Maternity Town Hall Meetings

Discussion of a Quality Improvement Program in Perinatal Health

March, 2012

Agenda

Background

Quality and patient safety

Program Purpose

Program Overview

Protocols

Maternity Care: 2008 Stats

- 4.2 million births in US hospitals
- 11% of all hospital stays
- $18.9 billion in hospital costs
- Average delivery $4500 ($3400-$9400)
- 53% Private insurance; 40% Medicaid
  - In Alabama, ~ 50% of all deliveries are funded by Alabama Medicaid Maternity Care Program.

HCUP, 2008

Infant mortality rate

- US infant mortality rate: 7 per 1000 births
  - Higher than 30 other developed countries
- 2010 Alabama infant mortality rate: 8.7 per 1000
  - White: 6.6 per 1000
  - Black: 13.7 per 1000

www.statehealthfacts.org 2011; ADPHC for Health Statistics

Quality and Patient Safety

Focus of:

- Federal agencies
- State agencies
- Private insurers
- Hospitals
- Joint Commission

Value Based Purchasing

- AHRQ-designed
- Financial incentives to physicians/health care providers to meet defined quality, efficiency or other targets
- CMS looking for benchmarks to structure incentives
- Promotion and sustainment of quality improvement is essential

Value Based Purchasing—*Coming Soon: Penalties*

- 2017—Unmet benchmarks
  - 1% of reimbursement for services withheld
- Direct patients to better value hospitals and practices
  - Lower co-payments

Patient Safety

Minimizing error and preventing harm

Improving safety in healthcare

1. Provide leadership
2. Respect human limits in process design
3. Promote effective team functioning
4. Create a learning environment
5. Anticipate the unexpected

www.abog.org/safety 2011

Patient Safety

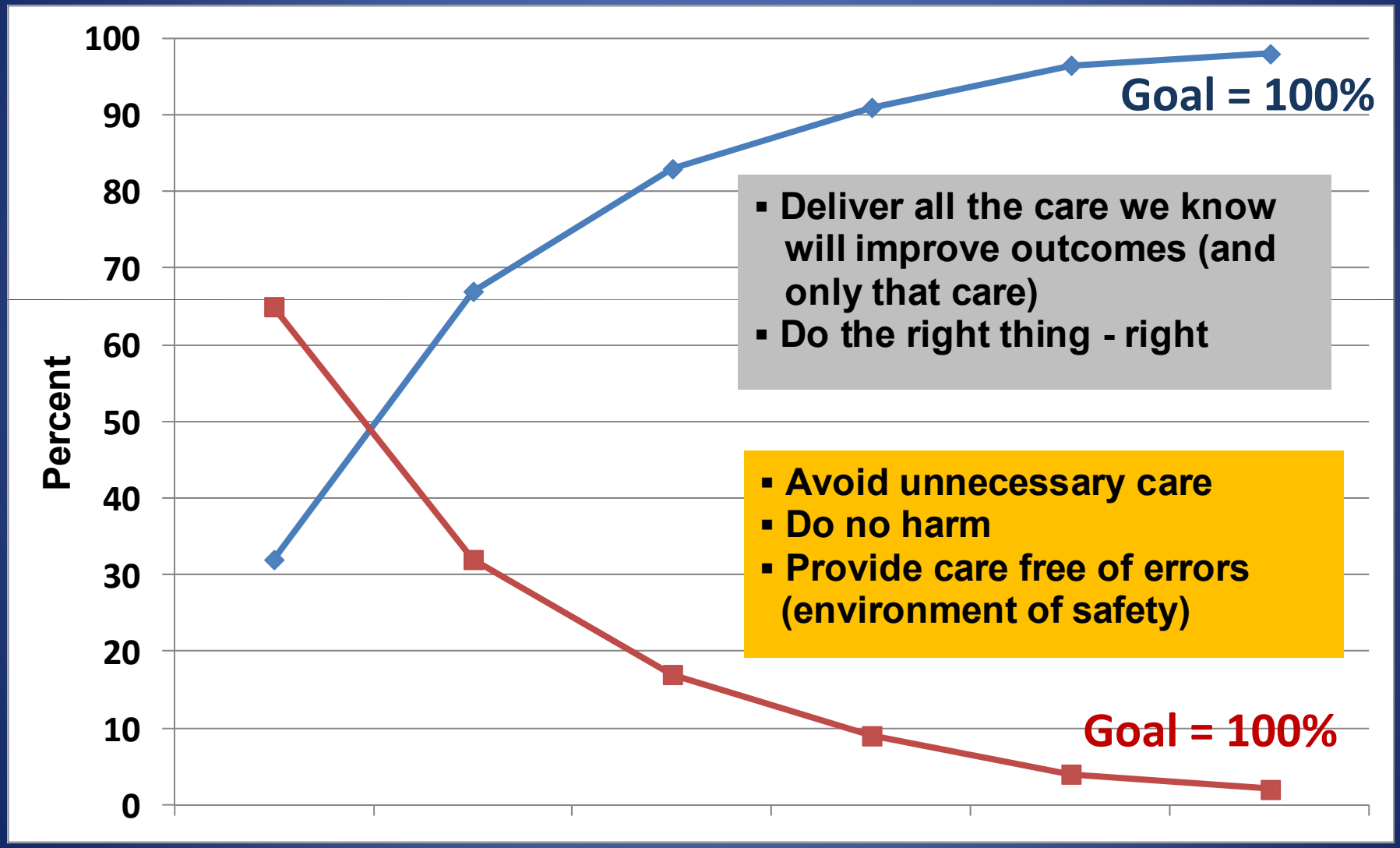
Minimizing error and preventing harm

The Institute of Medicine's Answer:

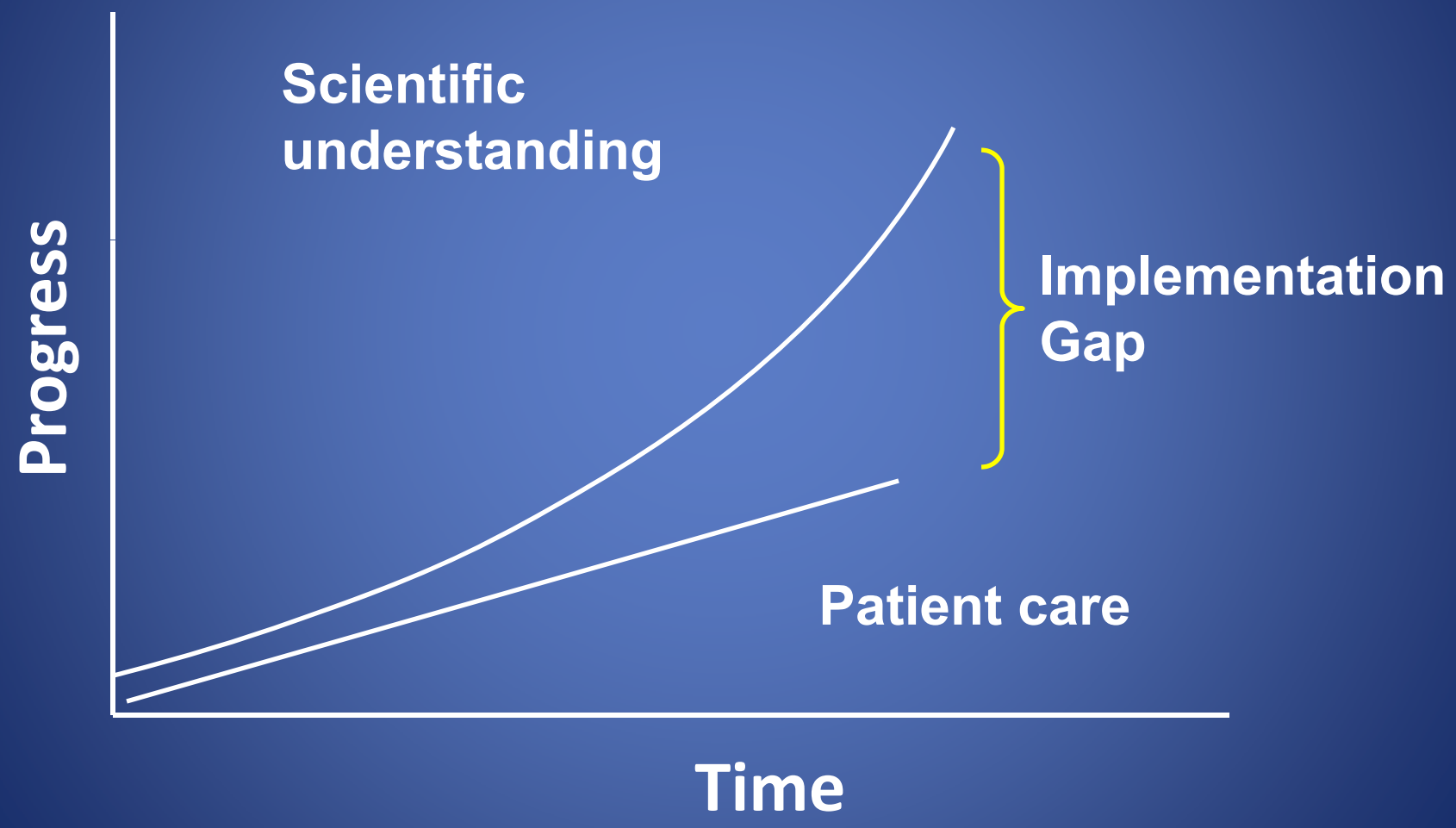
"The STEEEP Model"

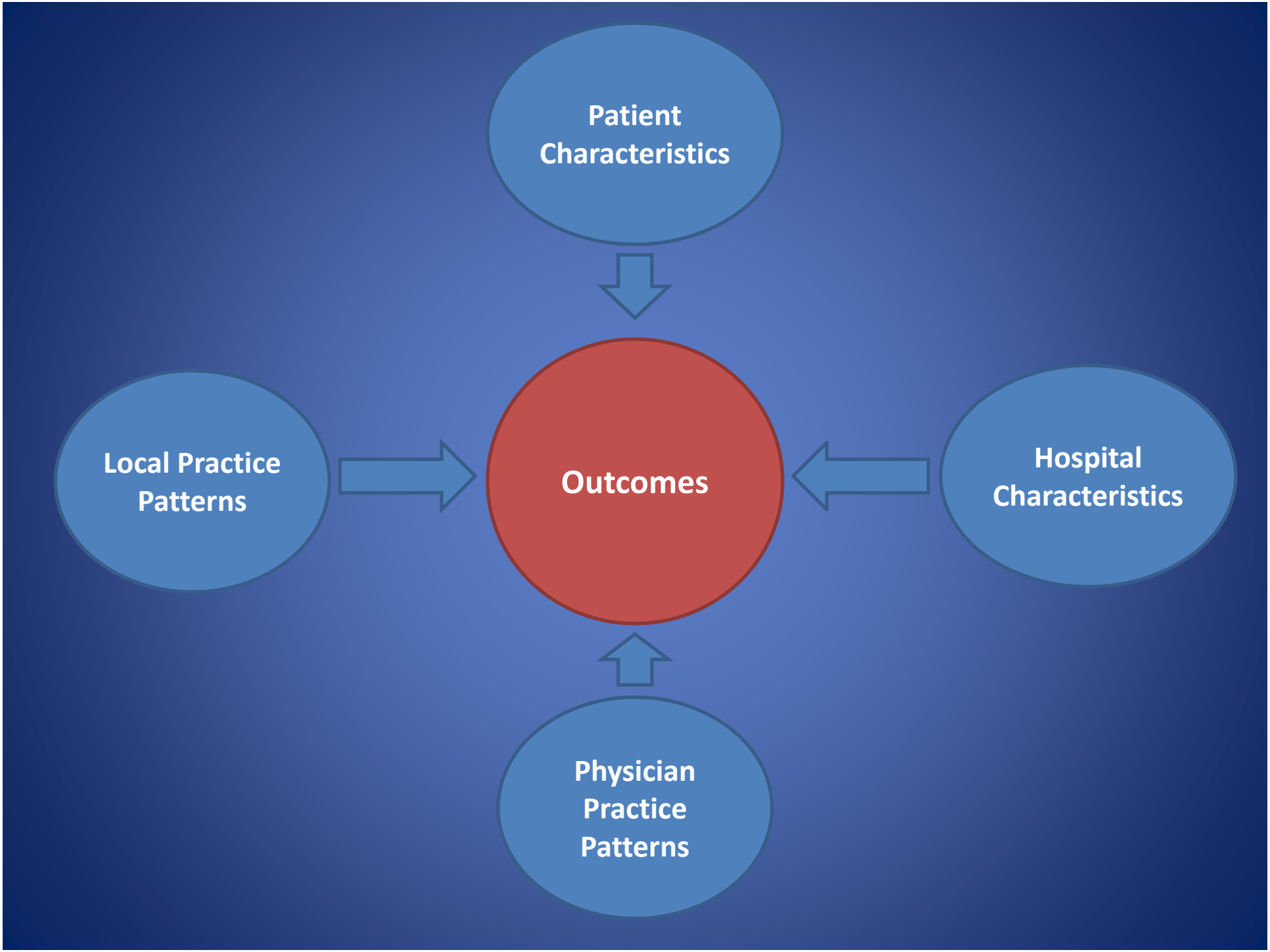
- **Safe** – patients should not be harmed by the care that is *intended* to help them
- **Timely** – unnecessary waits and harmful delays should be reduced (access)
- **Effective** – care should be based on sound scientific knowledge
- **Efficient** – care shouldn't be wasteful
- **Equitable** – shouldn't vary in quality because of patient characteristics
- **Patient-centered** – care should be responsive to individual preferences, needs, and values

Quality Care and Patient Safety



Bridging the Implementation Gap




Patient Characteristics
Local Practice Patterns
Outcomes
Hospital Characteristics
Physician Practice Patterns

"Every system is perfectly designed to produce the results it gets."

Paul Batalden, M.D.

To improve the system, change the system . . .

2011 Quality and Accountability Top Ten
University Health Consortium

1. University of Colorado Hospital
2. The University of Kansas Hospital Authority
3. Northwestern Memorial Hospital
4. Mayo Clinic in Rochester
5. UC San Diego Health System
6. Denver Health
7. University of Utah Hospitals and Clinics
8. Beaumont Health System (Beaumont Hospital, Royal Oak)
9. The Ohio State University Medical Center
10. Emory Healthcare (Emory University Hospital)

Shared Characteristics at Top Ten

- Standardization of care
- Evidence-based medicine protocols
- Quality monitoring program
- Continuous process improvement

Statewide and Regional Quality Programs

- The Ohio Perinatal Quality Collaborative "OPQC"
- The Maryland Perinatal Collaborative
- Northern New England Perinatal Quality Improvement Network
- Arkansas: Antenatal & Neonatal Guidelines, Education & Learning System "ANGELS"

Alabama Perinatal Excellence Collaborative
APEC

http://medicaid.alabama.gov

Alabama Medicaid Agency - APEC underway to improve obstetric patient care, patient safety - Microsoft Internet Explorer provide

http://medicaid.alabama.gov/news_detail.aspx?ID=6155

Alabama Medicaid Agency

Medicaid

Together for Quality

Newsroom | Apply for Medicaid | Programs | Resources | Providers | Fraud/Abuse Prevention | Contact | Recipients

News

Print

APEC underway to improve obstetric patient care, patient safety

February 14, 2012

A statewide initiative to improve obstetric patient safety and quality care is now underway following a series of Maternity "Town Hall" meetings in four cities to involve obstetric care providers in discussions on how to improve the care provided to Alabama Medicaid recipients.

Maternal fetal specialist William Andrews, Ph.D, M.D., of the University of Alabama at Birmingham, led the first session on Jan. 12 in Montgomery to launch the Alabama Perinatal Excellence Collaborative (APEC). Four more sessions and a webinar are planned for March.

"This program represents a partnership that is built upon the existing

For Recipients, Applicants, Sponsors

For Providers

News | Alerts | Calendar

1.1 billion in state spending = 8.9 billion in economic benefit

gency fraud and abuse revention efforts result in low rror rate

PEC underway to improve bstetric patient care, patient afety

My Medicaid

Patient 1st

One Health Record

APEC Partnership

- Alabama Medicaid Maternity Care Program
- University of Alabama at Birmingham
- University of South Alabama
- Statewide OB Providers and Hospitals
- Patients

APEC
Vision Statement

To be an exemplary resource for obstetric and other healthcare providers throughout the State of Alabama for assistance in improving perinatal outcomes and ultimately the health and welfare of women and infants throughout Alabama

APEC
Mission Statement

To lower infant mortality and improve maternal and infant health in Alabama through:

1. Implementation and utilization of evidence-based obstetric care protocols
2. Assessment of meaningful quality benchmarks
3. Enhanced communication and collaboration with providers, both primary and subspecialty, and patients

APEC Goals

1. Help guide OB providers via evidence-based practice protocols and decision trees
2. Identify meaningful quality benchmarks
3. Develop data collection measures
4. Review quality data and provide feedback to individual providers and institutions
5. Develop mechanisms to help providers in achieving benchmarks

Ultimate Goal: Improve Pregnancy Outcomes

Protocol Components

- Evidenced-based
- One page quick view summary sheet
- Longer narrative version
  - Rationale
  - Supporting evidence

Protocol Components

- Benchmarks for performance assessment
  - Linked to each protocol
  - Meaningful
  - Modifiable factors
  - Rationally achievable

Program Benefits

- Improvement in outcomes
- Improvement in access to care
  - Guidance available regardless of zip code
- Statewide guidelines for care
- Meaningful incentive development

Initial APEC Protocols

1. Guidelines for routine prenatal care
2. Guidelines for scheduled deliveries prior to 39 weeks gestation
   - One page summary sheet
   - Narrative with supporting evidence
   - Benchmarks

Guidelines for routine prenatal care

- Routine prenatal care labs and screening tests
  - Performed at specific time points for all women
  - Identify risk factors and
  - Initiate preventive care measures
- Screening, treatment and documentation requirements per trimester
- Quality indicators/benchmarks include
  - Lab test: VDRL/RPR, Urine culture, HIV, MSAFP, GBS
  - Ultrasounds: 17-20 wk anatomy scan
  - Assessments: fundal height

Initial Visit-First Trimester

- Labs
- History and physical exam
- Family planning counseling
- Assess and adapt care plan for risk factors (prior PTD or C/S, H/O GDM, H/O IUGR)
- Smoking and substance abuse assessment and cessation counseling as indicated
- Depression scale and domestic violence assessment
- Ultrasound for dating
- Discuss weight gain recommendations
- Discuss screening for aneuploidy birth defects
- Discuss risks associated with births prior to 39 weeks GA

• Blood type and Rh factor	• GC/ Chlamydia
• Antibody screening	• VDRL/RPR*
• HCT/HGB	• Urine culture*
• Pap smear age 21 and up	• HB S AG
• Rubella	• HIV*
Other screening as clinically indicated: drug screen, TB skin test, Hgb electrophoresis, Tay-Sachs, Cystic fibrosis, familial dysautonomia	

Subsequent PNC Visits

Assessment Each Visit:

- Weight gain
- Urine dip: glucose/albumin/ketones
- Blood Pressure
- FHR present/absent
- Fetal movement present/absent
- Fundal height*
- Signs and symptoms of labor

Frequency of visits

- **Up to 28 weeks at least q 4 weeks**
- **28 to 36 weeks-at least q 2 weeks**
- **36 weeks to delivery q week**

Second Trimester Assessments

- 17-20 weeks-anatomy ultrasound*
- 15-20 weeks-MSAFP and aneuploidy screening*
- 24-28 weeks-
  - Hct/Hgb
  - Diabetes screening-50gm OGTT
  - Glucose tolerance test if OGTT abnormal
  - Rh antibody screen if Rh negative
  - Rh-immune prophylaxis if indicated
- Repeat depression scale and domestic violence assessment
- Repeat smoking and substance abuse assessment and cessation counseling as indicated

Weight gain recommendations	Fundal ht guidelines
BMI<18.5: 28-40 lbs	Symphysis pubis to top of fundus
BMI 18.5-24.9: 25-35 lbs	≥20 weeks cm = GA
BMI 25.0-29.9: 15-25 lbs	GA and cm off >3 order US
BMI>30: 11-20 lbs	BMI 36-40: sonar for growth @ 28 weeks followed by growth Ultrasound every 4-6 weeks.

Third Trimester Assessment

At 32-34 weeks:

- Repeat VDRL/RPR*
- GC and Chlamydia tests
- Hct/Hgb
- Repeat HIV

At 35-37 weeks

- GBS culture*
- Depression scale and domestic violence assessment
- Repeat smoking and substance abuse assessment
- Ultrasound if clinically indicated

Guidelines for scheduled deliveries prior to 39 weeks gestation

- To assist the provider and the facility in implementing systems to decrease the rate of < 39 week elective scheduled deliveries—both inductions and scheduled cesareans
- Reducing demand through:
  - Education
  - Changing delivery scheduling processes
  - Collecting and reporting outcome measures and trends.

Provide patient education on risks of early delivery < 39 weeks

- Document in medical record discussion of risks early delivery at 36 0/7-38 6/7 weeks.

Confirm gestational age using ACOG criteria and document criteria utilized to establish GA

- US measurement ≤ 20 wks GA that confirmed or established due date
- FHT documented as present for 30 weeks by Doppler US
- 36 weeks since positive serum or urine HCG pregnancy test

An amniocentesis for fetal lung maturity should only be done if there is a medical indication that would support its performance.

- Document amniocentesis and lung maturity result in medical record if done.

Accepted medical/obstetrical indications for scheduled deliveries <39 weeks

- Abruption
- Previa
- Placenta accreta/increta/percreta
- Preeclampsia/eclampsia
- Fetal Anomaly
- Gestational HTN
- GDM with insulin or poor control
- Pre-gestational diabetes
- PROM
- Oligohydramnios
- IUGR
- Non-reassuring Fetal Status
- Isoimmunization with concern for fetal anemia
- Multifetal gestation with complication (Delivery of twin gestation at 38 weeks may be a reasonable alternative even in the absence of complications)
- Maternal medical condition—cardiac, pulmonary, GI, autoimmune, neurologic—with deterioration or worsened by pregnancy
- Acute fatty liver
- Cholestasis of pregnancy
- HIV infection (Delivery at 38 weeks considered standard and no lung maturity required)

For induction document:

- Cervical exam
- Informed consent

For cesarean document:

- Indication
- Informed consent

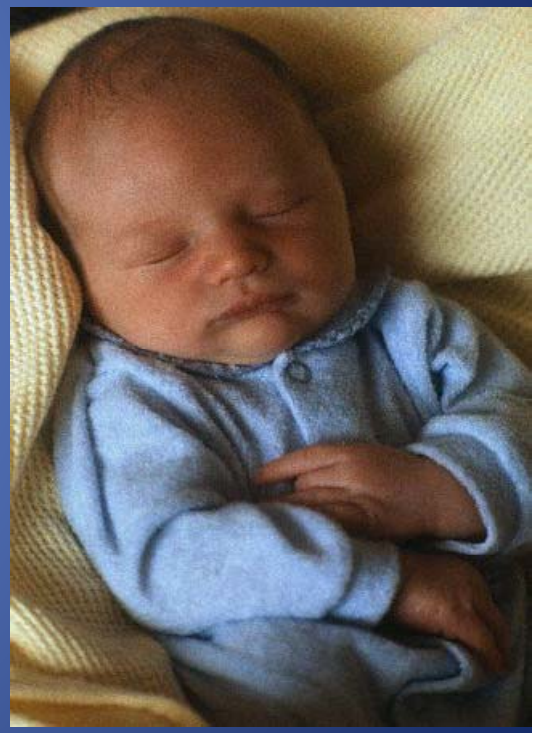
Guidelines for scheduled deliveries prior to 39 weeks gestation

- California Maternal Quality Care Collaborative (CMQCC) "Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age" toolkit http://cmqcc.org/resources/1974
- Quality Indicators/Benchmarks:
  - GA at delivery
  - Indication for delivery
  - Neonatal outcomes

Later Guideline Topics

- Chronic Hypertension in Pregnancy
- Diabetes in Pregnancy
- Preterm Birth Prevention Strategies
- Suggestions for other topics?

Discussion

Suggestions

Questions