivered at hospitals not appropriate for that size infant		
PC-03 Antenatal Steroids: Patients at risk of preterm delivery at >=24 and <34 weeks gestation receiving antenatal steroids prior to delivering preterm newborns	X	
Appropriate DVT prophylaxis in women undergoing cesarean delivery	X	X
Maternity care: Cesarean delivery rate		
Neonatal Measures		
PC-05 Exclusive Breast Milk Feeding: number of newborns exclusively fed breast milk during the newborn´s entire hospitalization and the subset measure PC-05a Exclusive Breast Milk Feeding Considering Mother´s Choice: includes only those newborns whose mothers chose to exclusively feed breast milk		X
PC-04 Health Care-Associated Bloodstream Infections in Newborns		

In addition to these measures, the SQMS includes the following maternity measures:

- Incidence of Episiotomy
- Timeliness of prenatal care: percentage of deliveries that received a prenatal care visit as a member of the health plan in the first trimester or within 42 days of enrollment in the organization.
- Frequency of Ongoing Prenatal Care (FPC)
- Birth Trauma – Injury to Neonate (PSI 17)

- Low Birth Weight Rate (PQI 9)
- Maternal Depression Screening (NQF 1401)
- Newborn Bilirubin Screening & DVT Prophylaxis in Women Undergoing Cesarean Section

Cross Cutting Dimensions

The SQAC believes it is important to consider maternity across a number of dimensions including disparities, transparency, care coordination and patient experience/activation.

Ways that disparities in maternity care could be measured and improved: Measures can be stratified by race/ethnicity, income, geography, type of coverage (commercial insurance vs MassHealth) and by hospital.

Improving transparency: Birth rates can be reported by hospital.[4] These rates can separately look at rates for C-sections, vaginal birth after C-section, early effective delivery, patient experience, post-delivery maternal morbidity, birth trauma and newborn outcomes. Measures and rates for provider and provider groups could be developed so that patients can better select providers.

Link to care coordination: Transitions in care are a concern for this quality priority area. Mothers transition from obstetric care to primary care and newborns transition from delivery to pediatric care. Further transitions occur when a child is admitted from delivery into a neonatal intensive care setting (NICU) and then discharged to an outpatient pediatrician. Additionally there are a number of specialists and provider types that can be involved in maternity care including nurse practitioners, genetic counselors, perinatologists, lactation consultants, midwifes, doulas and others that influence maternal and newborn quality of care that are not typically captured in hospital based measures. Care coordination across all of these different settings may help improve care and patient experience.

Patient experience/patient activation: Patient experience of maternity care is an area where there is interest in increased quality reporting. Patient experience with care in the ambulatory setting, which is where prenatal care and patient education occur, is not currently measured today. HCAHPs measures of patient experience do exist, but mostly focus on the patient's experience and comfort in the hospital and not their experience of receiving care in all settings.

Potential implementation steps and how to leverage existing efforts: CHIA has already conducted research into measures in this area and based on this research has found that collecting and reporting on hospital specific measures is feasible and currently underway by CHIA. It also noted that reporting at the individual provider level is currently not feasible.

[4] CHIIA Currently reports this data looks at the percent of total deliveries that were C-section and percent that were vaginal using the casemix database.

Reporting at the obstetrical group level, however, could provide additional information on practice variation.

State Actors Who Are Working in this Area: CHIA, MassHealth, DPH through the Massachusetts Perinatal Quality Collaborative[5].

[5] http://www.mapqc.org/