CMQCC
California Maternal
Quality Care Collaborative

Statewide Initiative to Support Vaginal Birth & Reduce Primary Cesareans

Webinar Speakers: Elliott Main, MD
Anne Castles, MA MPH

October 2016

Statewide Initiative to Support Vaginal Birth & Reduce Primary Cesareans:

Today's Objectives

- Why Focus on Cesareans?
- Understanding Cesarean Measures
- CMQCC Maternal Data Center
- CMQCC Toolkit
- Statewide Collaborative

CMQCC's Key Stakeholders/ Partners

State Agencies

- CA Department of Public Health, MCAH
- Regional Perinatal Programs of California (RPPC)
- DHCS: Medi-Cal
- Office of Vital Records
- Office of Statewide Health Planning and Development (OSHPD)
- Covered California

Membership Associations

- Hospital Quality Institute (HQI)/ California Hospital Association (CHA)
- Pacific Business Group on Health (PBGH)
- Integrated Healthcare Association (IHA)

Key Medical and Nursing Leaders

- UC, Kaisers, Sutter, Sharp, Dignity Health, Scripps, Providence, Public hospitals

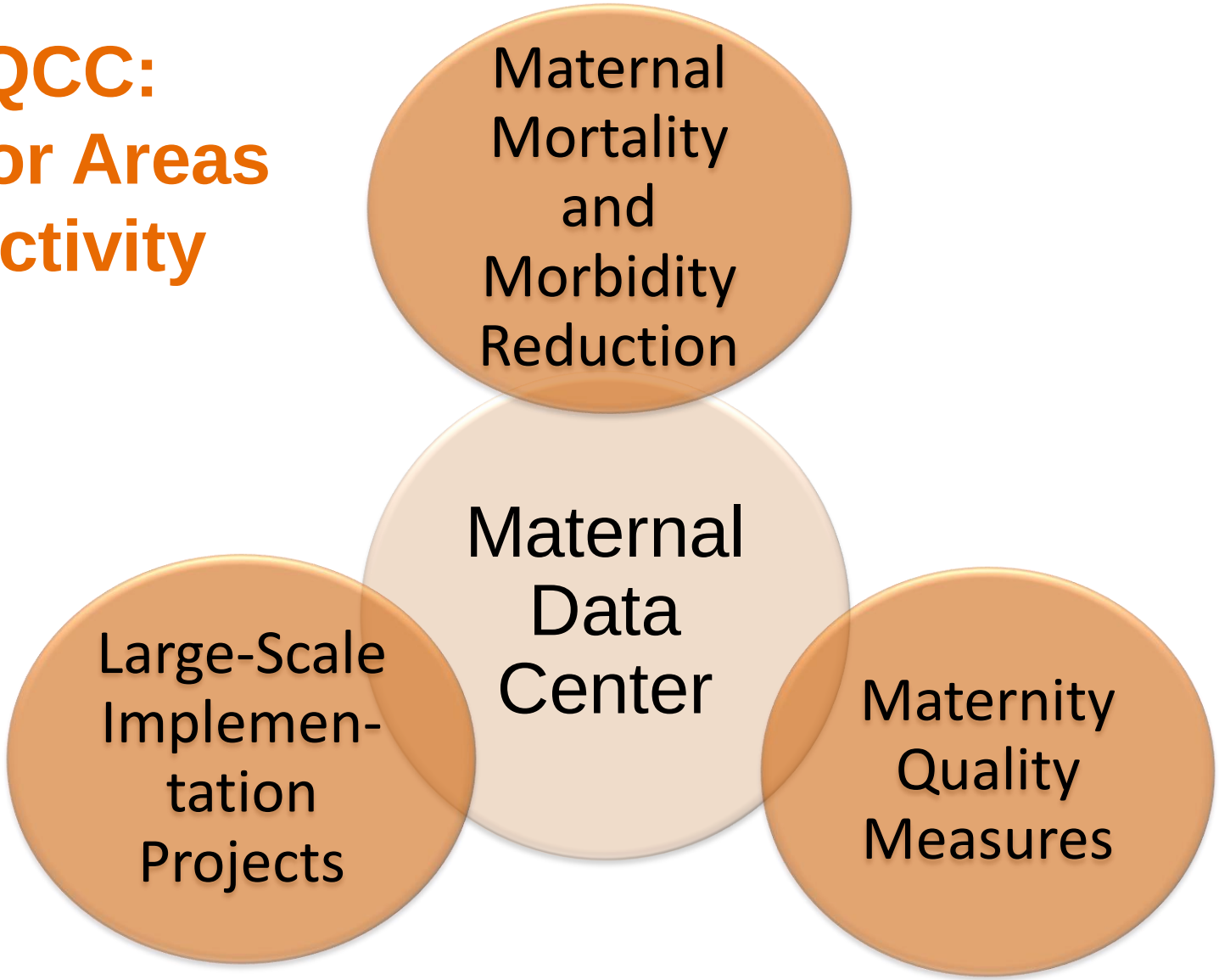
Professional Groups (California sections of national organizations)

- American College of Obstetrics and Gynecology (ACOG)
- Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)
- American College of Nurse Midwives (ACNM)
- American Academy of Family Physicians (AAFP)

Public and Consumer Groups

- California HealthCare Foundation (CHCF)
- March of Dimes (MOD)
- California Hospital Accountability and Reporting Taskforce (CHART) / CalHospitalCompare

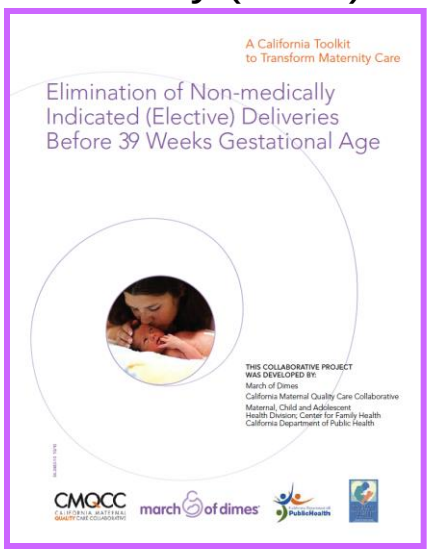
CMQCC: Major Areas of Activity



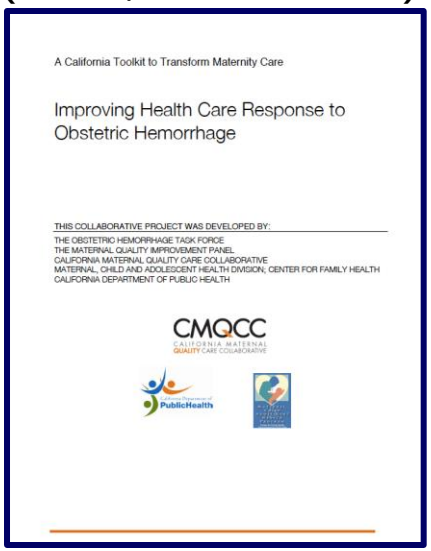
CMQCC: Leader for Maternity QI Projects

- Statewide multi-disciplinary Taskforces that develop QI toolkits and implementation guides
- Large-scale quality collaboratives in California
- Widespread adoption by other states and national

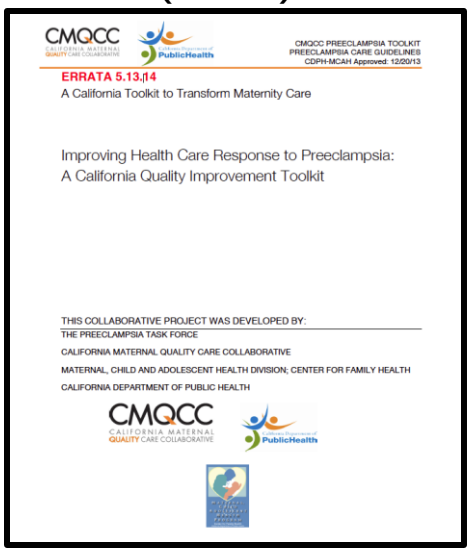
Elimination of Early Elective Delivery (2010)



Response to OB Hemorrhage (2010; 2nd Ed 2015)

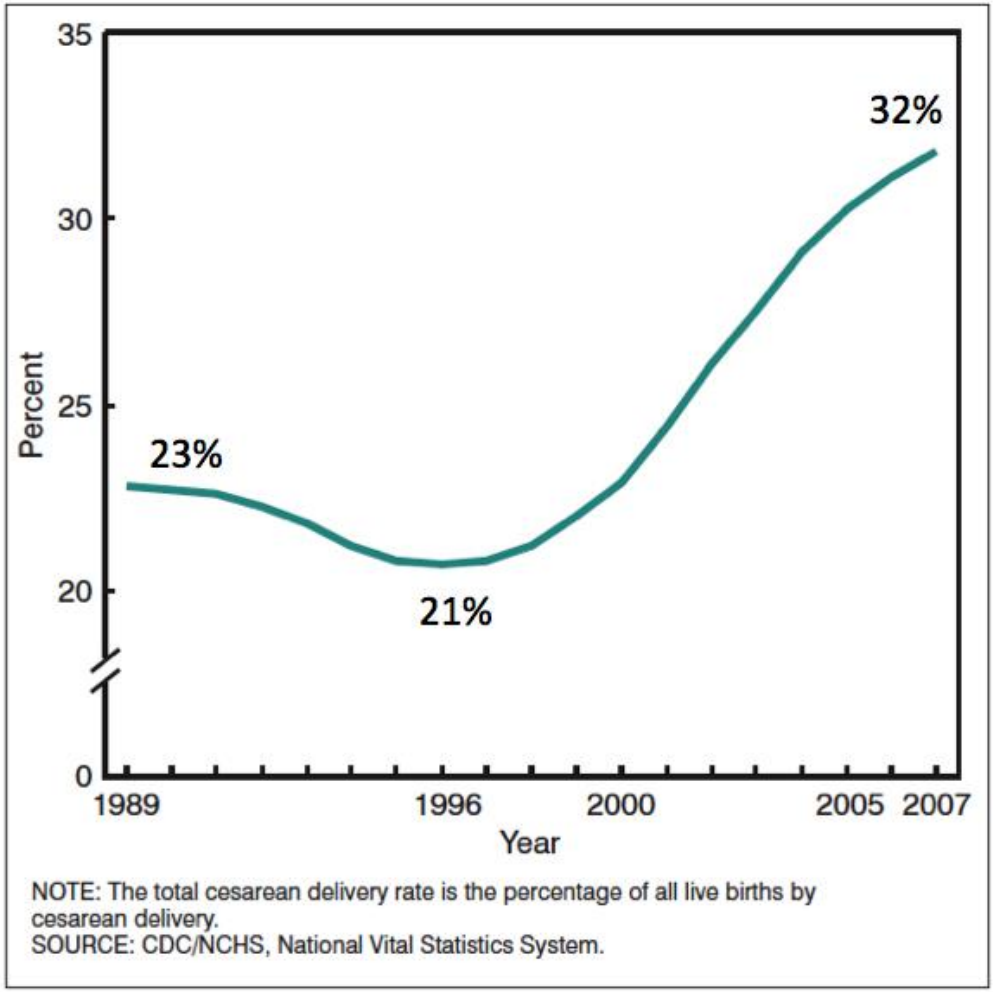


Response to Preeclampsia (2013)



CMQCC
California Maternal
Quality Care Collaborative

Cesarean Births Have Risen by Over 50% in the Last 15 years



US 2013= 32.7%
CA 2013= 33.1%

Even more dramatic is the degree of variation among hospitals and among providers

By Katy Backes Kozhimannil, Michael R. Law, and Beth A. Virnig

Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality And Cost Issues

DOI: 10.1377/hlthaff.2012.1030
HEALTH AFFAIRS 32,
NO. 3 (2013): 527–535

ABSTRACT **Cesarean delivery is the most commonly performed surgical procedure in the United States, and cesarean rates are increasing. Working with 2009 data from 593 US hospitals nationwide, we found that cesarean rates varied tenfold across hospitals, from 7.1 percent to 69.9 percent. Even for women with lower-risk pregnancies, in which more limited variation might be expected, cesarean rates varied fifteenfold, from 2.4 percent to 36.5 percent. Thus, vast differences in practice patterns are likely to be driving the costly overuse of cesarean delivery in many US hospitals. Because Medicaid pays for nearly half of US births, government efforts to decrease variation are warranted. We focus on four promising directions for reducing these variations, including better coordinating maternity care, collecting and measuring more data, tying Medicaid payment to quality improvement, and enhancing patient-centered decision making through public reporting.**

Katy Backes Kozhimannil (kbk@umn.edu) is an assistant professor in the Division of Health Policy and Management, School of Public Health, University of Minnesota, in Minneapolis.

Michael R. Law is an assistant professor in the Centre for Health Services and Policy Research, School of Population and Public Health, at the University of British Columbia, in Vancouver.

Beth A. Virnig is associate dean of research and a professor at the School of Public Health, University of Minnesota.

CMQCC
California Maternal
Quality Care Collaborative

Why should we care about CS rates?

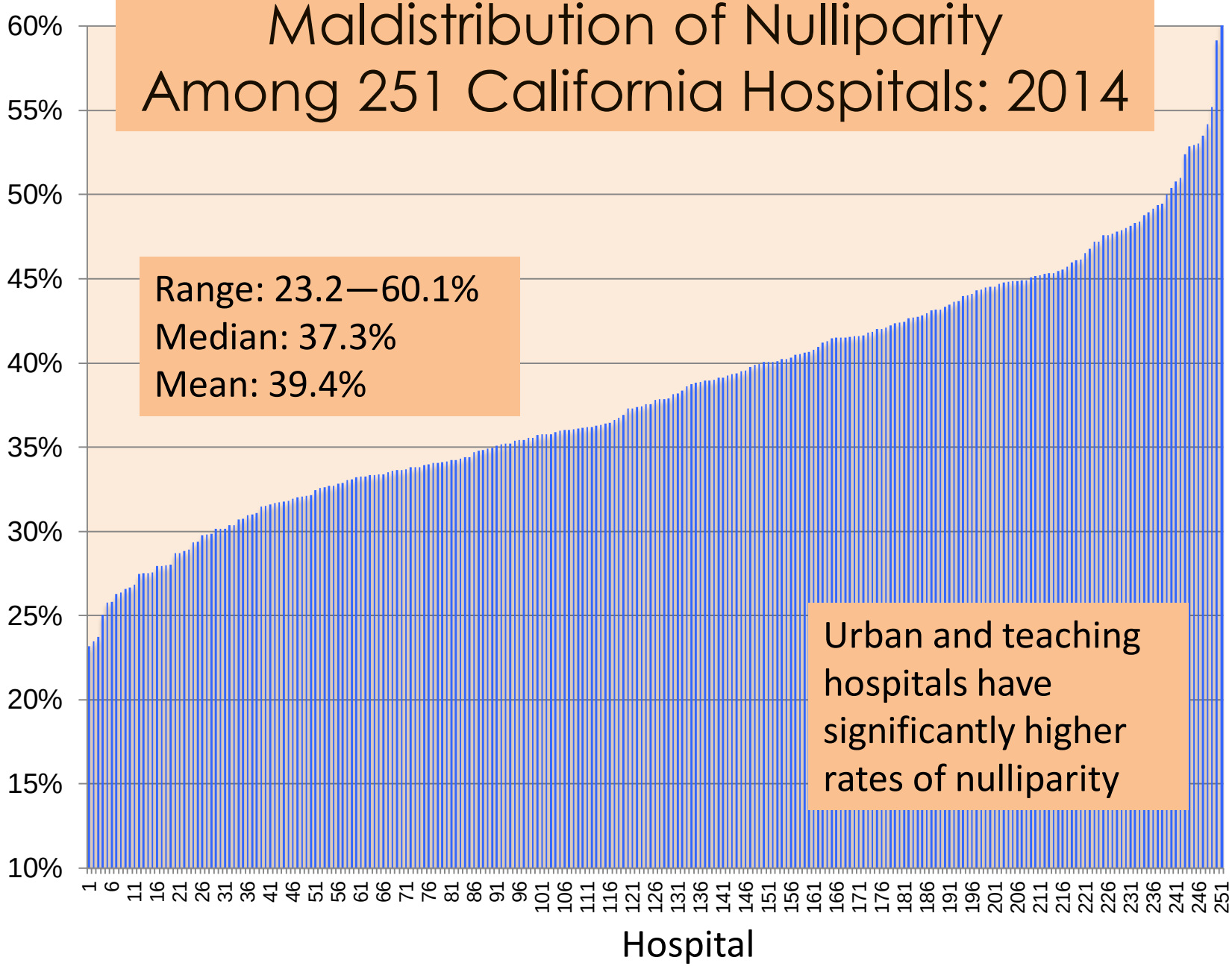
- Relentless Rise without Baby or Mother benefit
  - 6% in early 70's, 20% in mid 80's, 33% in 2010
  - CP rates, neonatal seizures unchanged since 1980
  - Overall, no benefit for long-term urinary continence
- Increased maternal and neonatal morbidity
  - Impaired neonatal respiratory function, NICU admits
  - Affects maternal-infant interaction/Breast Feeding
  - Increased maternal PP infections, VTE, transfusions
  - Longer recovery, 2X PP re-admissions
- Prior CS can have major complications
  - Placenta previa and accreta (invasion deep into or thru the uterine wall)➔ hysterectomy or worse
  - Uterine rupture; abdominal adhesions

Which CS Rate?

- *Total Cesarean Rate*
  - Includes repeats: very different issues and significant variation of hospital rates of women with prior CS
- *Primary CS Rate and AHRQ TSV CS rate*
  - Better but major variation of hospital rates of nulliparity—the most important driver of different CS rates
  - Term Singleton Vertex is bettter but still mixes nullips with multips (Note: nullips have 4-8X higher rates than multips)
- *NTSV Cesarean Rate*
  - Nulliparous, Term, Singleton, Vertex
  - Most commonly used

9

Maldistribution of Nulliparity Among 251 California Hospitals: 2014



Range: 23.2—60.1%
Median: 37.3%
Mean: 39.4%

Urban and teaching hospitals have significantly higher rates of nulliparity

10

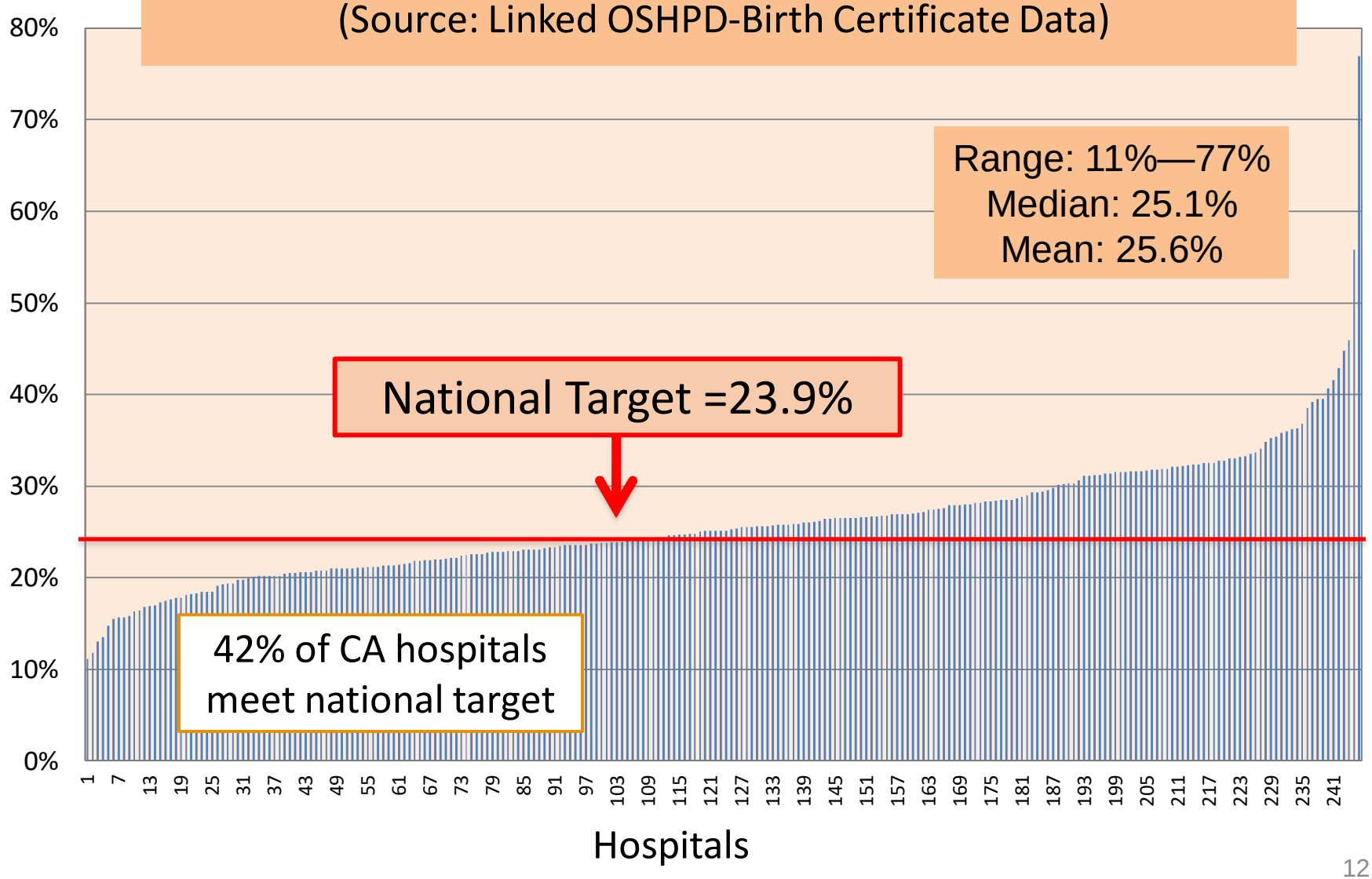
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Section Rate: Performance Measure

- Risk Stratified ("standard population")
  - No further risk-adjustment needed (more discussion later)
- Widely adopted nationally
  - ACOG: Task Force on Cesarean Section rates (2000)
  - DHHS: Healthy Person 2010 and 2020
  - NQF endorsed, Joint Commission Perinatal Core Measure (PC-02), LeapFrog, CMS e-measure
- >15 years experience
- National data and trends available

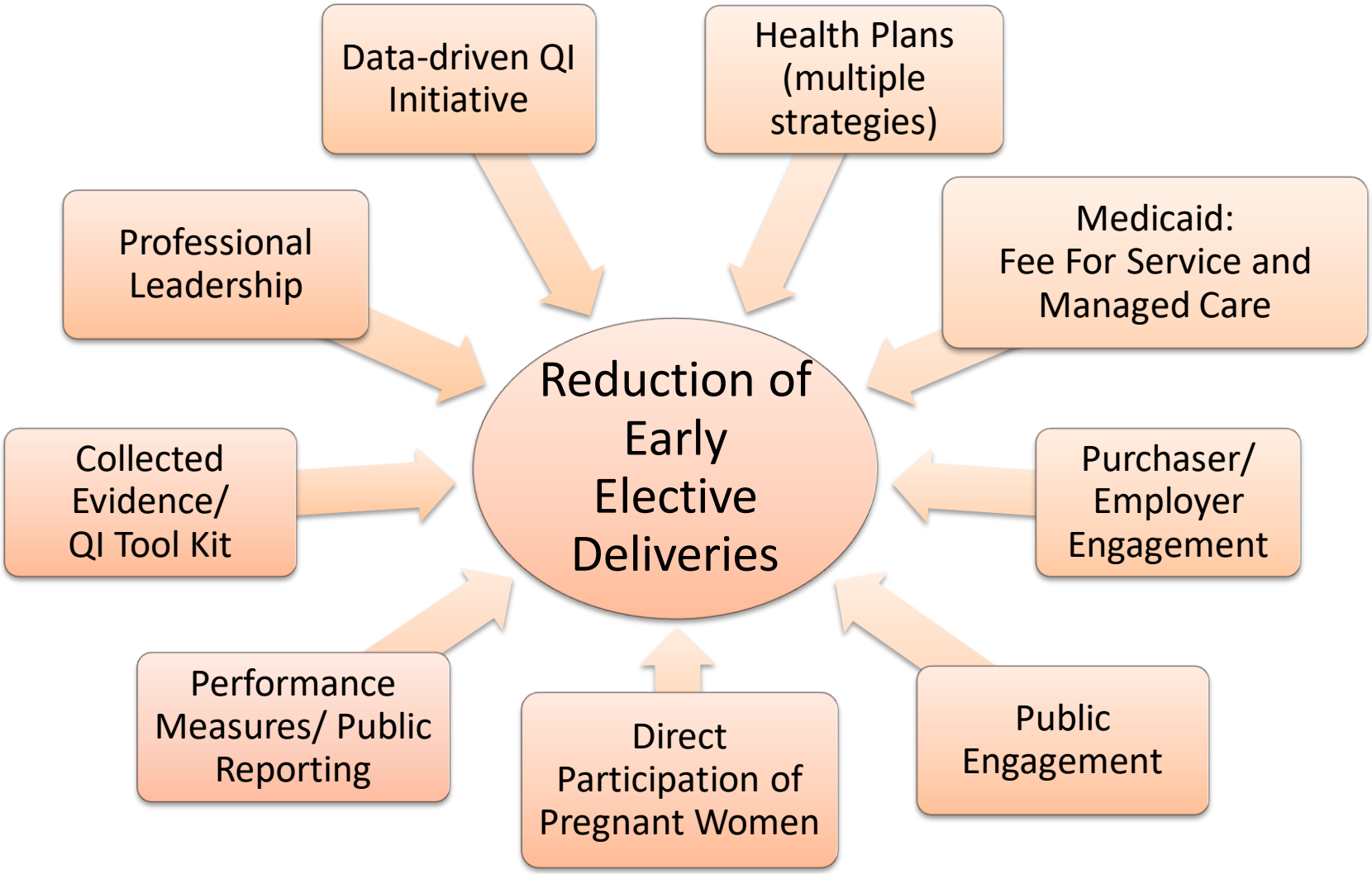
NTSV CS Rate Among CA Hospitals: 2015

(Nulliparous Term Singleton Vertex)

(Source: Linked OSHPD-Birth Certificate Data)

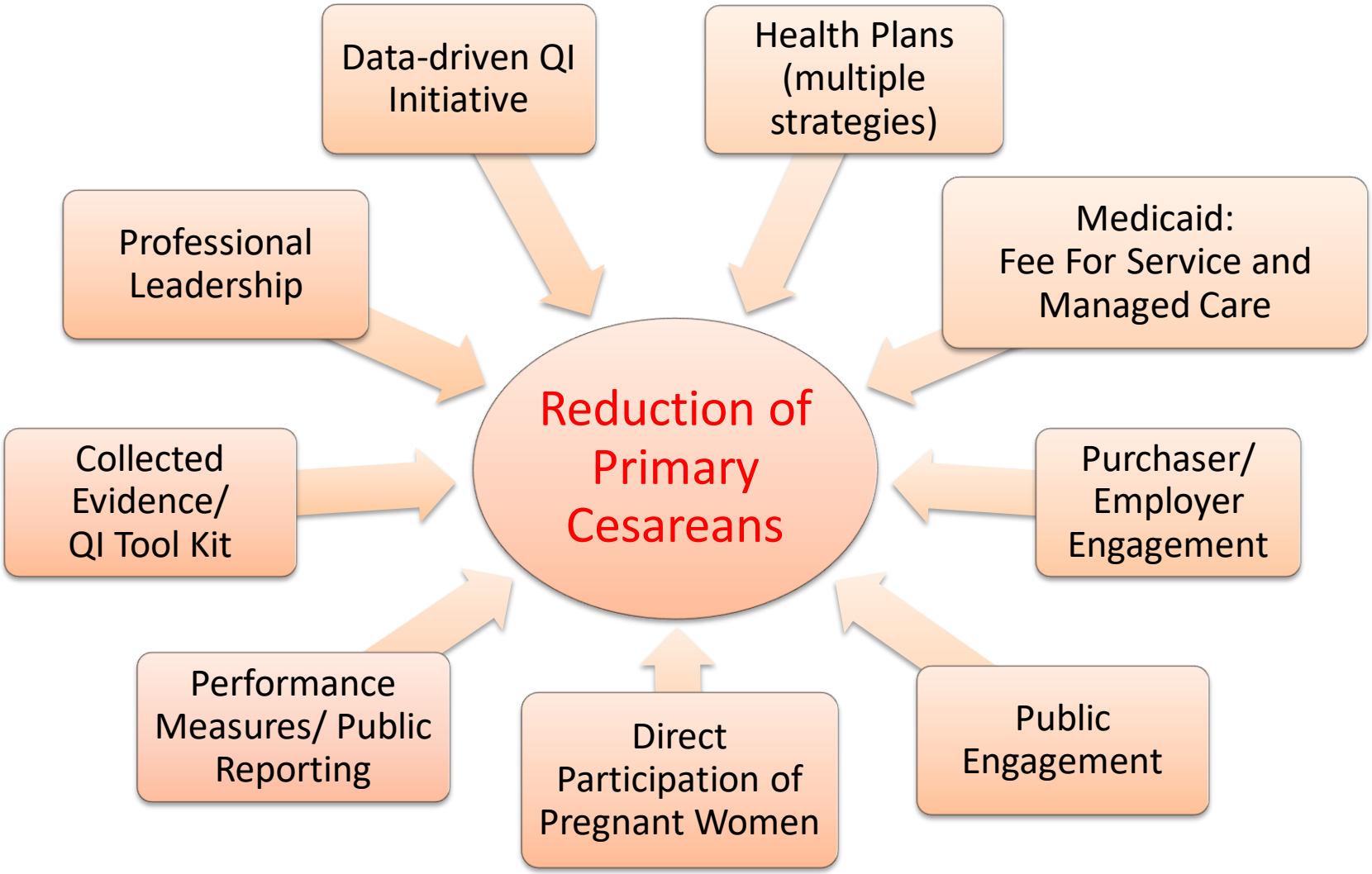


Collaborative Action : Collective Impact



Multiple Leverage Points are much more effective than one or two alone

Collaborative Action : Collective Impact



Multiple Leverage Points are much more effective than one or two alone

Collaborative Actions: Collective Impact

- ACOG/AWHONN/ACNM Speaker's Bureau
  - Support for grand rounds and "light" QI support
  - All day training on 5/4/2016
- Slide set for Speaker's Bureau, Collaborative
- Regional *Labor Support Workshops* for labor nurses
  - Lead by CNMs, Doulas and Nurse educators
- Webinars
  - Monthly talks by national leaders on key topics on supporting vaginal birth/preventing primary cesareans
  - Archived for later viewing

Collaborative Actions: Collective Impact

- Public Reporting of NTSV CS rates
  - CHART / CalHospitalCompare.org
  - Dept of Insurance/UCSF/Consumers Union
  - Media coverage (LA, SD and Sacramento)
  - Oct 26th: HHS Secretary Dooley Press Conference with CHA and PBGH: “Smart Care” (Overuse Group)
- Public Engagement
  - Consumers Union
  - Social Media strategies
  - Consumer Reports: Education handouts at prenatal care sites—e.g. clinics/WIC

CMQCC
California Maternal
Quality Care Collaborative

CalHospitalCompare.Org

Consumer website updated as of 10/26/16!

Hospital Quality Institute notified all hospital CEOs of new release

Mother & Baby	Hospital A	Hospital B	Hospital C
C-Section Rate (NTSV)	POOR 46.50% (lower is better)	BELOW AVERAGE 32.30% (lower is better)	SUPERIOR 15.30% (lower is better)
Breastfeeding Rate	POOR 32%	POOR 11.40%	SUPERIOR 84.70%
Episiotomy Rate	AVERAGE 25.40% (lower is better)	POOR 59.30% (lower is better)	SUPERIOR 1.60% (lower is better)

Collaborative Actions: Collective Impact

- Does Anyone Care?
- Purchasers/Health Plans
  - Covered California: in their 2017 contracts with Health Plans—For hospitals be included their Network, they need to have an NTSV rate ≤23.9% by 2019
  - Allowed Exception: if actively working on the topic and showing improvement
  - This has engaged many managed care groups in the State who are now reaching out to hospitals
  - Other large Health Plans are working on their strategies for alignment on this topic

My hospital's rate is higher than the 23.9% target!

What to do?

Hospital Action Steps: How Can We Help?

- **Understand what drives your cesarean birth rate—using rapid-cycle data with standard measures and QI tools**
  1. **CMQCC Maternal Data Center**

- **Improve support for labor and vaginal birth—**
  2. **CMQCC Toolkit** on *Supporting Vaginal Births and Reducing Cesareans*
  3. **CMQCC QI Collaborative** on *Supporting Vaginal Births and Reducing Cesareans*

CMQCC
California Maternal
Quality Care Collaborative

Action Step #1

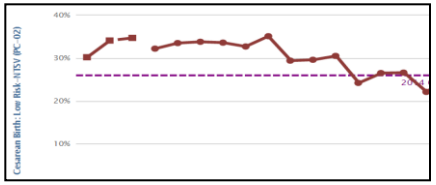
Join the CMQCC Maternal Data Center!

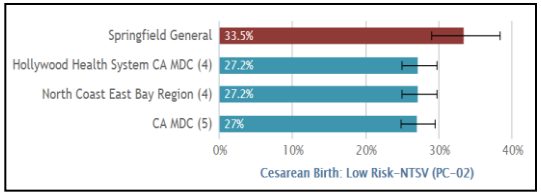
Anne Castles, MA MPH

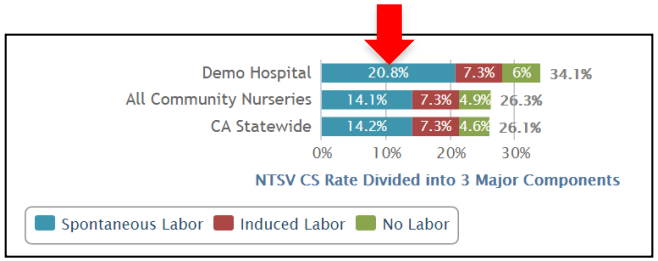
Amanda Woods, MA

Using the Maternal Data Center to Drive Improvement

- ✓ Monitor hospital performance over time
- ✓ Make peer and benchmark comparisons
- ✓ Assess provider variation
- ✓ Identify QI opportunities
- ✓ Risk-Adjustment







CMQCC
California Maternal
Quality Care Collaborative

Over 200 Hospitals have joined the MDC

Launched 2014
34 Hospitals

Launched 2015
16 Hospitals

Launched 2012
180+ Hospitals
82% of CA Deliveries

CMQCC
California Maternal
Quality Care Collaborative

CMQCC Maternal Data Center

Low-Burden, High-value

PDD—Discharge Diagnosis File
(ICD9/10 Codes)

Monthly uploads: mother and infant PDD (participating hospitals)

Real-Time!

Automated Linkage of all 3 files

Birth Certificate
(Clinical Data)

Monthly uploads: electronic files for all CA births

Chart Review
(optional selected metrics/QI projects)

Limited manual data entry for these measures

CMQCC

Maternal Data Center

Interactive Analytics Guide QI Practice

Links over 1,000,000 mother/baby records each year!

CMQCC
California Maternal
Quality Care Collaborative

Confidential Tool for Each Hospital

Demo Hospital

Data Entry Status

Measures

Period: Q1 2016

See your Leapfrog Results in Leapfrog Survey Format

Hospital Clinical Performance Measures

Early Elective Delivery (PC-01) (HEN)	10.7%
Cesarean Birth: Low Risk-NTSV (PC-02)	20.3%
Vaginal Birth After Cesarean (VBAC) Rate, Uncomplicated (AHRQ IQI 22)	6.5%
Cesarean Birth: Overall	33.5%
Cesarean Birth: Primary	19.7%
Failed Induction	16.3% *

View all 33 by **name**, **organization**, or **topic**

Hospital Data Quality Measures

Missing / Inconsistent Delivery Method	1.3%
Missing / Inconsistent V27/Z37 (Outcome of Delivery)	0.4%
Data Submission Trends	
Correction Reports	

View **all 16** Hospital Data Quality Measures

Provider Performance Measures

by Individual	by Practice Group
Cesarean Births	Cesarean Births
Elective Deliveries	Elective Deliveries
Vaginal Births	Vaginal Births
Attribution Recommendations	Group Management (35)

CS Collaborative Measures

Cesarean Birth: Low Risk-NTSV (PC-02)	20.3%
Structure Measures / To-Do List	44.4% *
NTSV Spontaneous Labor Arrest / CPD: Consistency with Guidelines	80.0% *
NTSV Induced Labor Management: Consistency with Guidelines	66.7% *

View **all 12** CS Collaborative Measures

Hospital Statistics

Mar 2016 Live Births	171 ▼
YTD Live Births	543 ▲
Demographic Statistics	
Delivery Statistics	
Comorbidity and Complications Statistics	
Baby/Prematurity Statistics	
Utilization Statistics	
CCS Report	

View Delivery Logbook

First you must authenticate using 2-factor authentication

CMQCC
California Maternal
Care Collaborative

Hospital Clinical Performance Measures: By Name

By Name | By Organization | By Topic

Show: ☐ Last 12 Months ☑ Last 3 Months ☑ Last Month

Measure	Q1 2014 Rate	Mar 2014 Rate	Jul 2012 - Jun 2013 Statewide
3rd & 4th Degree Lacerations in Instrument-Assisted Vaginal Deliveries	2.4%	0.0%	13.4%
3rd & 4th Degree Lacerations in NON-Instrument-Assisted Vaginal Deliveries	0.3%	1.0%	2.4%
3rd & 4th Degree Lacerations in Vaginal Deliveries	0.6%	0.9%	3.4%
5 Minute APGAR <7 Among All Deliveries >39 weeks (HEN)	0.5%	0.0%	0.4%
5 Minute APGAR <7 in Early Term Newborns (HEN)	0.0%	0.0%	0.4%
Antenatal Steroids (PC-03)	80.0%	0.0%	N/A
Appropriate DVT Prophylaxis in Women Undergoing CS	N/A	N/A	N/A
Birth Trauma - Injury to Neonate (AHRQ PSI 17)	0.0%	0.0%	0.1%
Cesarean Section Rate-Nullip, Term, Singleton, Vertex (PC-02)	34.5%*	30.6%*	28.5%
Cesarean Section Rate-Nullip, Term, Singleton, Vertex: Age Adjusted (PC-02)	26.7%*	26.9%*	25.9%
Cesarean Section Rate-Term, Singleton, Vertex (AHRQ IQI 21)	33.3%	32.5%	29.7%
Elective Delivery <39 Weeks (PC-01)	4.4%	5.6%	N/A
Episiotomy Rate	9.3%*	3.5%*	9.4%
Exclusive Breastfeeding (PC-05)	N/A	N/A	N/A
Exclusive Breastfeeding with Mother's Choice (PC-05a)	N/A	N/A	N/A
Failed Induction	13.7%	7.9%	23.0%
Induction Rate	17.7%	21.0%	14.3%
Newborn Bilirubin Screening Prior to Discharge	N/A	N/A	N/A
OB Hemorrhage Risk Assessment on Admission	N/A	N/A	N/A
Operative Vaginal Delivery	7.6%	5.5%	6.4%
Preeclampsia ICU Admissions	N/A	N/A	N/A
Preeclampsia Total ICU Days	N/A	N/A	N/A

32 Hospital Clinical Quality Measures

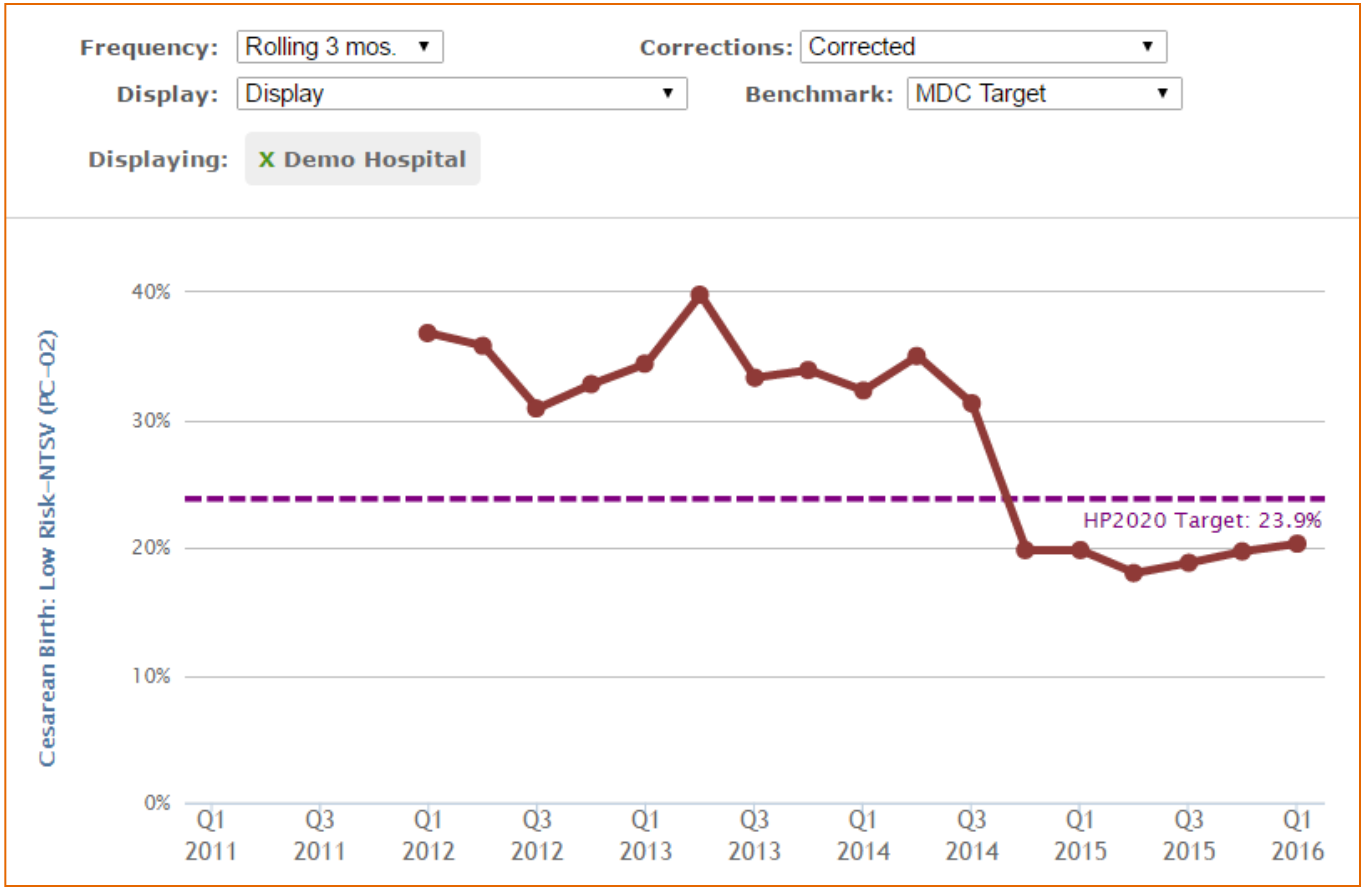
Focus on: *NTSV C-Section*

CMQCC
California Maternal
Quality Care Collaborative

Hospital Performance Over Time

For each hospital quality measure:

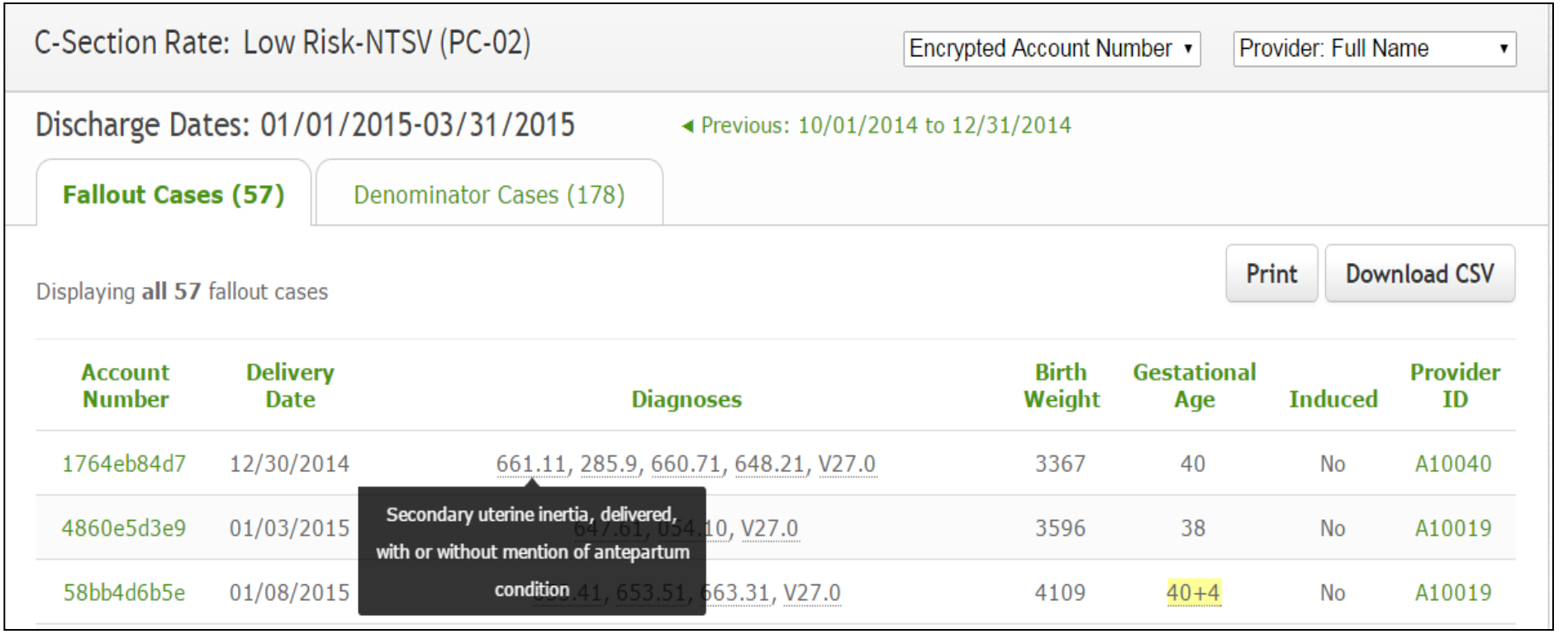
- View reports on monthly/quarterly/annual basis
- Easy downloads of the graphics or numerical data



CMQCC
California Maternal
Quality Care Collaborative

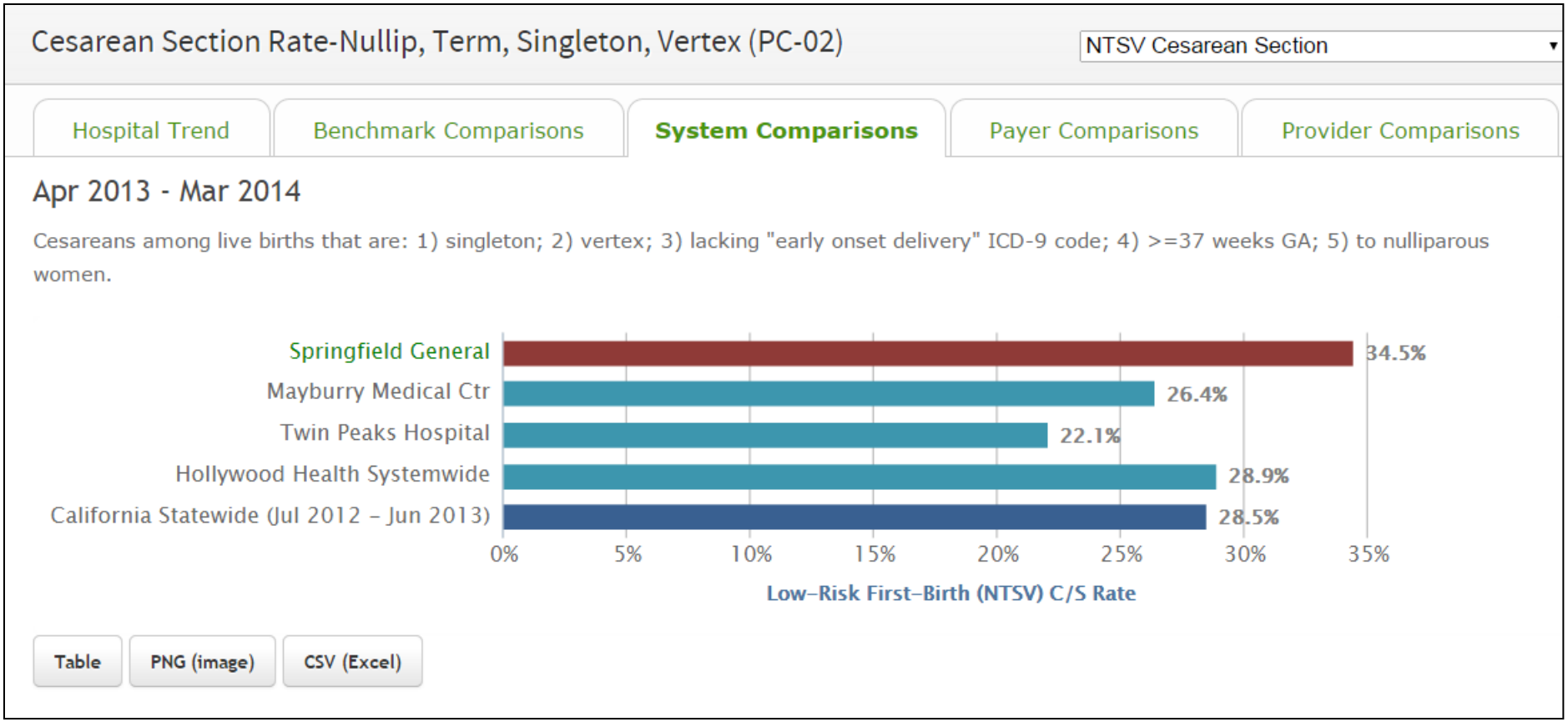
Drill Down Information

- Drill down to case-level information within own hospital account
- Hover boxes show definitions for ICD-10 codes



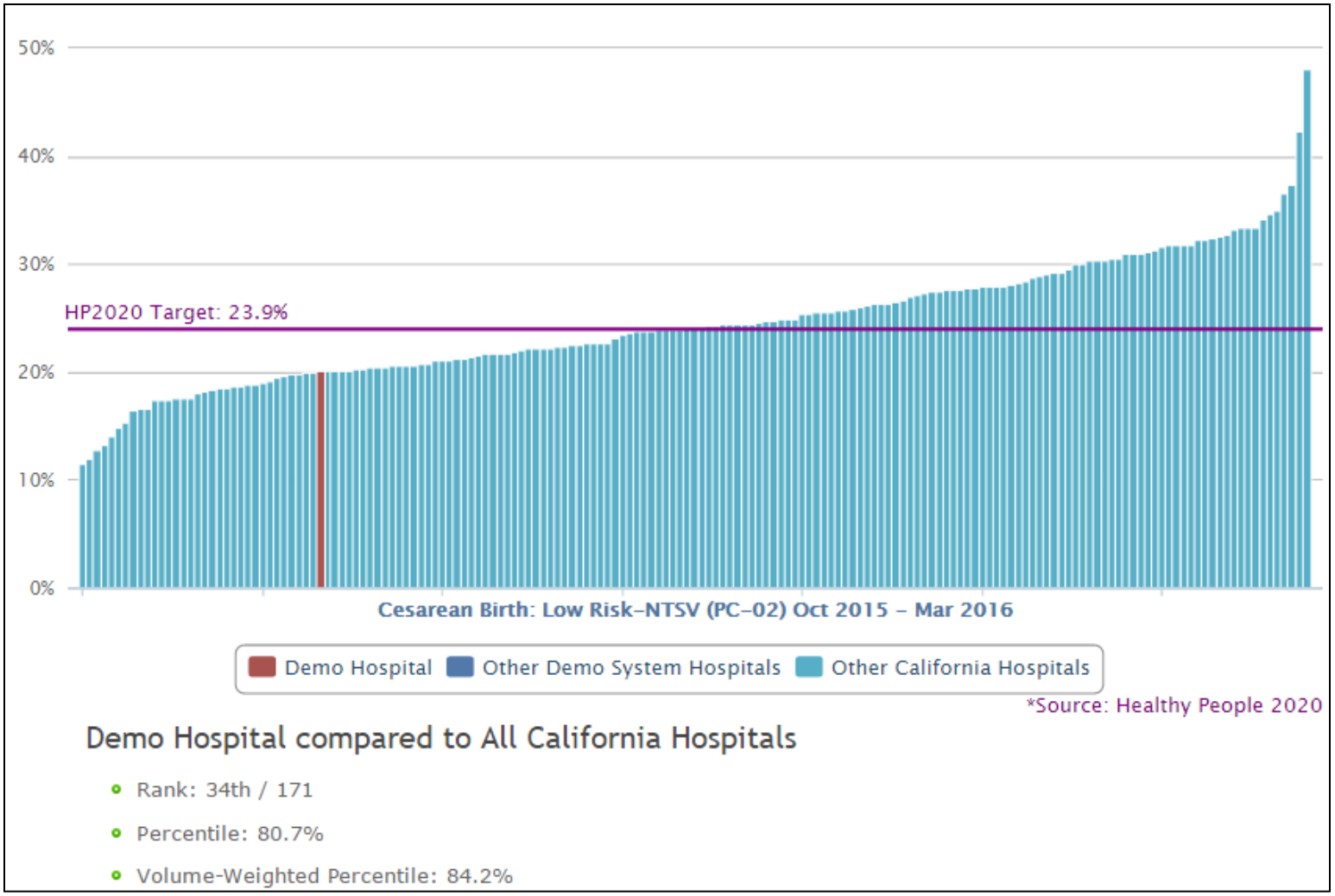
System-Wide Comparisons

- If part of a multi-hospital system, can view all hospital rates within the system

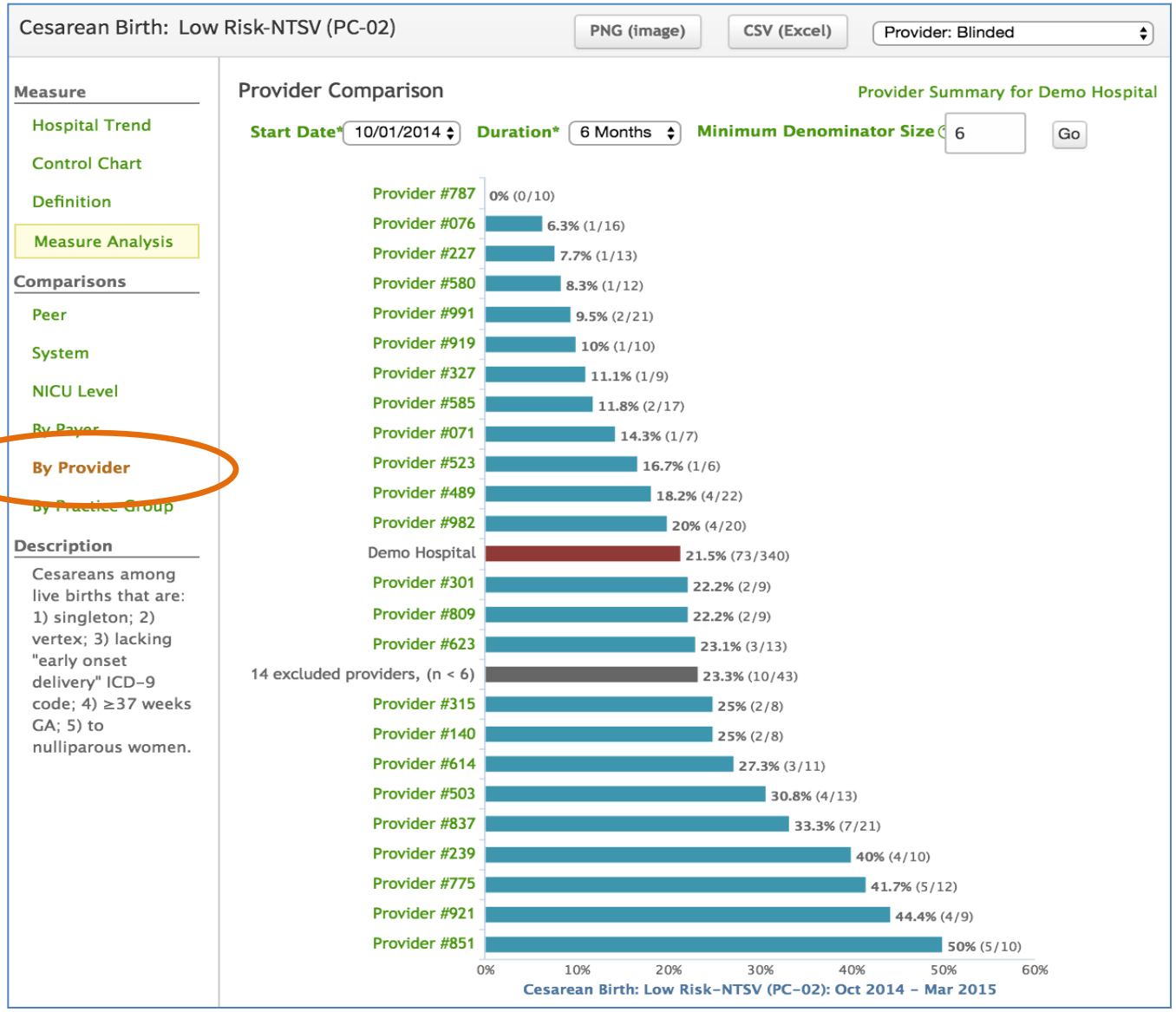


Identify your hospital's relative performance

- Able to toggle comparison groups (e.g. your state, your NICU level, your region)
- Able to show your hospital alone or all the hospitals in your system

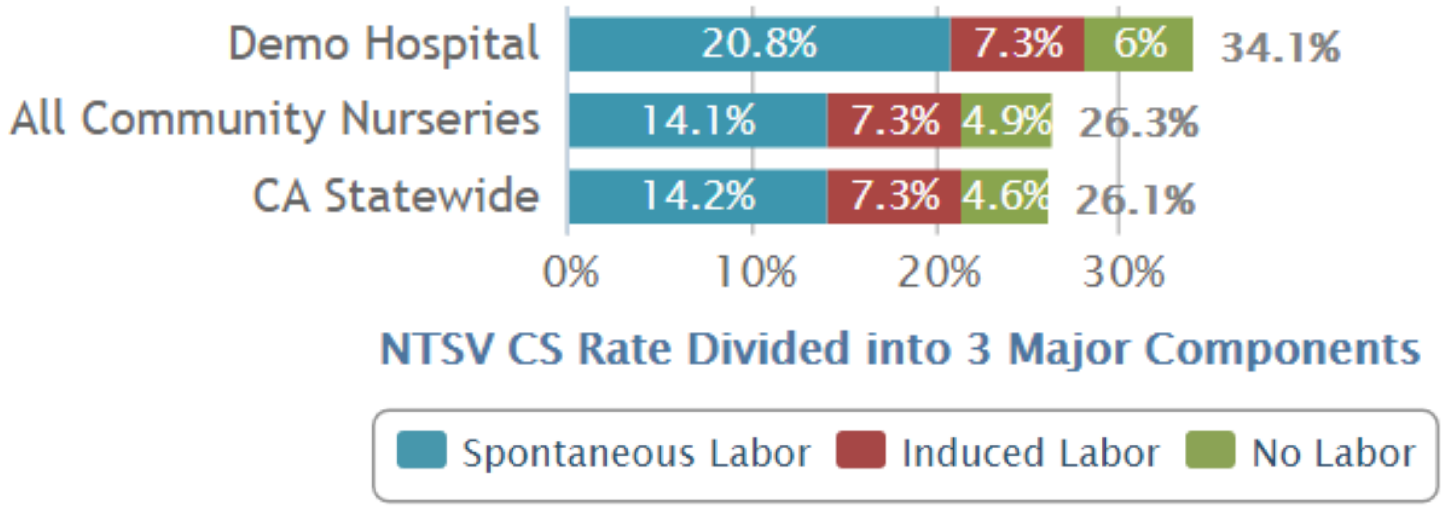


Example View: Provider-level Measure



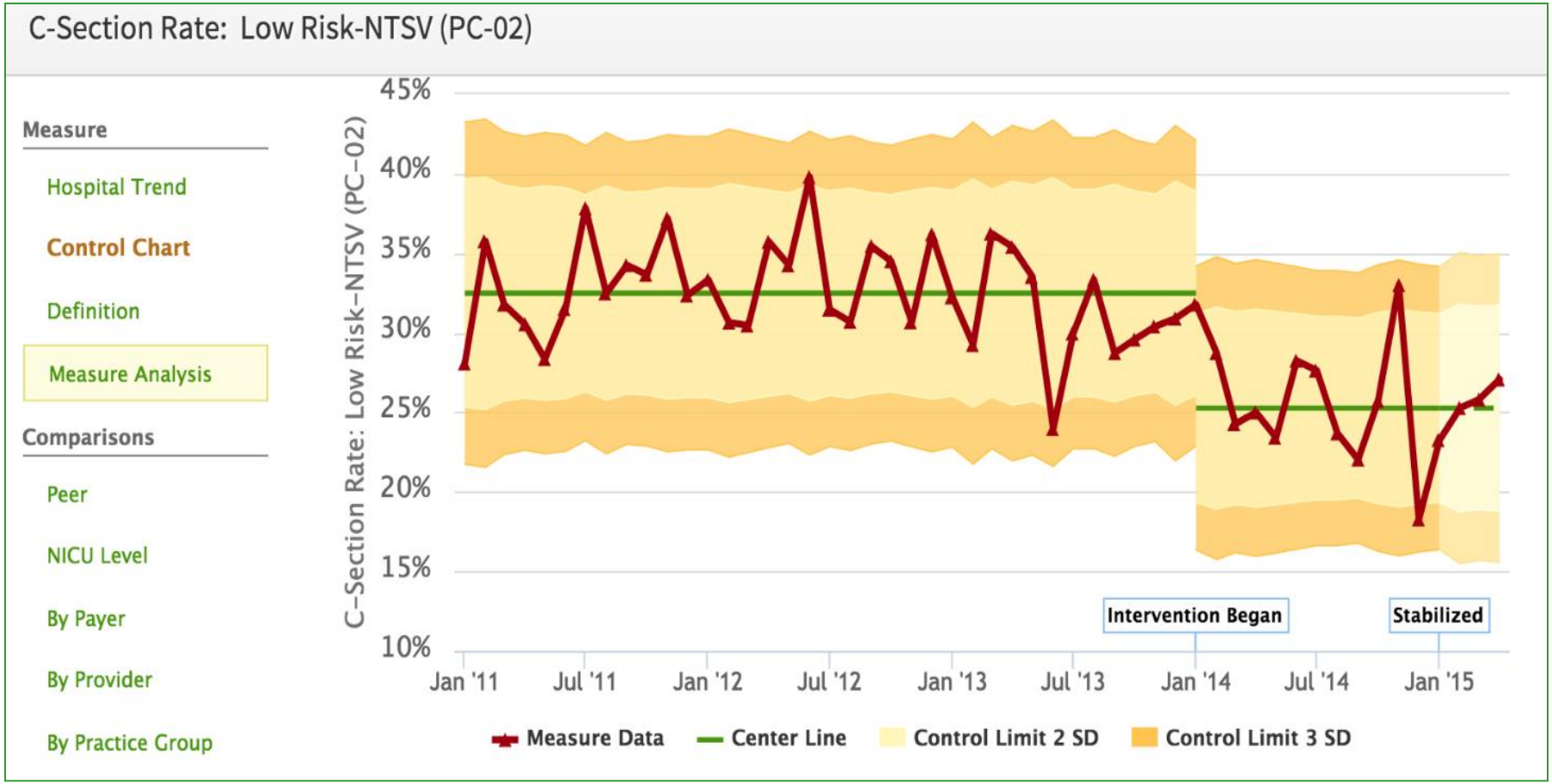
Measure Analysis: Identify "Drivers" of the CS Rate

What Drives Our Nulliparous Term Singleton Vertex (NTSV) CS Rate?



Screen Shot from the CMQCC Maternal Data Center

Assess Impact of QI Interventions using Control Charts



Screen Shot from the CMQCC Maternal Data Center

CMQCC
California Maternal
Quality Care Collaborative

Joining the MDC….as simple as ABC

A. Complete Participation Agreement

B. Submit Patient Discharge Data

Data your hospital already generates for OSHPD!

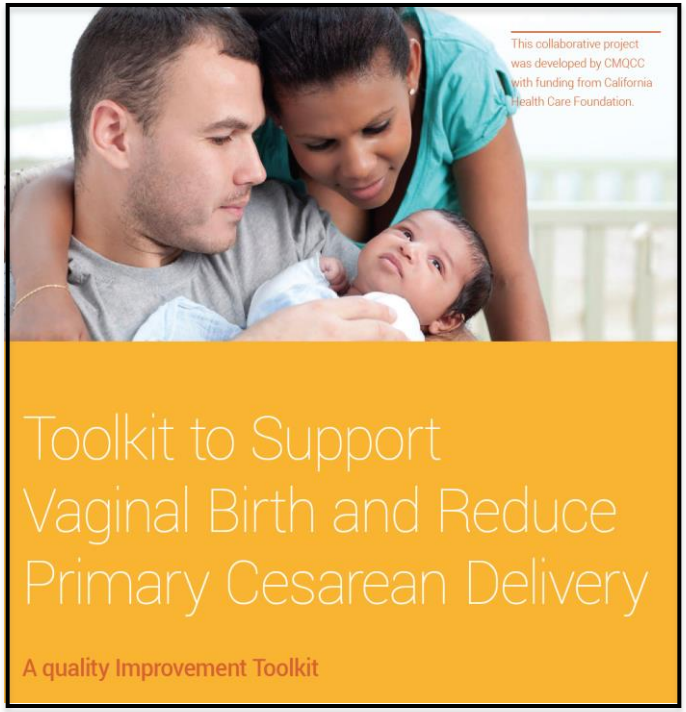
C. Participate in training session with CMQCC

Use tool to advance your quality agenda!

CMQCC
California Maternal
Quality Care Collaborative

Action Step #2

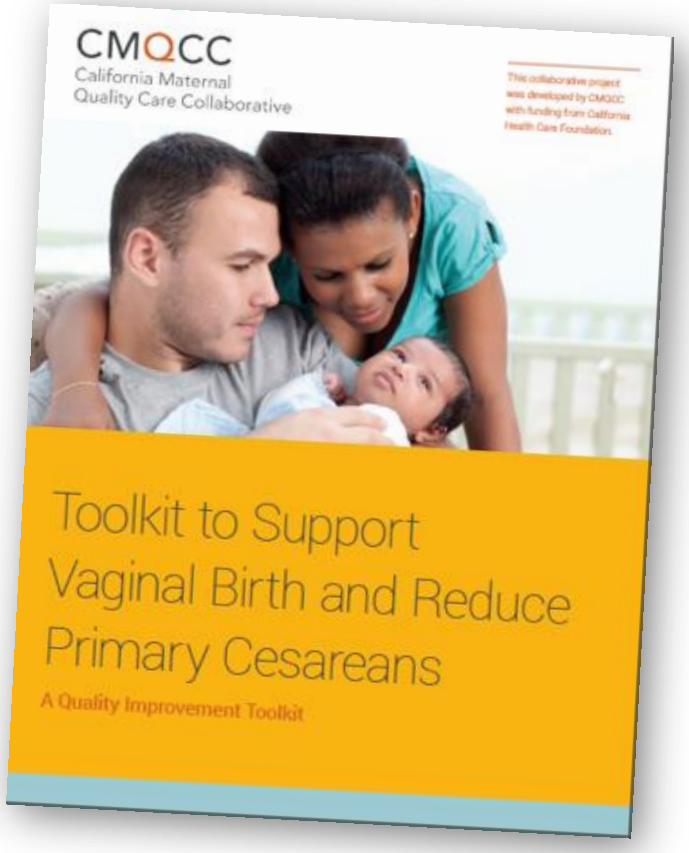
CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans



Editors:
Holly Smith, CNM, MSN, MPH
Nancy Peterson, MSN, RNC-OB
David Lagrew, MD
Elliott Main, MD

The CMQCC Toolkit

- Comprehensive, evidence-based "How-to Guide" to reduce primary cesarean delivery in the NTSV population
- Will be the resource foundation for the CA QI collaborative project
- The principles are generalizable to all women giving birth
- Released on the CMQCC website April 28, 2016
- Has a companion *Implementation Guide*



CMQCC
California Maternal
Quality Care Collaborative

The over 50 experts who wrote and advised for the toolkit represent organizations such as:

- American Congress of Obstetricians and Gynecologists (including current District IX Chair)
- American College of Nurse-Midwives
- Association of Women's Health, Obstetric, and Neonatal Nurses (including current California Chair)
- California Hospital Association/Hospital Quality Institute (including current President/CEO of HQI)
- Childbirth Connection/National Partnership for Women and Families
- Blue Shield of California
- BETA Healthcare Group
- Kaiser Permanente, Sutter Health, MemorialCare Health System, various university health systems, various birth centers, urban and rural hospitals alike
- Doulas of North America, Lamaze International, Coalition for Improving Maternity Services

Key National Foundation Materials

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

Number 1 • March 2014

Safe Prevention of the Primary Cesarean Delivery

New National Guidelines for Defining Labor Abnormalities and Management Options

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

READINESS

Every Patient, Provider and Facility

- Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.

RECOGNITION AND PREVENTION

Every patient

- Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
- Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Use standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using NICHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.

PATIENT SAFETY BUNDLE

Safe Reduction of Primary Cesarean Births

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

May 24, 2016

John Wachtel, MD
Chair: District IX
American Congress of Obstetricians and Gynecologists

Dear Dr. Wachtel:

In representing the American College of Obstetricians and Gynecologists (ACOG), we would like to congratulate you and all the contributors involved in the development of the CMQCC "Toolkit to Support Vaginal Birth and Reduce Primary Cesareans". We have had the honor to review this comprehensive toolkit and ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate. The toolkit includes a number of resources that could be implemented, and the plan to disseminate the information via speaker training sessions and site visits to encourage implementation are laudable.

Clearly, the rising Cesarean delivery rate, and particularly the primary Cesarean rate, is concerning to all involved in the provision of women's healthcare, and although here have been a number of efforts nationwide to address this problem, they have been met with mixed success. This excellent resource, and the plan for encouraging awareness and implementation is unquestionably a commendable program to address this issue and should set a benchmark for achieving success in reducing the primary Cesarean delivery rate. We look forward to the program's implementation, and to hear of the future successes.

Again, we express our sincere gratitude and strong support for everyone who had a part in developing this toolkit. Congratulations, and best wishes moving forward!

Sincerely,

Hal. C. Lawrence III, MD
Executive Vice President and CEO

Christopher M. Zahn, MD
Vice President, Practice Activities

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

May 24, 2016

John Wachtel, MD
Chair: District IX
American Congress of Obstetricians and Gynecologists

Dear Dr. Wac

In representi
congratulate
Vaginal Birth
toolkit and A
primary Cesa
and the plan
implementat

Clearly, the rising Cesarean delivery rate, and particularly the primary Cesarean rate, is concerning to all involved in th
nationwide t
and the plan
program to a
Cesarean del
successes.

Again, we ex
this toolkit. C

Sincerely,

Hal. C. Lawrence III, MD
Executive Vice President and CEO

Christopher M. Zahn, MD
Vice President, Practice Activities

We have had the honor to review this comprehensive toolkit and ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate.

This excellent resource, and the plan for encouraging awareness and implementation is unquestionably a commendable program to address this issue and should set a benchmark for achieving success in reducing the primary Cesarean delivery rate.

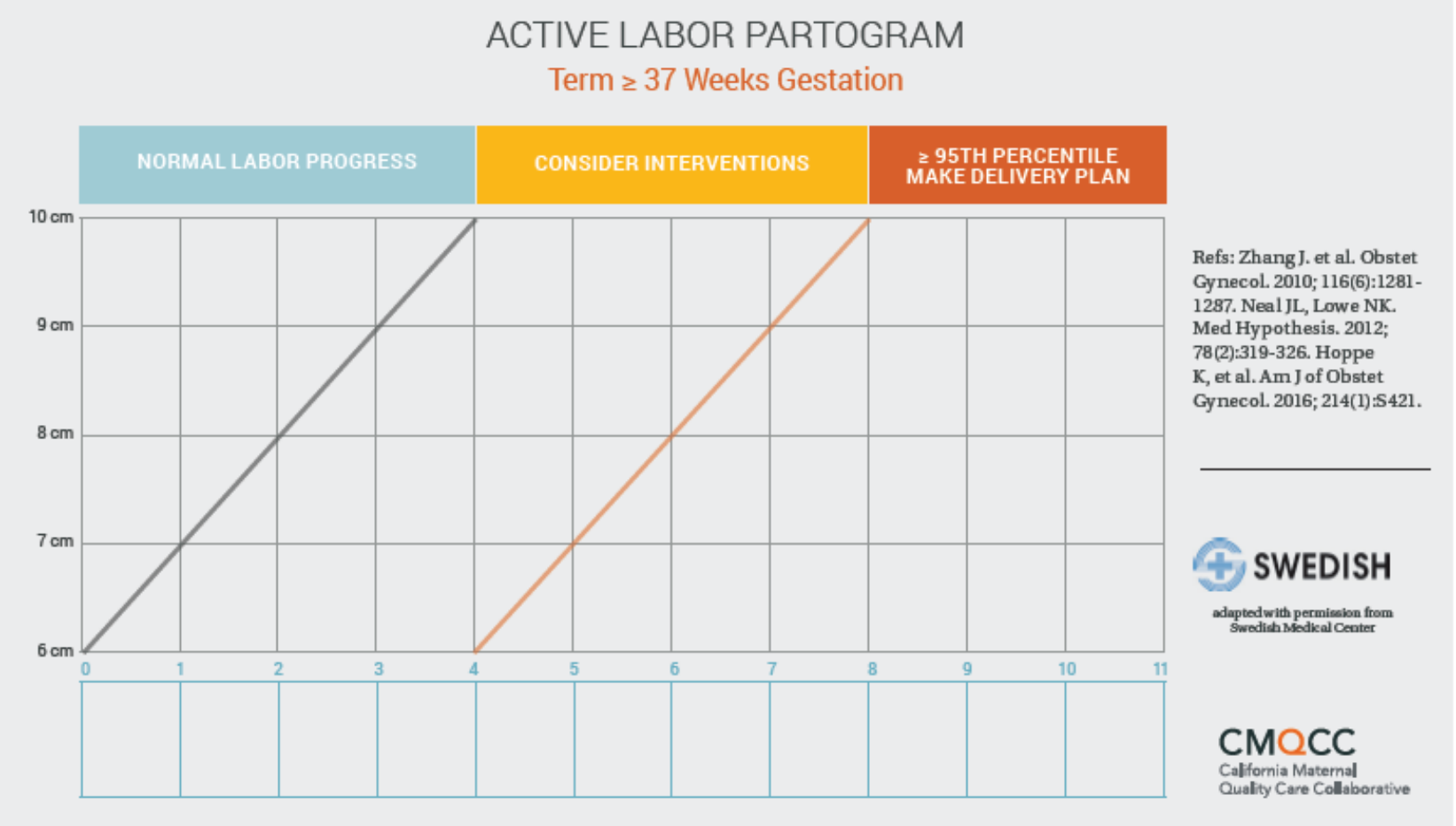

Lamaze International 2016
Annual Conference
October 20-23, 2016 • Hilton West Palm Beach • West Palm Beach, Florida

The Toolkit Mirrors the National Safety Bundle

READINESS	RECOGNITION	RESPONSE	REPORTING/ SYSTEMS
Improving the Culture of Care, Awareness and Education	Supporting Intended Vaginal Birth	Management of Labor Abnormalities	Using Data to Drive Improvement
*Education *Shared Decisions *Support *Payment	*Early labor supportive care *Doulas *Care during regional analgesia *Intermittent auscultation (fetal monitoring) *Modifiable conditions	*Standard response to abnormal FHR and labor challenges *Operative vaginal delivery *Safe, efficient out of hospital transfer process	*Create awareness *Share data *Improve data quality *Reduce data burden

Each Section: Discussion of Barriers and Strategies,
with multiple examples (case studies), diagrams and references

Active Labor Partogram



Response

Peanut Ball

- ✓ Decrease length of labor
- ✓ Decreasing CS rate in patients with epidurals

Recognition

Tussey, C. M., Botsios, E., Gerkin, R. D., Kelly, L. A., Gamez, J., & Mensik, J. (2015). Reducing length of labor and cesarean surgery rate using a peanut ball for women laboring with an epidural. *The Journal of Perinatal Education*, *24*(1), 16-24. http://dx.doi.org/10.1891/1058-1243.24.L16

What does Shared Decision Making Really Mean?

…and how to implement it in OB…

READINESS: Build a provider and maternity unit culture that values, promotes, and supports intended vaginal birth and optimally engages patients and families

Create a team of providers (e.g. obstetricians, midwives, family practitioners, and anesthesia providers), staff and administrators to lead the effort and cultivate maternity unit buy-in

Develop program for ongoing staff training for labor support techniques including caring for women regional anesthesia

Develop a program positive messaging to women and their families about intended vaginal birth strategies for use throughout pregnancy and birth

RECOGNITION AND PREVENTION: Develop unit-standard approaches for admission, labor support, pain management and freedom of movement

Implement protocols and support tools for women who present in latent (early) labor to safely encourage early labor at home

Implement Policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women

RESPONSE: Develop unit-standard approaches for prompt identification and treatment of abnormal labor and fetal heart patterns

Implement standard criteria for diagnosis and treatment of labor dystocia, arrest disorders and failed induction

Implement training/procedures for identification and appropriate interventions for malpositions (e.g. OP/OT)

REPORTING AND SYSTEMS LEARNING: Utilize local data and case reviews to present feedback and benchmarking for providers and to guide unit progress

- Share provider level measures with department (may start with blinded data but quickly move to open release)
- Perform monthly case reviews to identify consistency with dystocia and induction ACOG/SMFM checklists
- Establish a project communications plan (at least monthly education and progress updates

For a Deeper Dive on the Toolkit!

Webinar:

November 1, 2016: 12-1:30

Presented by:

David Lagrew, MD

Toolkit Co-Author and Editor

Register at www.CMQCC.org

Action Step #3

Join the Supporting Vaginal Birth /Reducing Primary Cesarean Collaborative

CMQCC
California Maternal
Quality Care Collaborative

CMQCC QI Collaboratives

- Two rounds of participation
  - First round (30) kicked off May 20, Los Angeles
  - Second round kicks off January 2017
- Use the Mentor Model CMQCC California Maternal Quality Care Collaborative for collaborative work
- 65 hospitals, *minimum*
  - Already at enrollment target
  - Special attention for higher rate/higher volume facilities

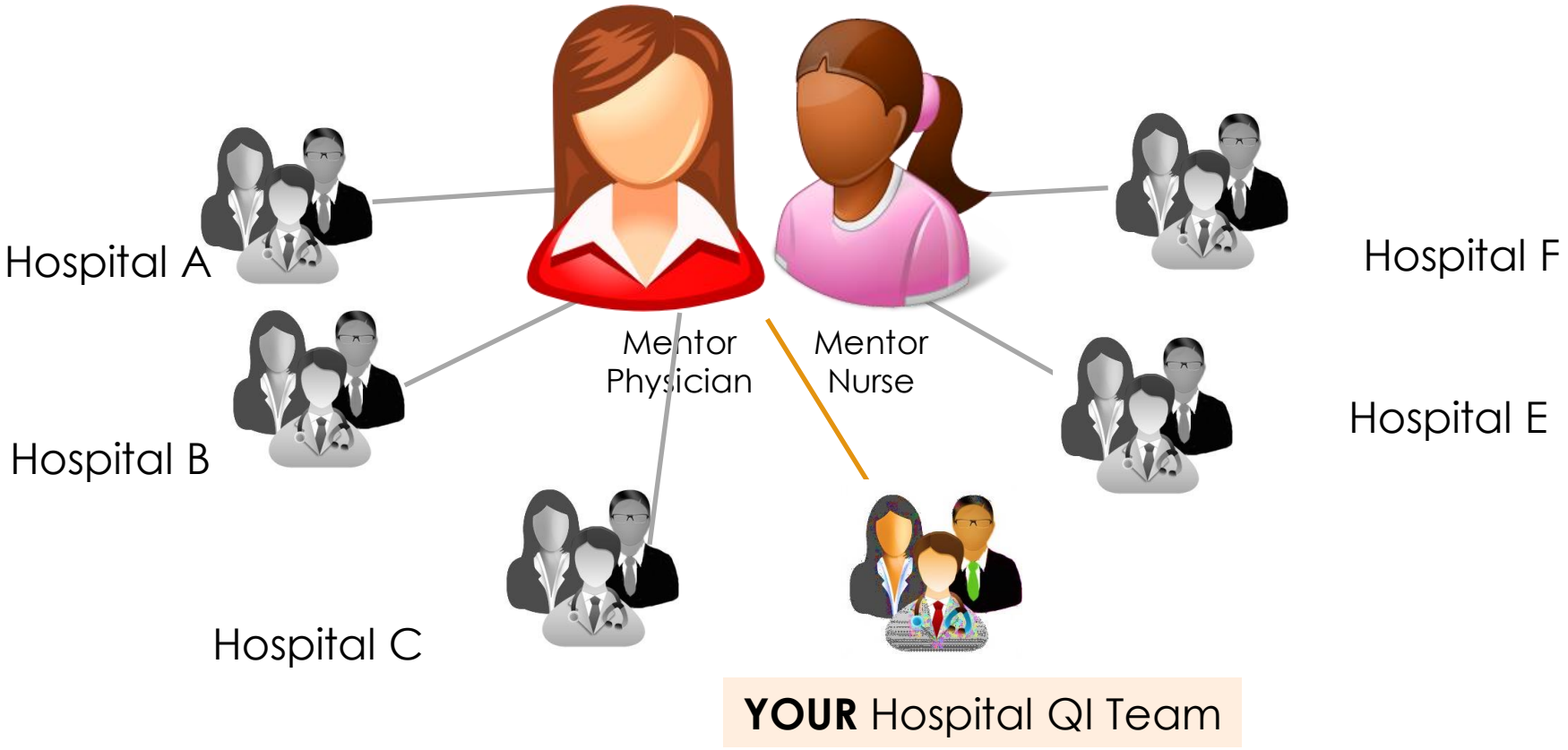
CMQCC
California Maternal
Quality Care Collaborative

What are the advantages of the Collaborative?

- Use of all of the features of the **CMQCC Maternal Data Center**
- **Mentor support** from experts for implementation of bundle elements in smaller groups
- Access to national and local experts through grand rounds, in-person and virtual education and **mentor/team monthly calls**

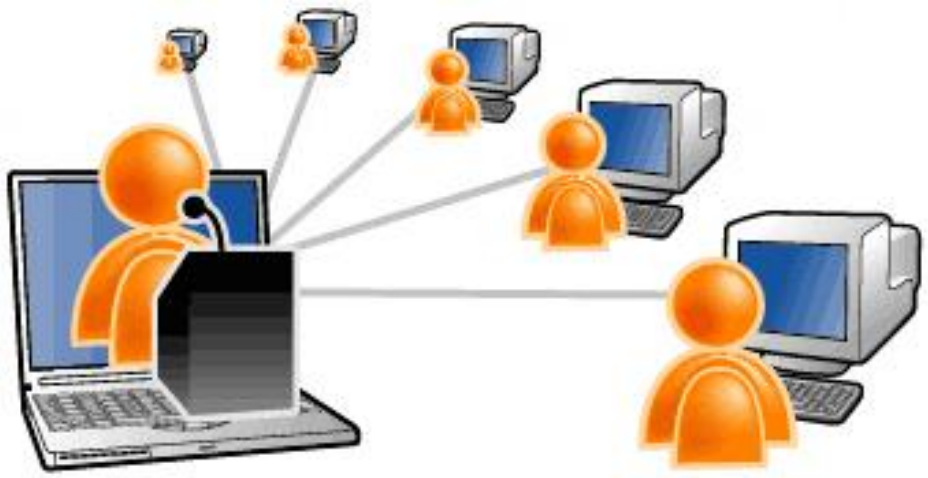
CMQCC
California Maternal
Quality Care Collaborative

Supporting Vaginal Birth Collaborative Mentor Model



Structure of the Mentor Model

- Monthly web based meetings
- Facilitated by mentors
- Team report outs
- CMQCC Support



What is the Cost to Participate?

- **NO COST** to join collaborative

- Hospitals will provide the internal resources necessary for success during the Collaborative by identifying:
  - Clinician and Nursing champions
  - Time for the Perinatal Quality Improvement team to work on implementation, education and data analysis

CMQCC
California Maternal
Quality Care Collaborative

Gather Your Perinatal Quality Improvement Team

Primary Physician champion

Nursing – CNS, Manager, Bedside RN

Administration
Quality Team
Risk Mgr

Improved Maternity Care

CMQCC
California Maternal
Quality Care Collaborative

Still….. Why Do I Need A Collaborative?

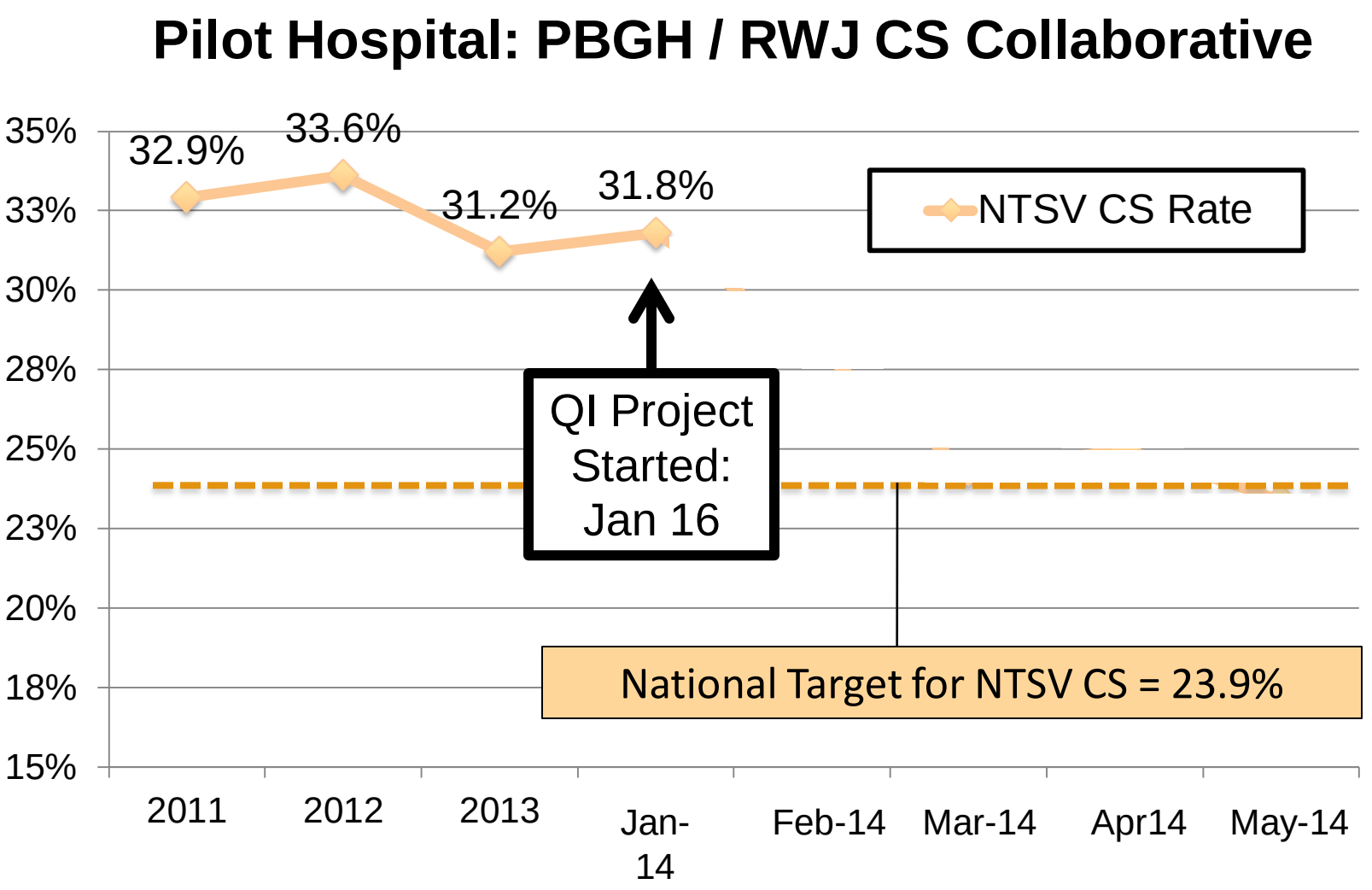
- Peer to peer learning, networking and sharing of best practices are THE BEST WAY to improve further, faster
- Gives hospitals the ability to translate the knowledge “that” into the knowledge “how”
- Ability to rapidly spread innovations that work
- Identify practical advice from peers sharing the same challenges how to implement best practices
- Ability to integrate reliability and sustainability into improvement work

CMQCC
California Maternal
Quality Care Collaborative

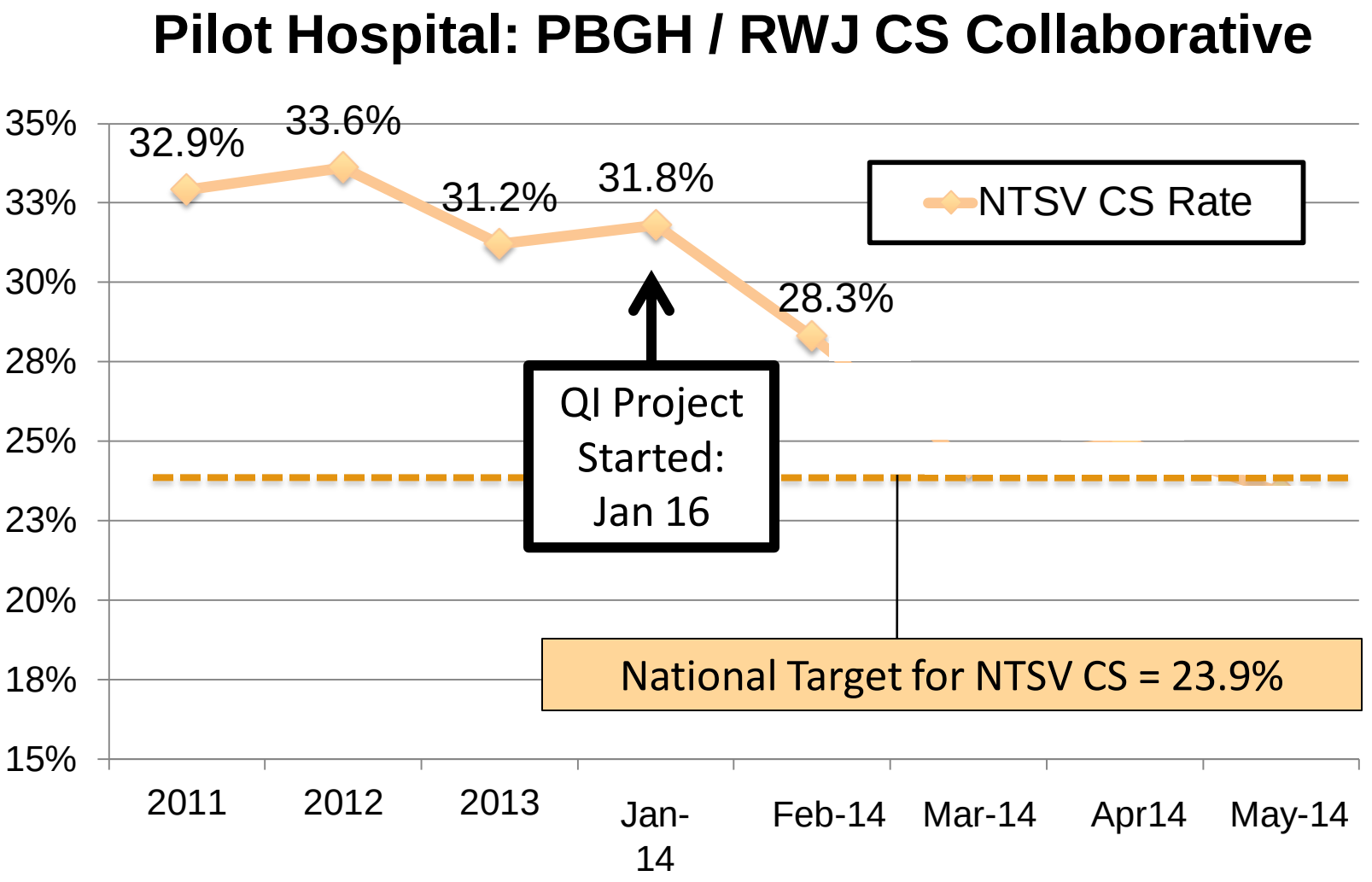
Pilot Project: Testing the Approach

- 3 SoCal Hospitals,
  - All with NTSV Rates ~30%
- Maternal Data Center
  - Real time data, un-blinded provider rates, analysis to understand drivers
- Prototype of the toolkit
  - Nursing and physician education and practice changes
- Shared ideas/best practices (mini-collaborative)
- Payer and employer interest
  - One payer negotiated a blended payment

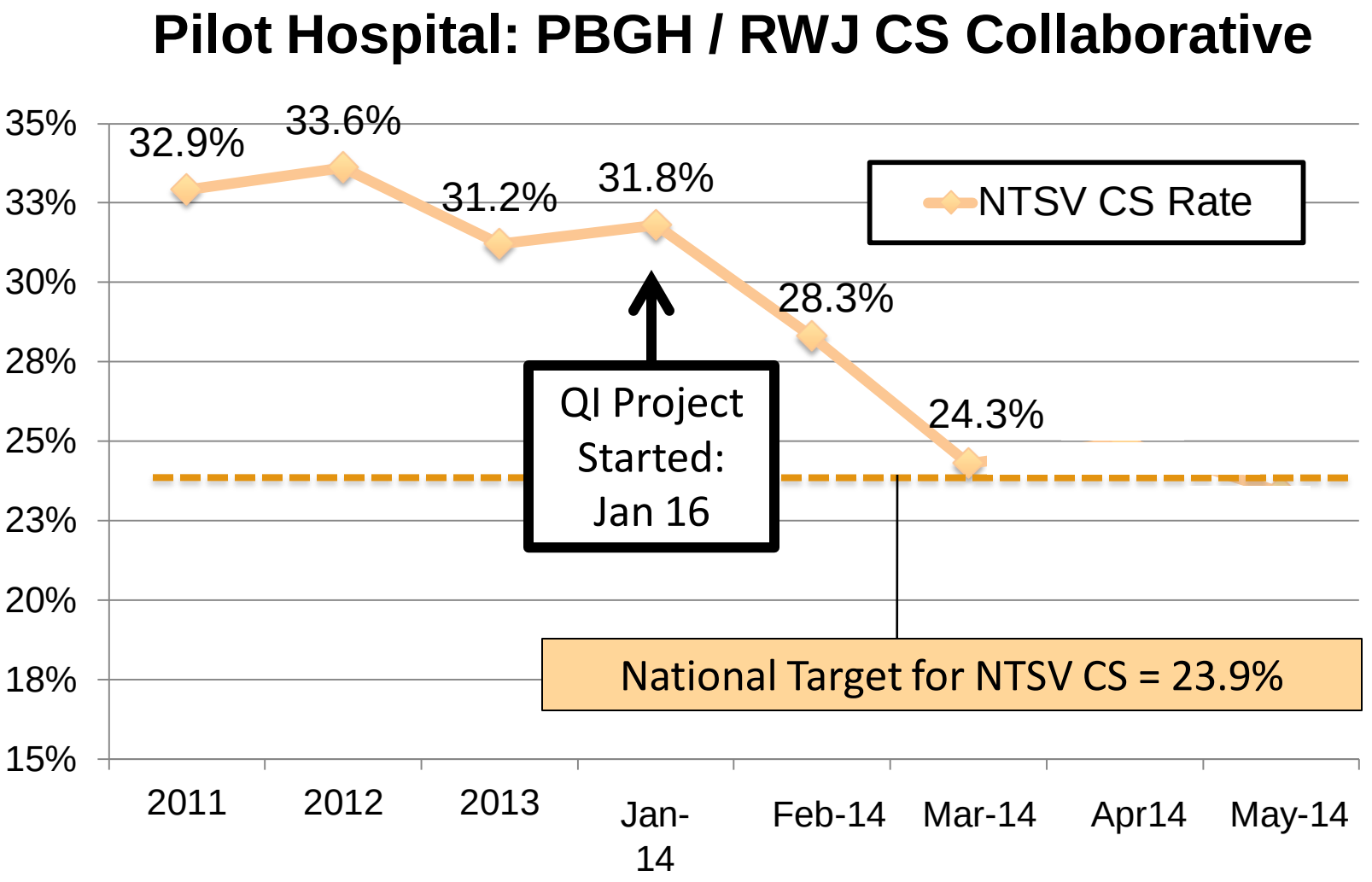
Data-Driven QI: NTSV CS



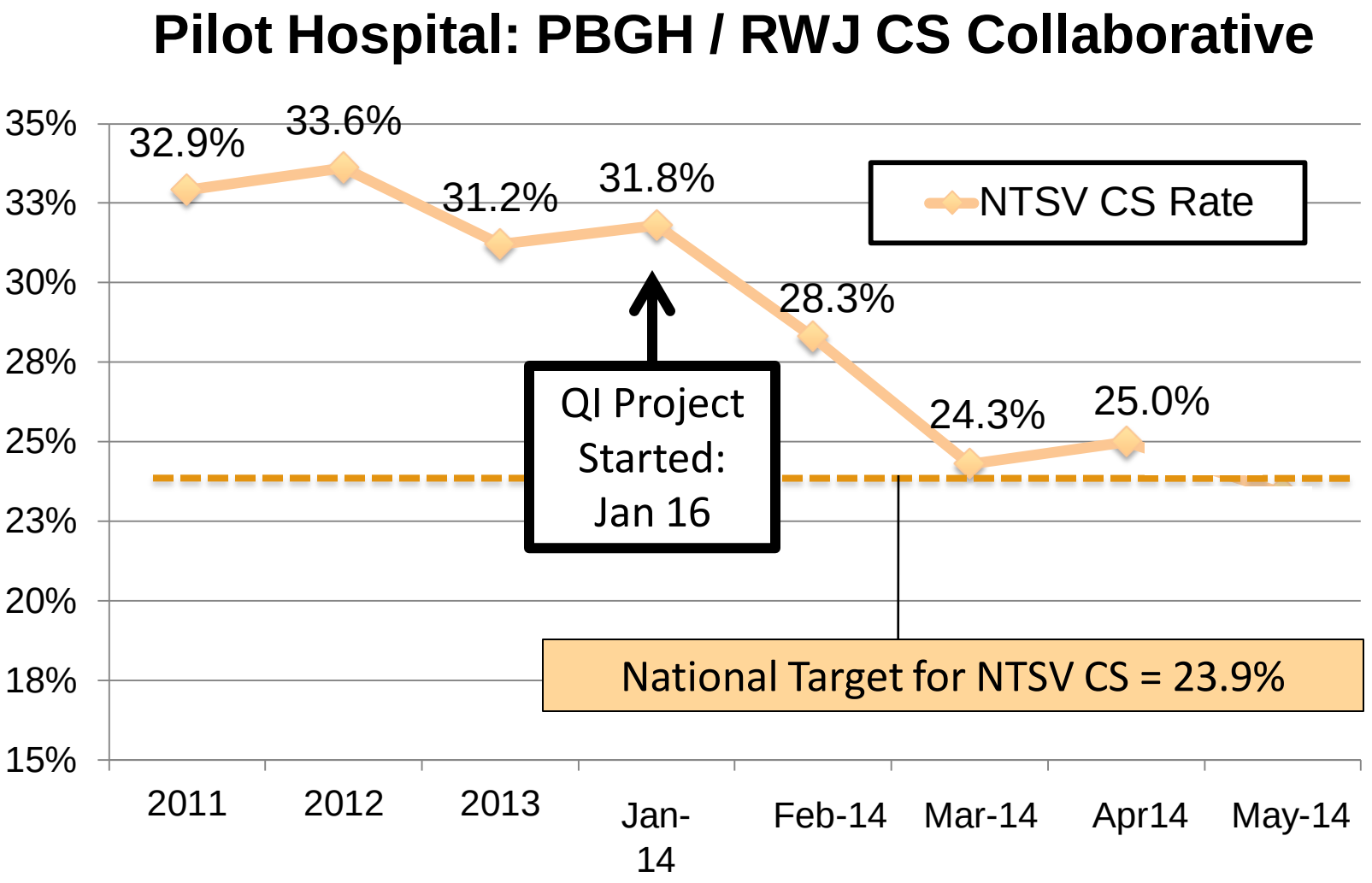
Data-Driven QI: NTSV CS



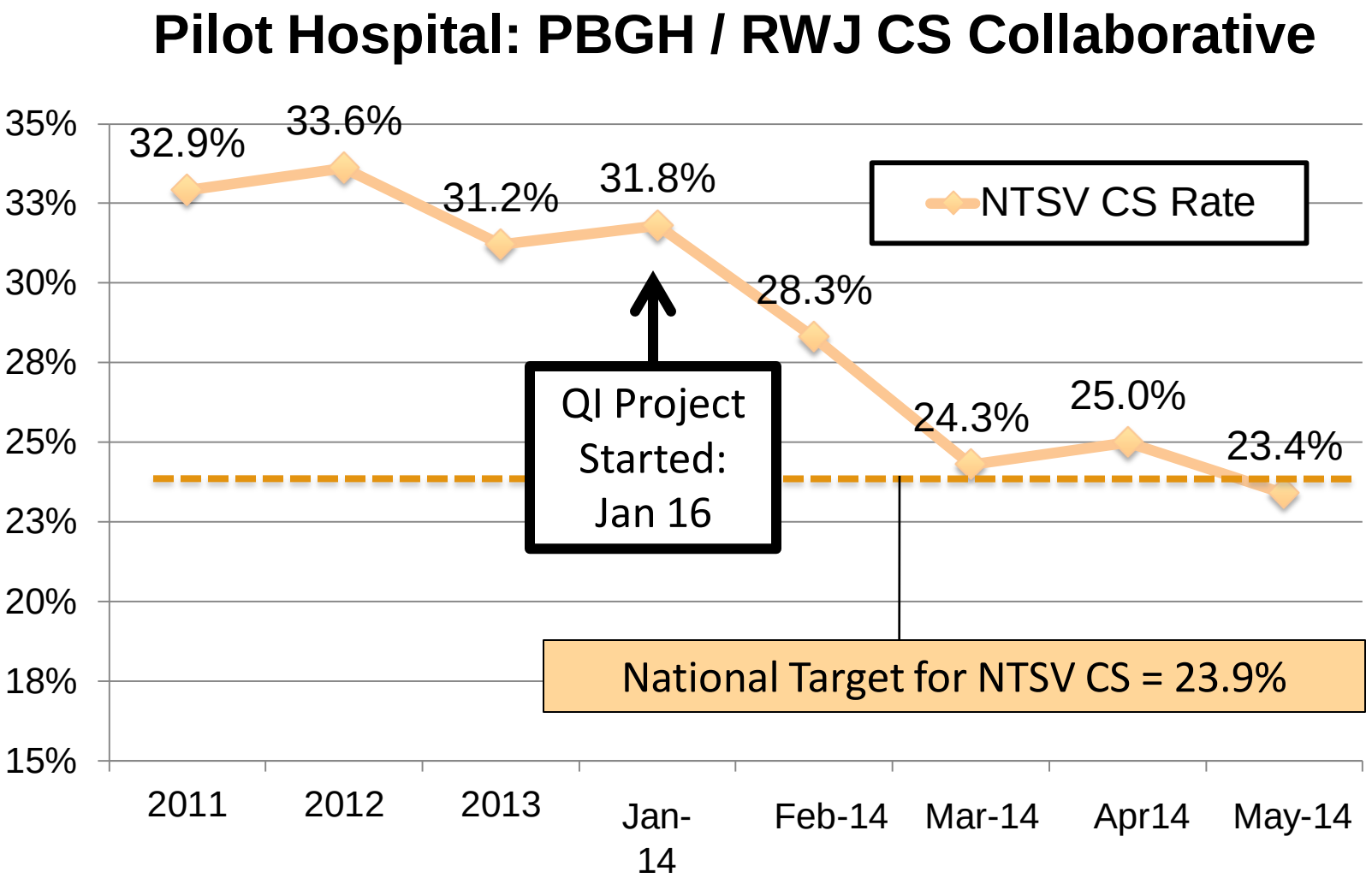
Data-Driven QI: NTSV CS



Data-Driven QI: NTSV CS



Data-Driven QI: NTSV CS



NTSV CS Pilot Project
Impressive Results: within 6 months

24.2 % Reduction	22.1% Reduction	19.5% Reduction
Baseline – 32.6% After QI – 24.7%	Baseline – 31.2 After QI – 24.3%	Baseline – 27.2% After QI – 21.9%

Any Downsides? –Balancing Measures

- More vaginal births--Any increase in 3rd or 4th degree lacerations?
  - Zero change from the prior 4 year baseline
- Most important outcome is a healthy baby
  - NQF measure "Unexpected Newborn Complications"
  - Asks whether term babies without preexisting conditions had any major complications during birth or neonatal period
  - No change in the 3 hospitals' rates

CMQCC
California Maternal
Quality Care Collaborative

Key Components for Quality Improvement

CMQCC
Maternal Data Center

Data Monitoring and Evaluation

CMQCC
Toolkit

Evidence-Based Support Tools

CMQCC
Collaborative

Engagement of Hospital Clinicians and Administrators

Your Hospital!

Improved Maternity Care

Additional Support Programs

1. Webinars

- Nov 7th—Intermittent Monitoring-Best Practices
- Jan 24th—Incorporating Doulas in to your hospital practice

2. Speakers' Bureau

- ACOG/AWHONN Partnership
- ~20 MD/RN teams trained with slide set
- Starting now!

3. Labor Support Workshops

- Goal: train trainers to return to their hospitals to train others for labor support techniques
- In partnership with ACNM, AWHONN and Doulas
- 6 all-day sessions scheduled all around the state—75 attendees each, nearly oversold (Sept-Dec 2016) More in the new year

4. Examples of Related State Activities

- Covered California Contract Requirements for 2019 includes NTSV CS rate ≤23.9%
- DHCS PRIME hospital project (County, District and University hospitals)

5. New Partners / Recruitment

- Working on alignment with purchasers and payers, Medi-Cal Managed Care plans
- So Cal hospitals with high volume and high rates that are not yet engaged, identified and targeted recruitment underway

6. California Transparency Efforts

- 2015 Hospital-level NTSV rates released by CHART in late October (Preceded by sharing with hospitals)
- Public acknowledgement by Secretary Dooley October 26th of hospitals with rates ≤23.9%

Contacts and Resources

Maternal Data Center

- Anne Castles (acastles@cmqcc.org)
- Amanda Woods (amwoods@cmqcc.org)

Collaborative

- Valerie Cape (vcape@cmqcc.org)

Toolkit

- Nancy Peterson (peterson@cmqcc.org)

Resources @ **www.CMQCC.org**

- Collaborative FAQs
- MDC Project Description
- Toolkit