Promoting Primary Vaginal Deliveries Initiative

Improving and Sharing Data

PROVIDE Collaborative Session Webinar

Partnering to Improve Health Care Quality
for Mothers and Babies

Welcome!

- **Please join by telephone to enter your Audio PIN on your phone or we will be unable to un-mute you for discussion.**
- If you have a question, please enter it in the Question box or Raise your hand to be un-muted.
- This webinar is being recorded.
- Please provide feedback on our post-webinar survey.

Agenda

October 11, 2018

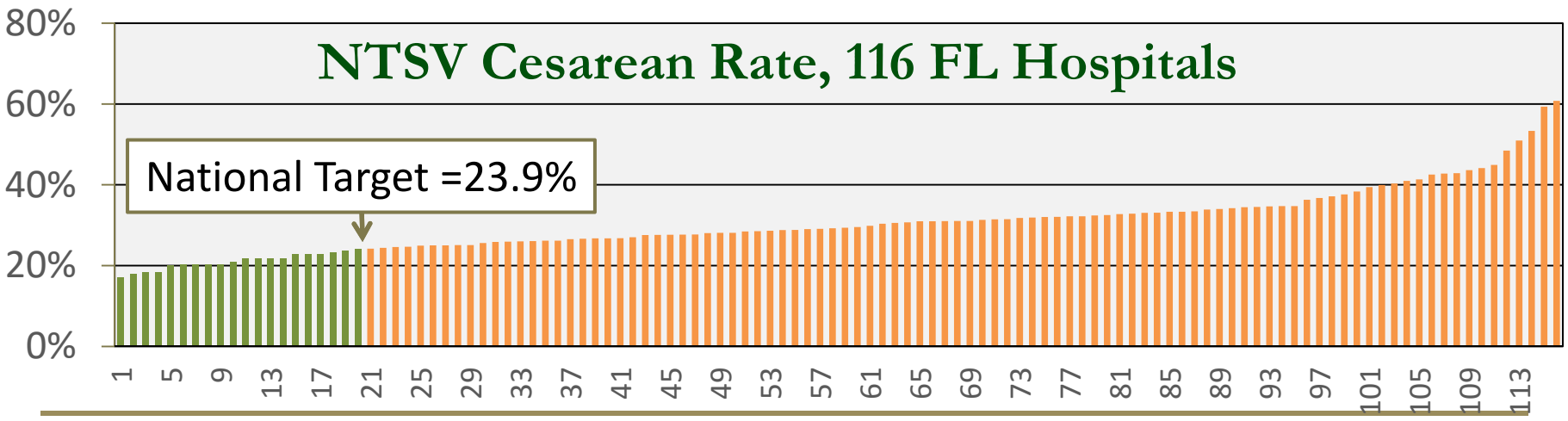
- Announcements
- Birth Certificate Accuracy: Why it is Important to PROVIDE—Estefania Rubio & Bill Sappenfield
- Experiences Sharing Provider Specific Cesarean Rates—Nancy Travis & Jane James
- Q&A

Update: New Medicaid Health Plans & NTSV Cesareans

- Florida Medicaid will have 12 new Medicaid Health Plan contracts starting around **Jan 1st**.
- New Health Plan contracts require plans to reduce their primary cesarean rates by 12% over 5 years.
- NTSV cesareans are the driver for primary cesarean rates.
- Each Health Plan will develop their own reduction strategies

Update: Hospital Recognition for Reaching the Healthy People 2020 NTSV Cesarean Rate Goal

- Florida Dept. of Health & AHCA Medicaid recently recognized hospitals at the Florida Hospital Association Annual Meeting.
- 17.2% or 20 Florida delivery hospitals met this goal in 2017.
- This will likely become an annual event.



Source: FL Vital Records, 2017

Partnering to Improve Health Care Quality for Mothers and Babies

Update: PROVIDE will be Extended & Expanded

- FPQC's Maternal Health Committee recommended that PROVIDE be extended for another 2 years.
- Other Florida hospitals will be interested in PROVIDE given the recent changes in Florida.
- 18 months time is not sufficient time for a hospital to reduce such a complex health care practice issue.
- Florida Department of Health has approved the recommendation.
- The new FPQC contract development process will begin soon.

Upcoming Webinar

Hold the date, invite providers:

December 13 at noon Eastern,

Dr. David Lagrew—Outpatient Cervical Ripening

FPQC

Partnering to Improve Health Care Quality
for Mothers and Babies

WEBSITE UPDATES

- Past webinars in archive with slides
- Slides from Mid-Project Meeting
- Round Robin ideas from Mid-Project Meeting

Labor Support Trainings

- October 22-23: Martin Health, Port St. Lucie
- October 29-30: Baptist Health, Homestead
- November 15-16: St. Joseph's Women's, Tampa
- *Registration opening soon for*:
  - December 9-10: Kendall Regional, Miami
  - January 10-11, 2019: Tallahassee Memorial
  - February 7-8: Sacred Heart Health System, Pensacola
  - March 28-29: Memorial Miramar

Birth Certificate Data Accuracy:
Why it is Important to PROVIDE?

PROVIDE outcome & balancing measures rely on the accuracy of key birth certificate variables.

Are there accuracy issues with the Birth Certificate?

1

A. Fetal presentation at birth: ___ Cephalic ___ Breech ___ Other *(Specify)*

- Birth certificate clerks at a hospital encountered a "Vertex" fetal presentation they decided to check "Other" because "Vertex" was not a birth certificate option.
- The clerks did not know "Vertex" = "Cephalic"
- More than 500 births were affected

Are there accuracy issues with the Birth Certificate?

2

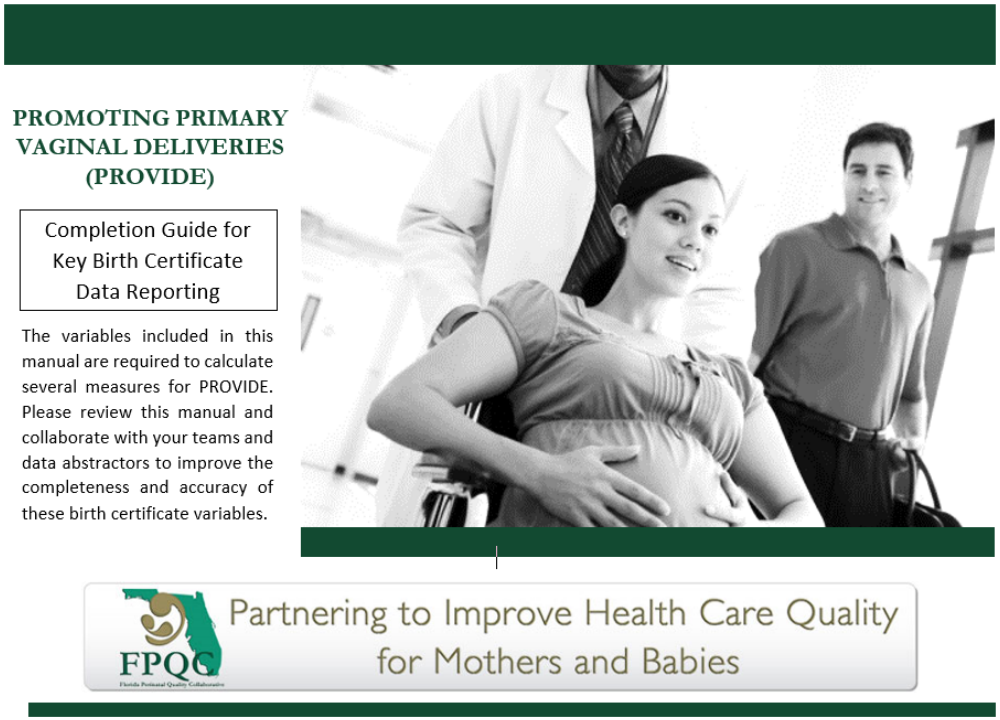
- One hospital with >2000 births/year reported **no inductions** during calendar year 2017
- NTSV agreement of induction on birth certificates compared with hospital discharges was problematic. 50% of **PROVIDE** hospitals had an agreement for inductions below 69%.
- Low agreement prevented **FPQC's** possibility of reporting NTSV induction rates

Are there accuracy issues with the Birth Certificate?

3

- NTSV agreement on delivery method (vaginal or cesarean) on birth certificates compared with hospital discharges was highly accurate: very useful for reporting NTSV cesarean rates.
- Only one hospital was below 96% agreement: They had low agreement at 80%

Available Birth Certificate Guide



INCLUDES:

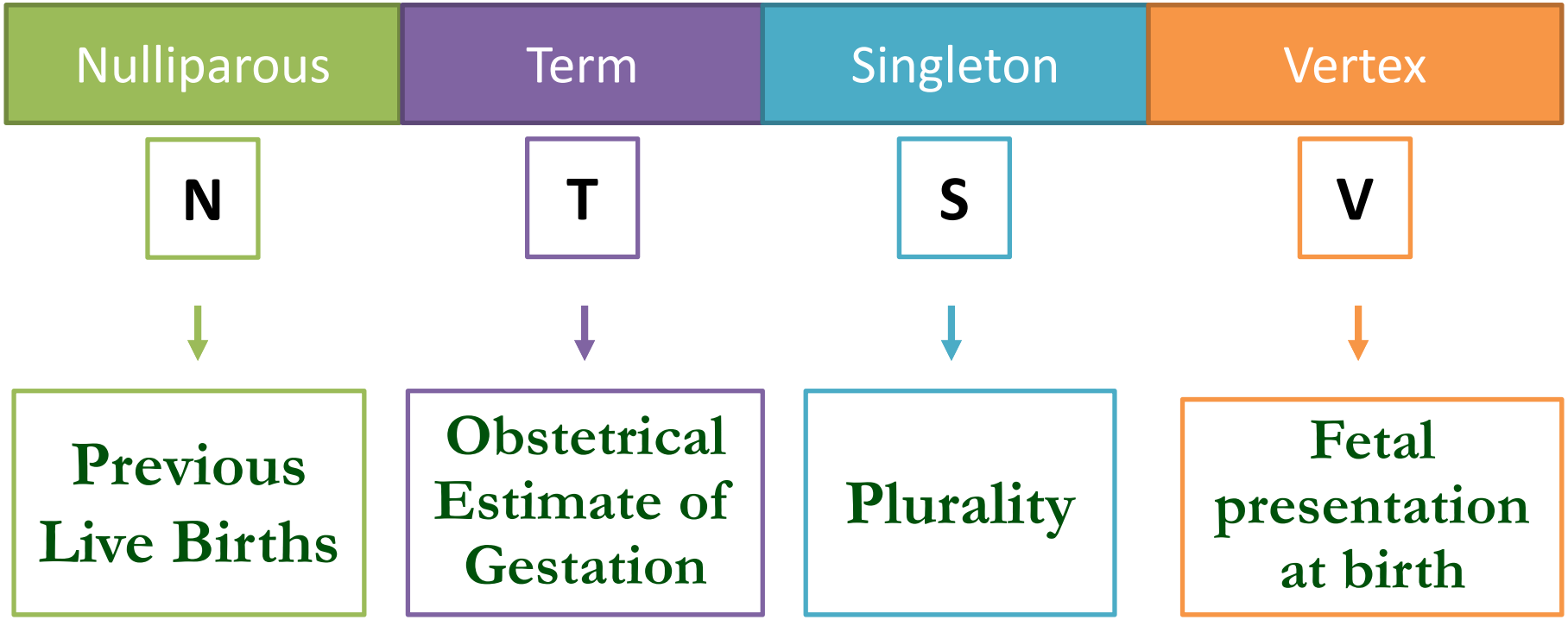
- ✓ Variable Definition
- ✓ Item Number in BC
- ✓ Tips for Entry
- ✓ Keywords and Abbreviations
- ✓ NCHS Recommended Source

If you have questions during the next few slides?

- Write and submit your question in the question box, or
- Raise your hand for us to unmute the line.

You must enter your **audio pin** if you have not already (find it in the audio section of the webinar control panel). On your phone, enter **<number>#**.

Birth Certificate Variables for NTSV



Previous Live Births

NUMBER NOW LIVING

Total number of **previous live-born infants** who are **still living**

- 1st Prenatal care record
- 2nd Labor and delivery nursing admission triage form
- 3rd Admission history and physical

NUMBER NOW DEAD

Total number of **previous live-born** infants who are **now dead**

- 1st Prenatal care record
- 2nd Admission history and physical

- **DO NOT** include this child
- **DO NOT** include abortions (spontaneous miscarriages or therapeutic or elective abortions), fetal deaths/stillbirths
- **Multiple Deliveries:** Include all live-born infants before this infant in this pregnancy

Previous Live Births

KEYWORDS

L–Now living

G–Gravida–Total number of pregnancies

P–Para–Previous live births & fetal deaths > 28 weeks of gestation

Obstetrical Estimate of Gestation

DEFINITION: The best estimate of the infant's gestational age in completed weeks based on the prenatal care provider's estimate of gestational age

SOURCE: OB admission H&P

- Ultrasound completed in the first trimester is preferred
- Determined by all perinatal factors and assessments but **NOT** the neonatal exam
- **NEVER** round up, enter number of completed weeks

e.g. infant is 36 weeks and 6 days, enter 36 weeks.

Plurality

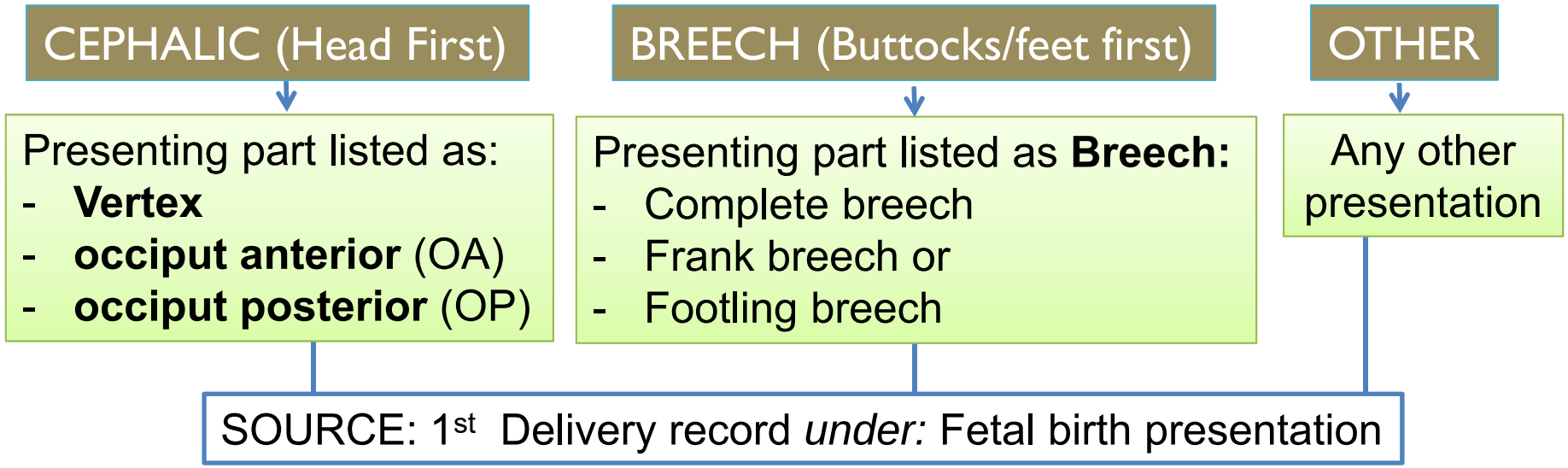
DEFINITION: number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age, or if the fetuses were delivered at different dates in the pregnancy

SOURCE:
1st Delivery record
2nd Admission history and physical (H&P)

- **DO NOT** count "Reabsorbed" fetuses (those that are not delivered: expulsed or extracted from the mother)
- **Select:** Single (1), Twin (2), Triplet (3), etc…

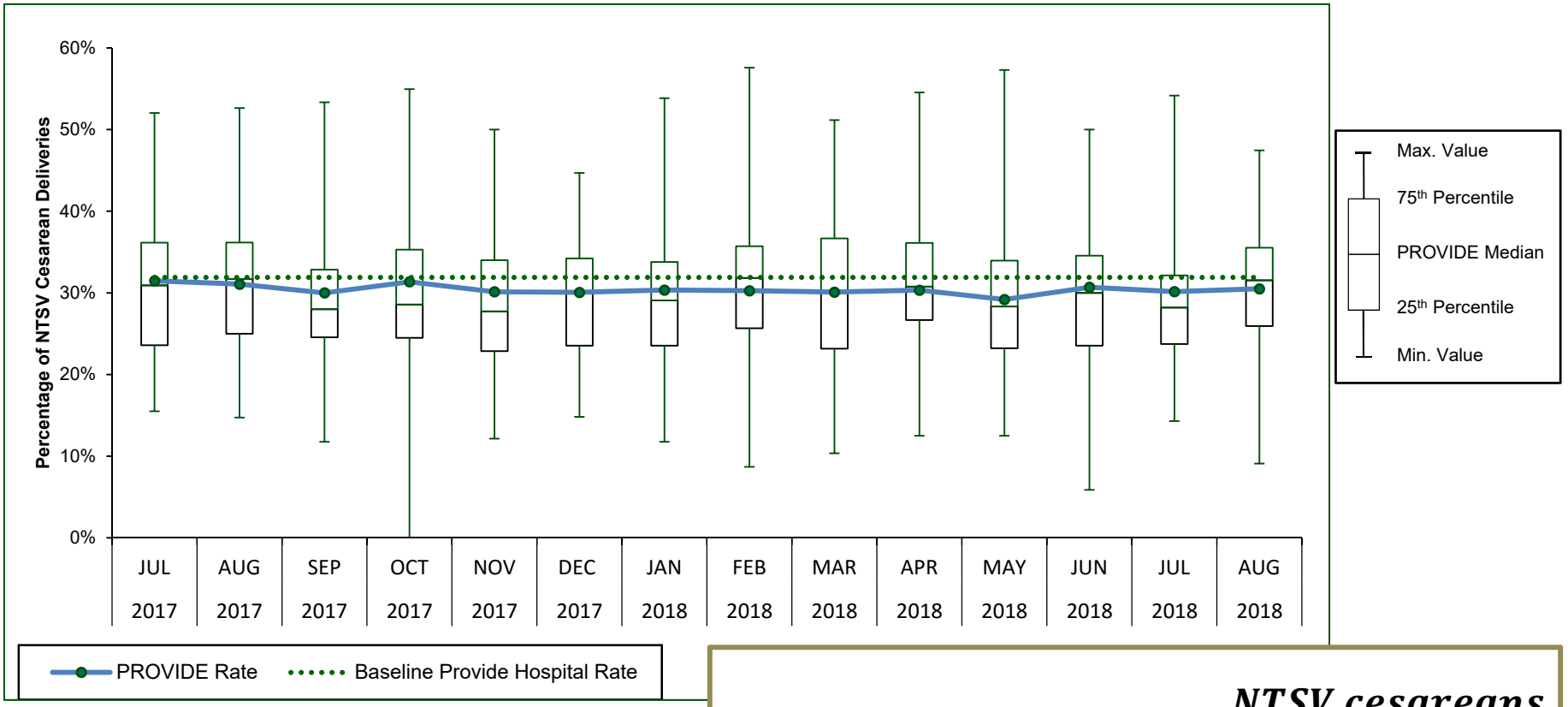
Fetal presentation at birth

Definition: part of the body of the fetus that is closer to the birth canal



- Check only the final presentation at birth

Percentage of Cesareans Among All NTSV Births For PROVIDE Hospitals, July 2017 to Aug 2018



$$\text{NTSV cesarean rate} = \frac{\textit{NTSV cesareans}}{\textit{NTSV births}}$$

Final route and method of delivery

VAGINAL

Delivery of the fetus through the vagina

Spontaneous

Forceps

Vacuum

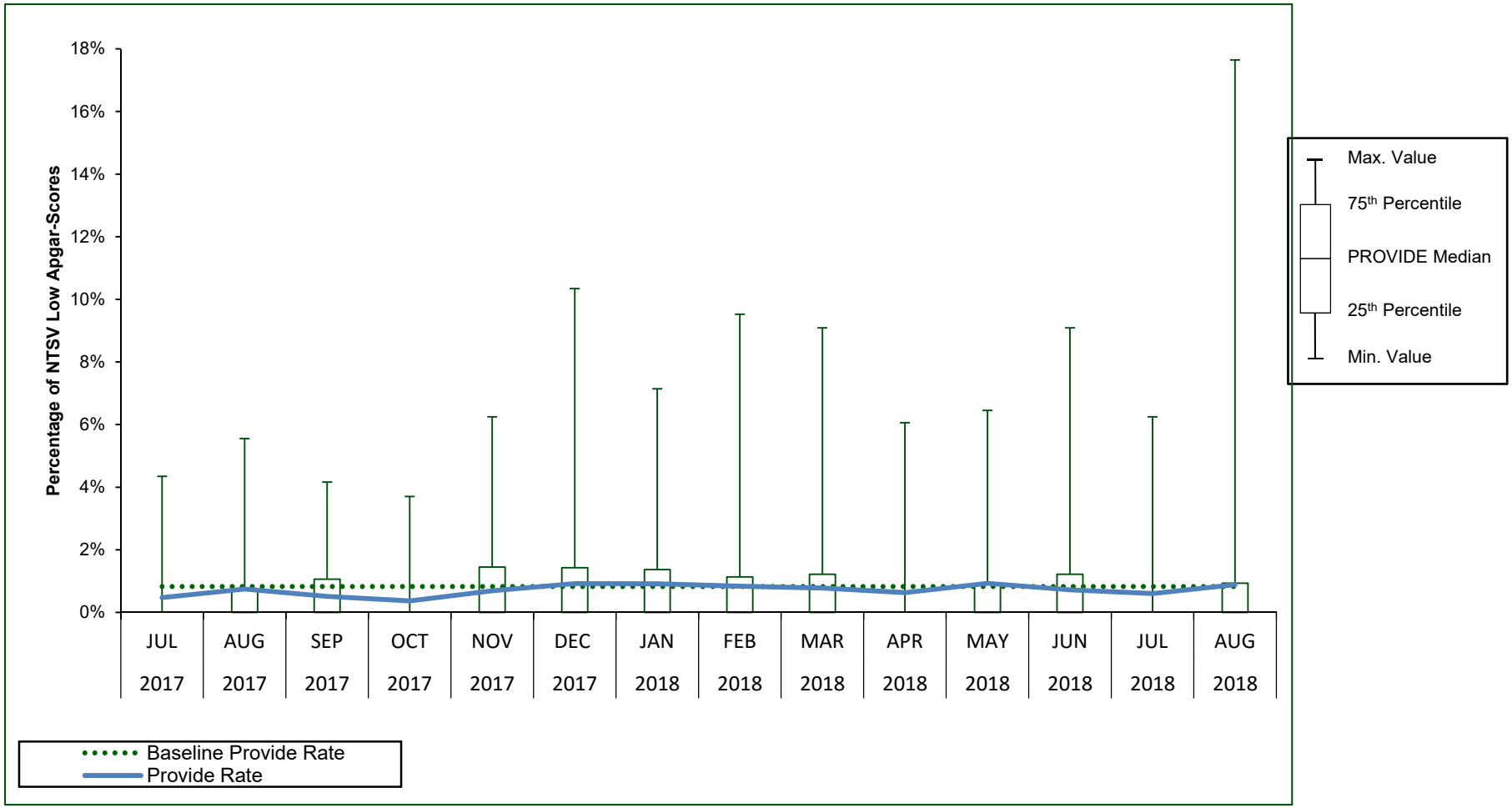
CESAREAN

Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls

SOURCES:

1st Delivery record *under:* Method of delivery
2nd Newborn admission H&P
3rd Recovery room record

Percentage of Low-Apgar Scores Among All NTSV Vaginal Births For PROVIDE Hospitals, July 2017 to Aug 2018



Apgar Score

DEFINITION: A quick assessment for evaluating the physical conditions of the infant at specific intervals following birth (1 minute, 5 minutes, and sometimes at 10 minutes)

SOURCE: 1st Delivery record *under*: Infant data

- Enter the infant's Apgar score **at 5 minutes**
- If the score at 5 minutes is less than 6, enter the infant's Apgar score at 10 minutes.

Extra Credit

Induction vs. Augmentation of Labor

INDUCTION OF LABOR

Initiation of uterine contractions by medical or surgical means **BEFORE** labor has begun

1st Delivery record
2nd Physician progress note
3rd L&D nursing admission triage form

AUGMENTATION OF LABOR

Stimulation of uterine contractions by medical or surgical means **AFTER** labor has begun

1st Delivery record
2nd Physician progress note

- Common medications and techniques:

  Oxytocin and Artificial Rupture of Membranes

- Check when labor began and select either one. **DO NOT mark both**

Induction vs. Augmentation of Labor

KEYWORDS

IOL – Induction of labor

ROM/NIL - Induction for rupture of membranes, not in labor

AROM–Artificial rupture of membranes

Sharing Provider Specific Cesarean Rates

What happens when data is transparent?

- Hospitals sometimes fear transparency on provider rates will upset their providers
- Some hospitals feel that having the data is a part of the improvement process
- Several reports on transparent rates for individual providers such as those in California, Colorado, Massachusetts and Virginia indicate that sharing the data and posting the data impacts rates positively
- Some will tell you that it helps to focus the team more on the overall goal and holds the team accountable

Does Sharing Data Impact Outcomes?

- Provider attitudinal differences are associated with NTSV cesarean rates. Those meeting the HP2020 goal hold attitudes more favorable towards vaginal birth.

Do provider birth attitudes influence cesarean delivery rate: a cross-sectional study, Emily White VanGompel, Elliott K. Main, Daniel Tancredi and Joy Melnikow. *BMC Pregnancy and Childbirth*2018**18**:184 https://doi.org/10.1186/s12884-018-1756-7

To cut its C-section rates, TriHealth focused on raising physician awareness by publishing each OB-GYN's rate every month in a blind fashion. Upon seeing this data, physicians with high rates questioned their practices and found ways to reduce instances of C-sections, such as allowing mothers more time in labor. As a result of these efforts, TriHealth's C-section rate decreased from 36% to 24.6% in just two years.

4 Ways Hospitals and Health Systems Can Reduce Cesarean Section Rates
By: Kshipra K
Date: June 19, 2018
https://www.healthcarebusinessinsights.com/blog/cost-quality/4-ways-hospitals-health-systems-can-reduce-cesarean-section-rates/

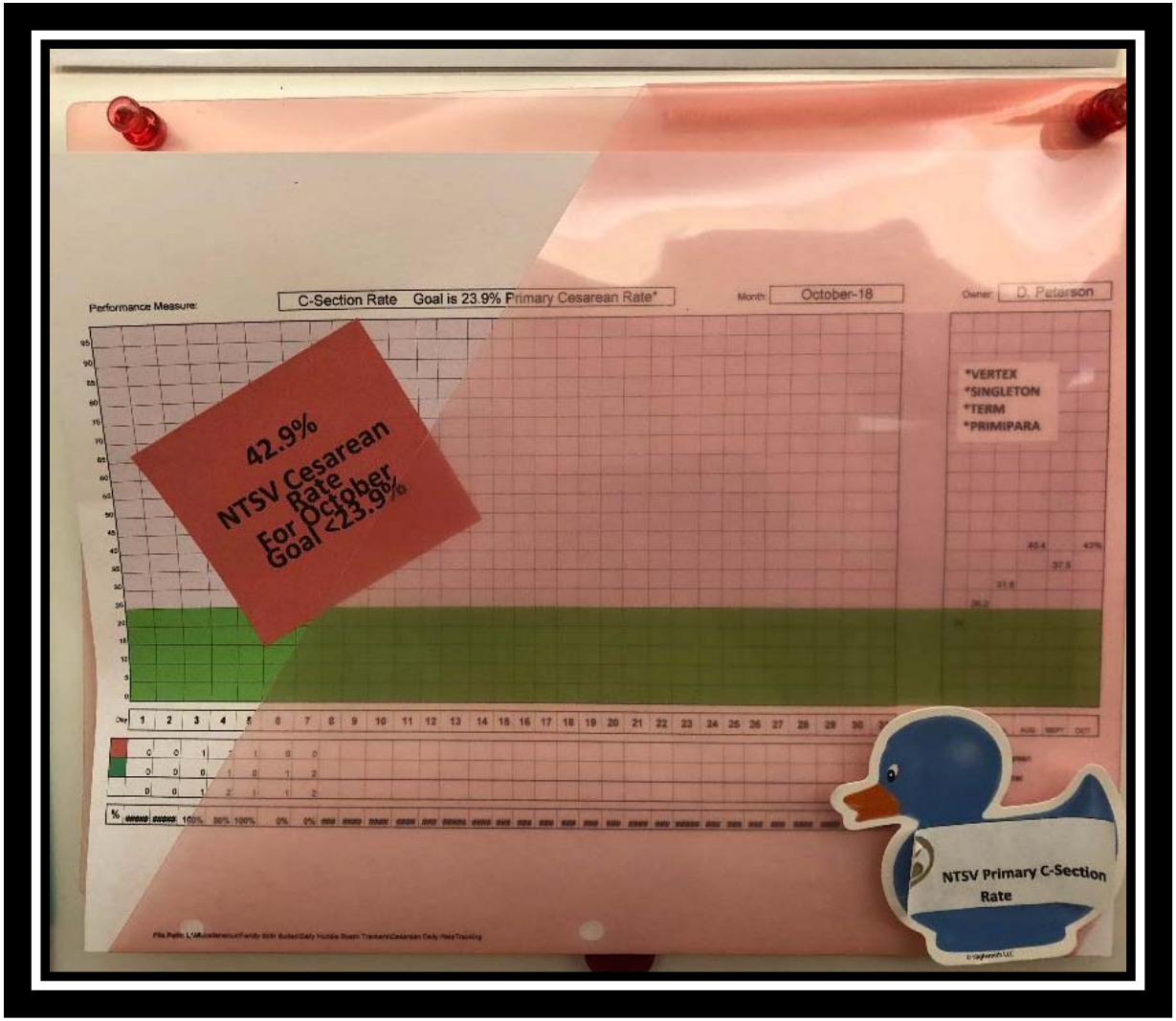
Lee Health Cape Coral Hospital

Nancy Travis, MS, BSN, RN,BC

Daily

- Data is updated Monday to Friday on the Huddle Board
- Green Folder is meeting goal
- Red Folder is not meeting goal

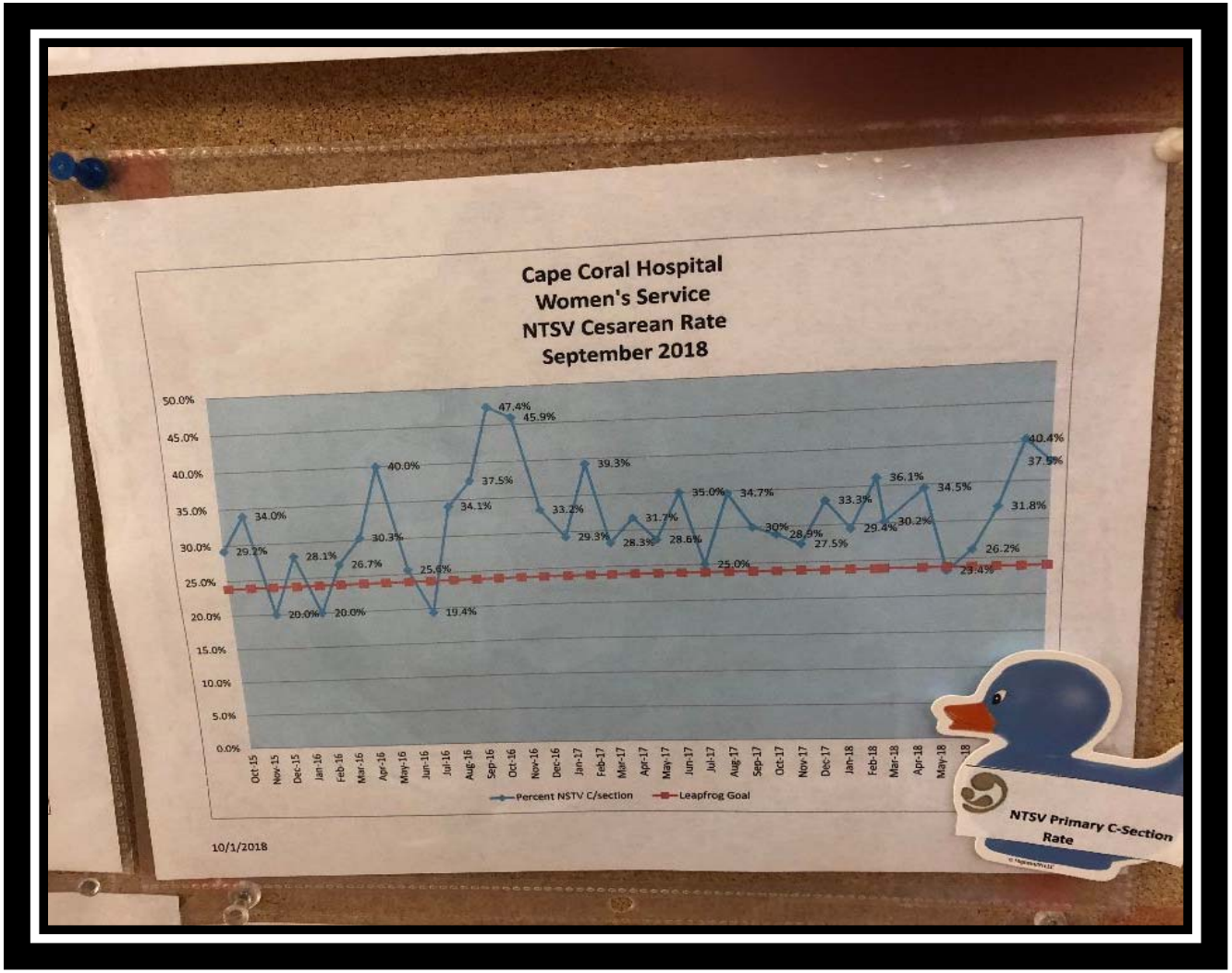
Huddle Board Tracker



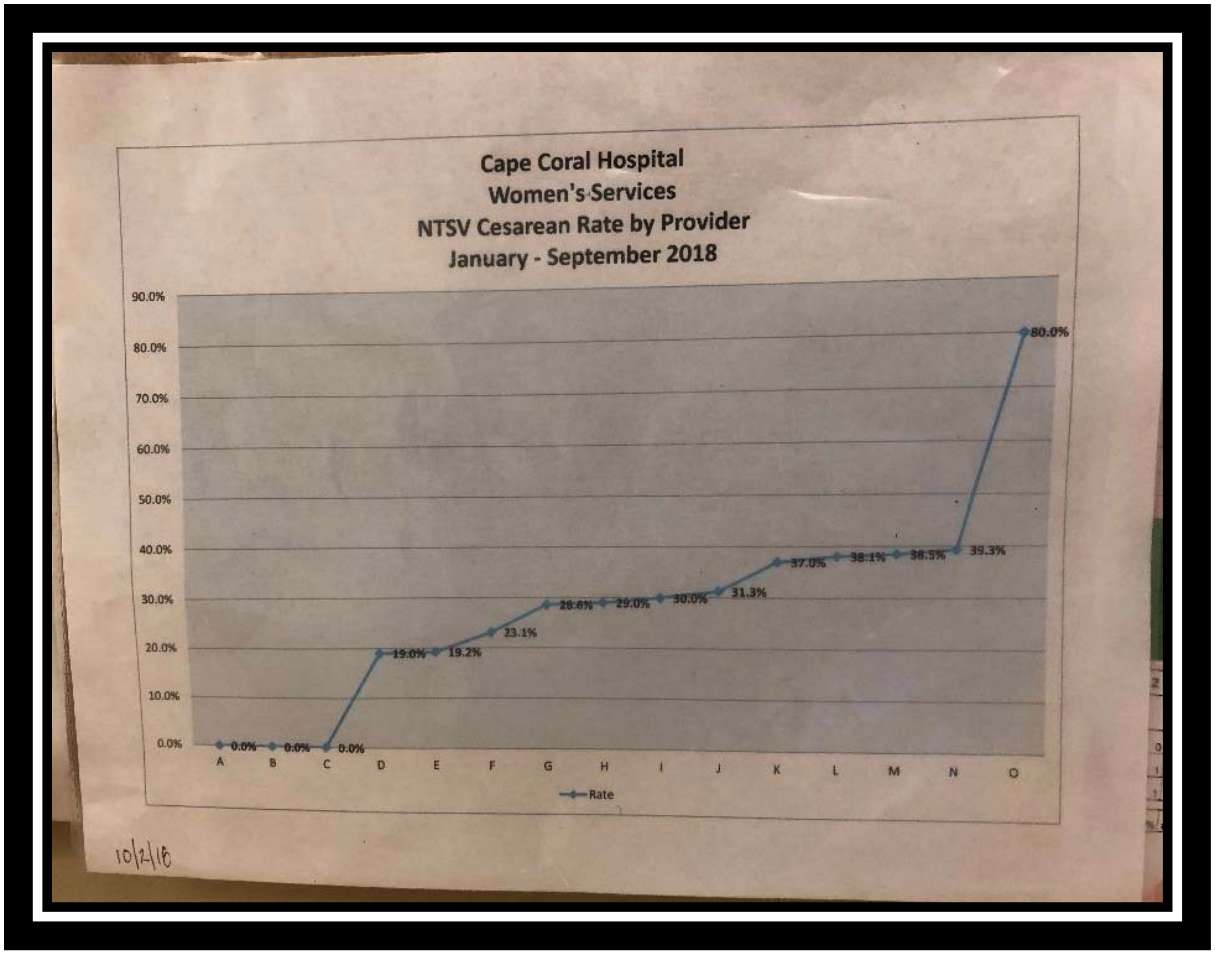
Monthly

- Monthly Statistics up on Unit's Key Performance Indicator Board
- Unit Specific Rate
- Physician Blinded Rates on KPI Board

KPI Board


Cape Coral Hospital
Women's Service
NTSV Cesarean Rate
September 2018
50.0%
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18
29.2% 34.0% 20.0% 28.1% 20.0% 26.7% 30.3% 40.0% 25.6% 19.4% 34.1% 37.5% 47.4% 45.9% 33.2% 29.3% 39.3% 28.3% 31.7% 28.6% 35.0% 25.0% 34.7% 30% 28.9% 27.5% 33.3% 29.4% 36.1% 30.2% 34.5% 29.4% 26.2% 31.8% 40.4% 37.5%
Percent NSTV C/section
Leapfrog Goal
10/1/2018
NTSV Primary C-Section Rate

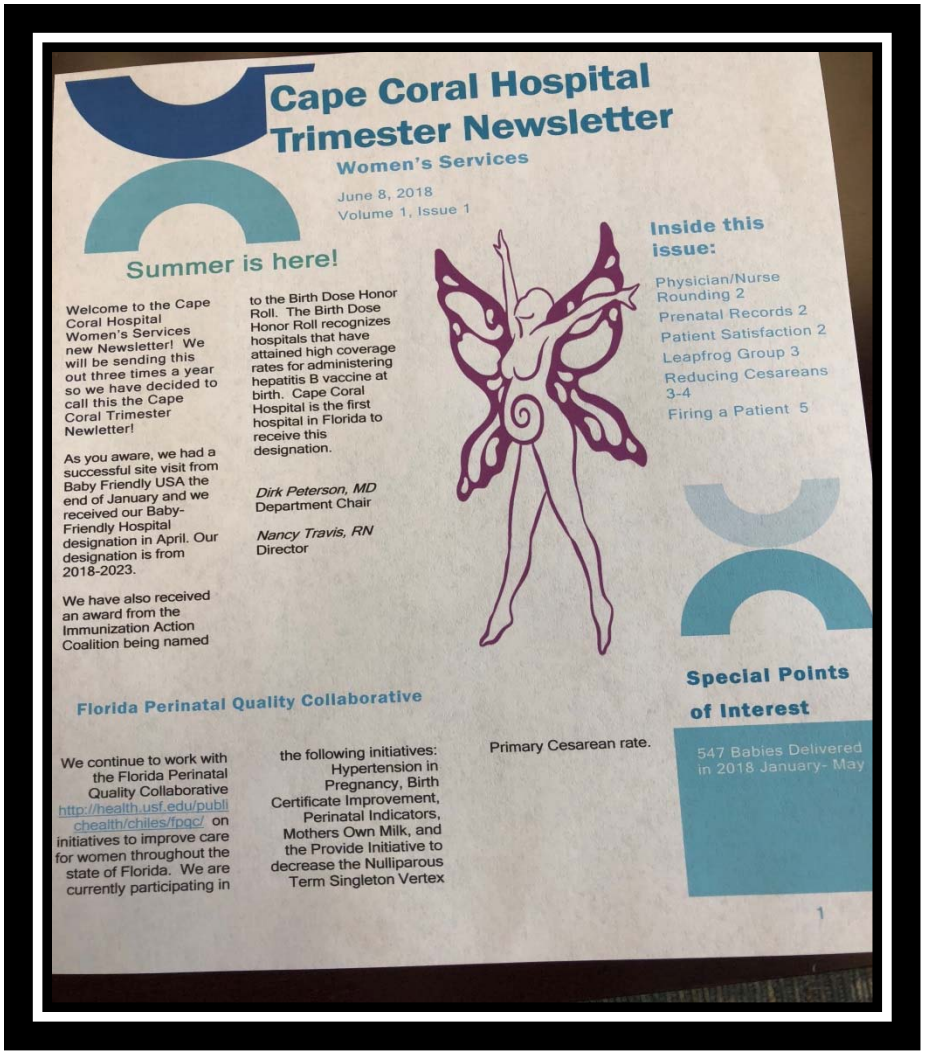
KPI Board


Cape Coral Hospital
Women's Services
NTSV Cesarean Rate by Provider
January - September 2018
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
0.0%
0.0%
0.0%
19.0%
19.2%
23.1%
28.6%
29.0%
30.0%
31.3%
37.0%
38.1%
38.5%
39.3%
80.0%
A
B
C
D
E
F
G
H
I
J
K
L
M
N
O
Rate
10/2/18

Quarterly

- Newsletter sent to all providers
- Individual Rates given to providers
- Group Rate for practice
- Unit Rates

Quarterly Newsletter



Cape Coral Hospital Trimester Newsletter

Women's Services

June 8, 2018
Volume 1, Issue 1

Summer is here!

Welcome to the Cape Coral Hospital Women's Services new Newsletter! We will be sending this out three times a year so we have decided to call this the Cape Coral Trimester Newletter!

As you aware, we had a successful site visit from Baby Friendly USA the end of January and we received our Baby-Friendly Hospital designation in April. Our designation is from 2018-2023.

We have also received an award from the Immunization Action Coalition being named to the Birth Dose Honor Roll. The Birth Dose Honor Roll recognizes hospitals that have attained high coverage rates for administering hepatitis B vaccine at birth. Cape Coral Hospital is the first hospital in Florida to receive this designation.

Dirk Peterson, MD
Department Chair

Nancy Travis, RN
Director

Inside this issue:

Florida Perinatal Quality Collaborative

We continue to work with the Florida Perinatal Quality Collaborative http://health.usf.edu/publichealth/chiles/fpqc/ on initiatives to improve care for women throughout the state of Florida. We are currently participating in the following initiatives: Hypertension in Pregnancy, Birth Certificate Improvement, Perinatal Indicators, Mothers Own Milk, and the Provide Initiative to decrease the Nulliparous Term Singleton Vertex Primary Cesarean rate.

Special Points of Interest

547 Babies Delivered in 2018 January- May

Quarterly Statistics

Cape Coral Hospital Women's Services Unit Statistics

Year	Total Deliveries	Primary C-Section Rate	Total C-Section Rate	NTSV Cesarean Rate Goal: 23.9% or less	Episiotomy Rate Goal: 5% or less	Exclusive Breastfeeding Rate Goal: 55% or greater
2018	547	22.1%	34.4%	30.72%	4.42%	65.5%

Your Group

Year	Total Deliveries	Primary C-Section Rate	Total C-Section Rate	NTSV Cesarean Rate Goal: 23.9% or less	Episiotomy Rate Goal: 5% or less	Exclusive Breastfeeding Rate Goal: 55% or greater
2018		%	%	%	%	%

XXX , MD

Year	Total Deliveries	Primary Cesarean Section Rate	Total Cesarean Section Rate	NTSV Cesarean Rate Goal: 23.9% or less	Episiotomy Rate Goal: 5% or less	Exclusive Breastfeeding Rate Goal: 55% or greater
2018		%	%	%	%	%

Meetings with Outliers

- Department Chair and Nursing Director meet with outliers quarterly

Mount Sinai Medical Center Miami Beach, Florida

Jane C. James, MSN/Ed, RNC

- Biggest C-section risk is the hospital --the culture of the hospital (most women choose their OB before the hospital)
- Hospitals have a culture that is made up from people and systems
- We are trying to improve the cesarean culture by looking at the systems and people

Elements for Improvement

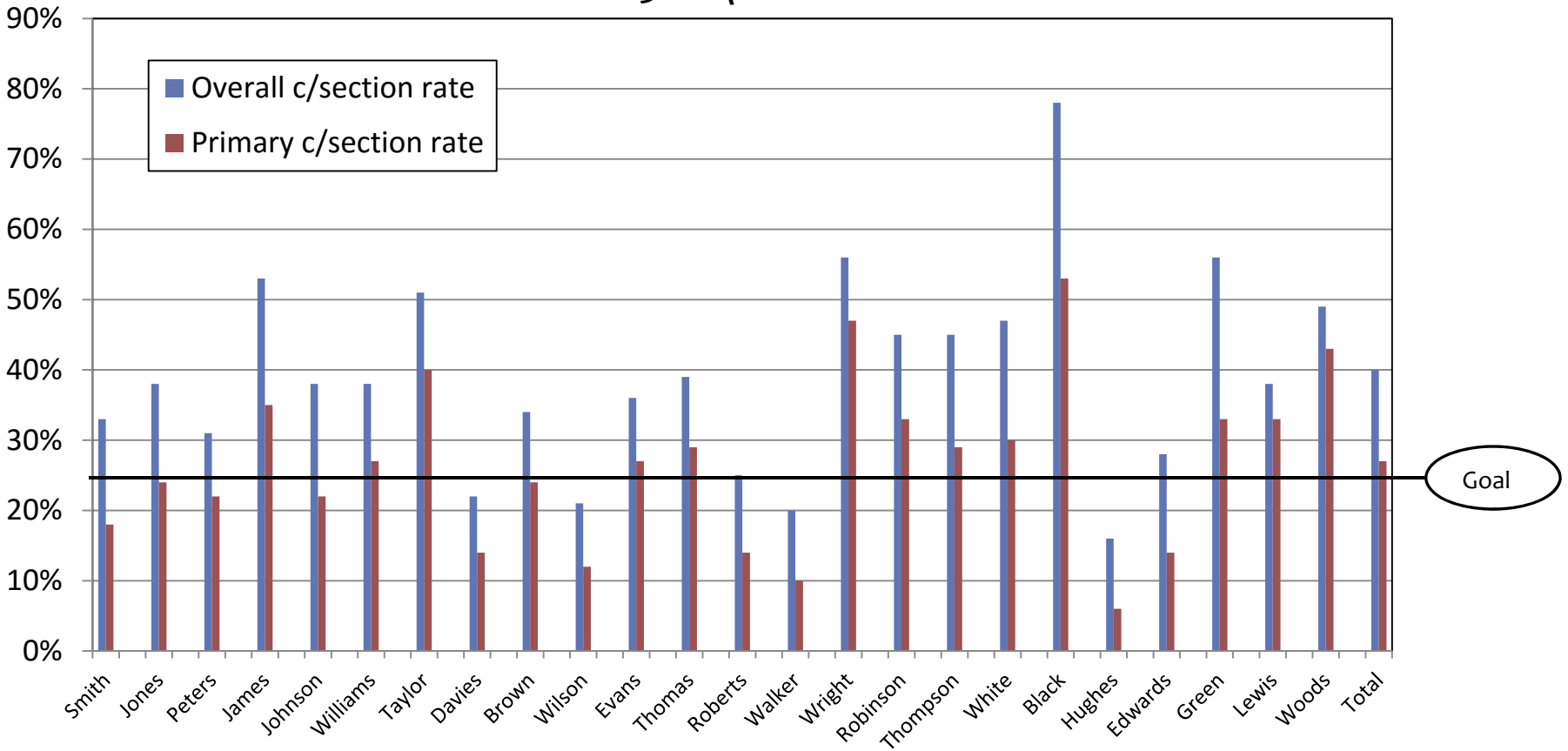
- Data collection
- Looking at patterns, trends
- Education
- Adjusting policies and practices

. Improvements

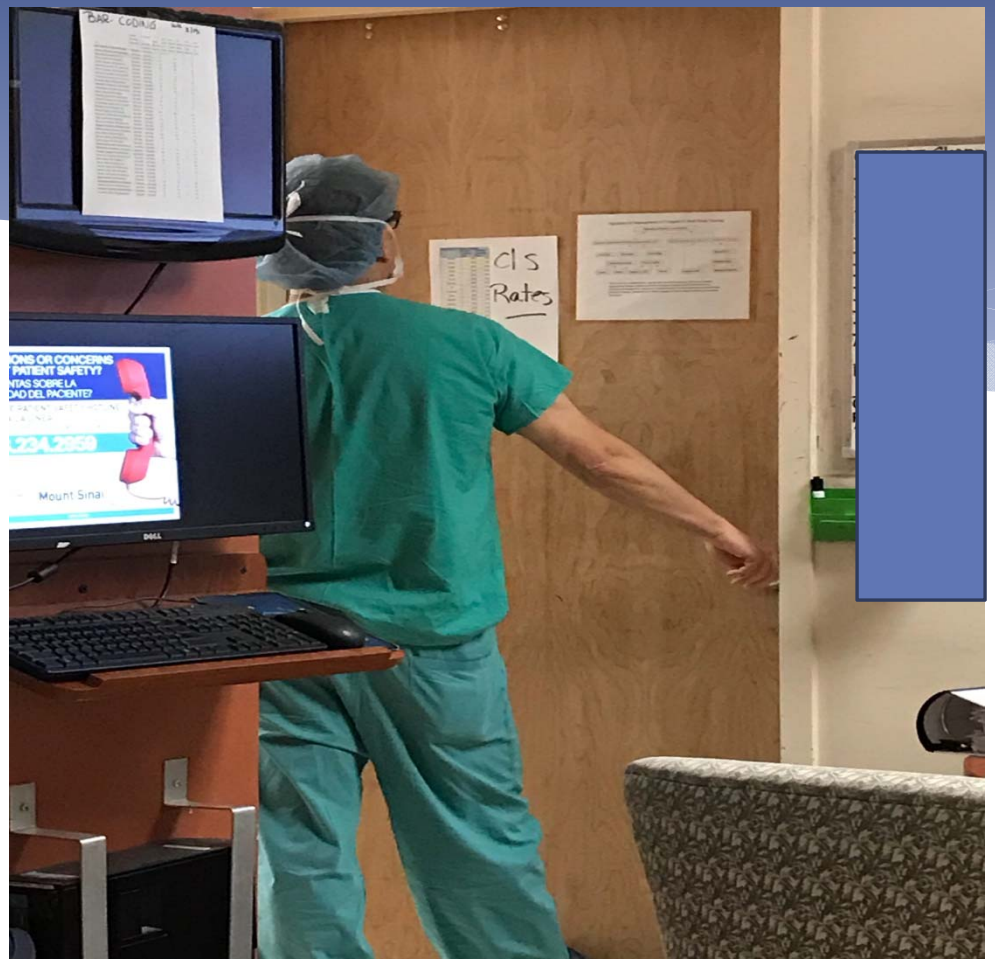
- Data collection-
  - Working with our EHR, for cesarean information and labor information

- Looking at patterns, trends
  - Time of day
  - HCP
  - Nurse

Cesarean Rate By HCP
3rd Quarter 2016

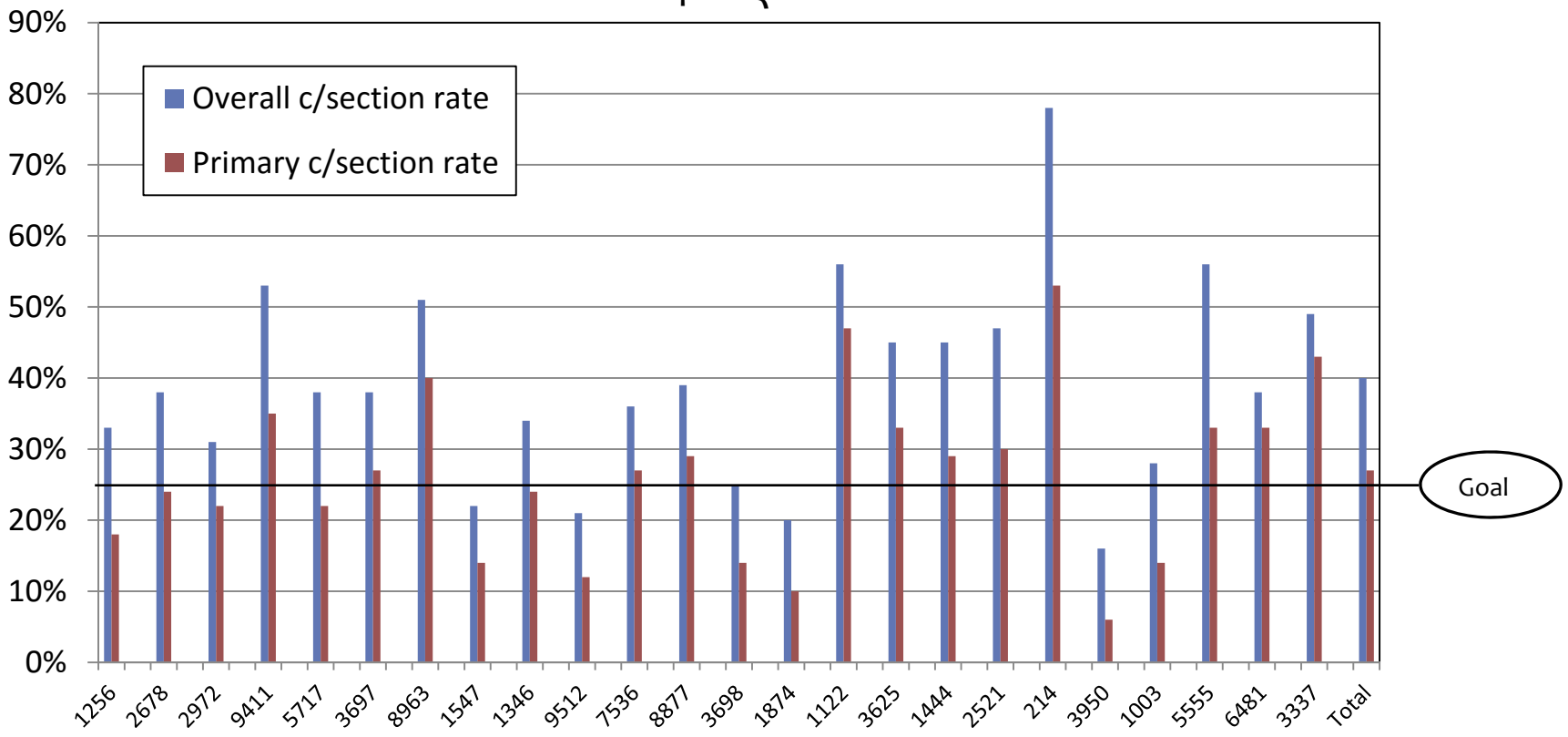


Not actual



“Dr ###### sure is studying this list hard…. for the past 20 minutes ??”

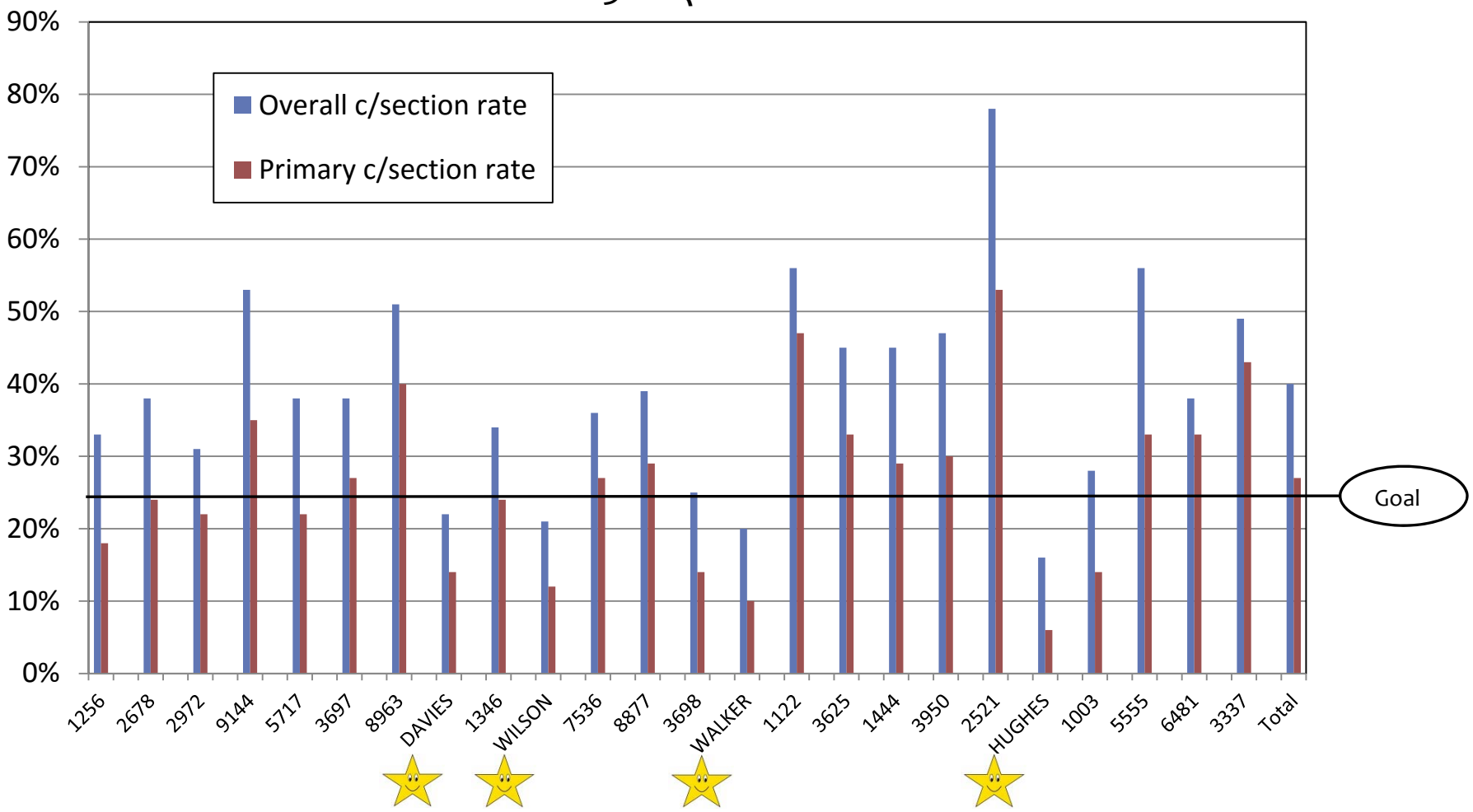
Cesarean Rate By HCP
4rd Quarter 2016

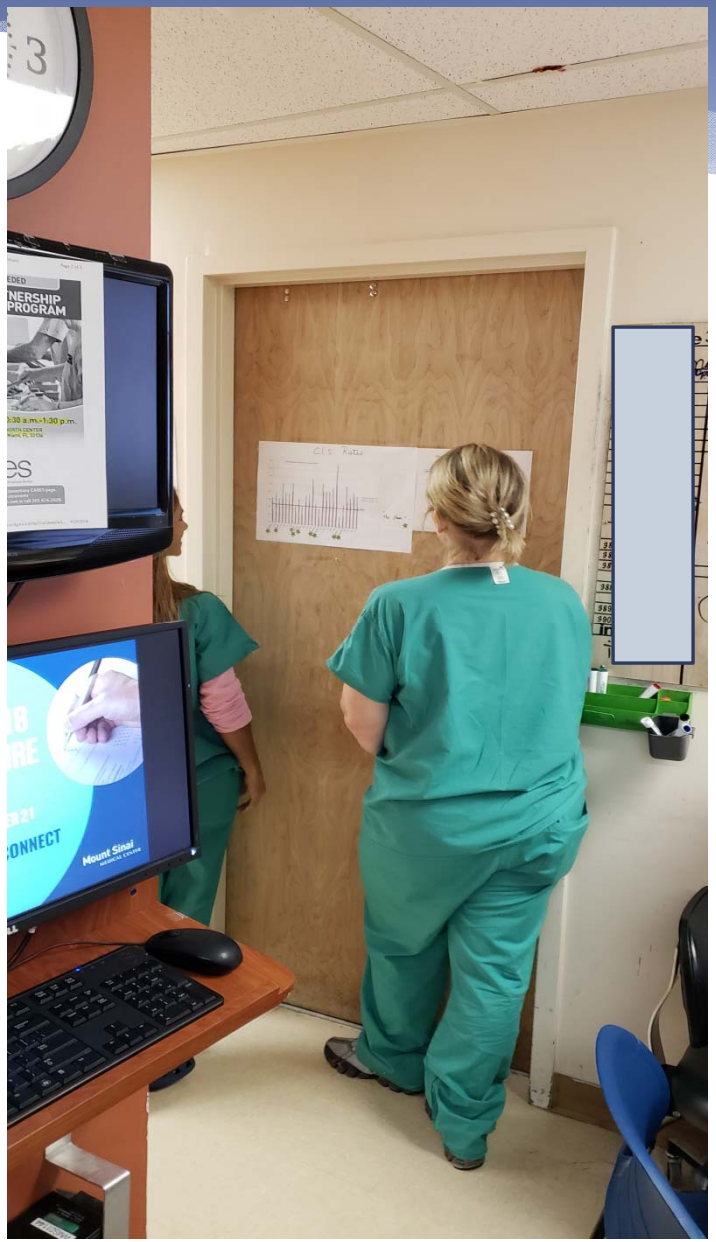


Posted under physician #

no one interested

OUR SHINING STARS




NERSHIP
PROGRAM
Mount Sinai

- 5 HCP's with highest cesarean rate were individually called in to meet with CMO and OB chief
- Nursing labor support education
- Peanut ball, lots of Peanut balls

We all know $$$ talks……

So I was happy to receive this.

UnitedHealthcare
Community Plan
PO Box 30449 Salt Lake City, UT 84130-0449

Aug. 28, 2018

Re: We Have a New Cesarean Delivery Reimbursement Policy, Effective Oct. 15, 2018

Dear Care Provider:

Unnecessary Cesarean births can be dangerous for both the mother and the unborn child. Therefore, to help keep our members safe, beginning **Oct. 15, 2018**, we'll implement a new Cesarean Delivery Policy. This policy, which will apply to claims with dates of services on or after Oct. 15, 2018, will reduce reimbursement by 20 percent for cesarean deliveries performed for claims that don't have a supporting diagnosis code.

Who This Affects
This policy applies to claims submitted for UnitedHealthcare Community Plan members on both paper form CMS-1500 and Electronic Data Interface (EDI) transaction 837P claim files.

What This Means to You
If you submit a claim for a cesarean delivery, it must include one of the ICD1- diagnosis codes included in the list for us to pay the claim at the full reimbursement rate for the following CPT codes: 59510, 59514, 59515, 59618, 59620 and 59622.

If you don't include one of the diagnosis codes listed within the reimbursement policy, your claim will be paid at a 20 percent reduction of the allowable amount.

For this policy, we're using the ICD-10 diagnosis codes list defined by the Joint Commission National Quality Measures that supports cesarean deliveries. You can find The Joint Commission National Quality Measures diagnosis embedded within the Cesarean Delivery Reimbursement Policy, located at UHCprovider.com/FLcommunityplan > Reimbursement Policies.

We're Here to Help
If you have questions about this policy, please call Provider Services at the number listed on the back of the member's ID card. Thank you.

Sincerely,

Stanley S. Lynch, Jr., M.D., F.A.A.P., M.M.
Chief Medical Officer

Still Working On/Challenges

- More Education for all: patients, nurses, and physicians
- Policy change and buy in
- ARRIVE Trial

We are on the road, moving slowly, but hopefully moving forward…I think we are still an egg.

It may be hard for an egg to turn into a bird: it would be a jolly sight harder for it to learn to fly while remaining an egg.
~C. S. Lewis

Oklahoma Medicaid

Beginning in January 2011 and continuing over the subsequent 8 months through August 2011, every contracted OHCA in-state provider & hospital that performed a minimum of 2 SoonerCare deliveries per month received a letter with their primary C-section rate and total C-section rate every month. After August, 2011, rates have been reported quarterly.

SoonerCare Rates	SFY 2009*	SFY 2015	SFY 2016	SFY 2017
Total C-Section Rate	32.16%	31.3%	30.9%	30.0%
Primary C-Section Rate	20.3%	16.0%	15.6%	15.5%

*Rates prior to Cesarean Section Quality Initiative

Conclusions: The cesarean section rate can be safely reduced by interventions that involve health workers in analyzing and modifying their practice. Our results suggest that multifaceted strategies, based on audit and detailed feedback, are advised to improve clinical practice and effectively reduce cesarean section rates. Moreover, these findings support the assumption that identification of barriers to change is a major key to success.
(BIRTH 34:1 March 2007)

Evidence-Based Strategies for Reducing Cesarean Section Rates: A Meta-Analysis
Nils Chaillet, PhD, and Alexandre Dumont, MD, PhD

Cesarean birth rates were stable in the baseline period from 1980 through 1988 at 24% to 25%. Introduction of the Perinatal Data Center outcomes system was associated with a reduction to 21% at the first hospital with no change in the control hospital. Subsequent introduction of the system 3 years later in the control hospital resulted in a decline from 25% to 20.5%. After merger of the two obstetric units and the institution of "open label" feedback, an additional decline to 18.5% was observed.
Conclusion: Physician practice patterns and cesarean birth rates can be altered with the intensive use of comparative outcome data and strong physician leadership. Nonblinded, intradepartmental distribution of outcomes is an even more effective tool.

Reducing Cesarean Birth Rates With Data-driven Quality Improvement Activities
Elliott K. Main, MD ***Pediatrics*** **1999;103:374–383.**

Partnering to Improve Health Care Quality
for Mothers and Babies

Q & A

Nancy: Nancy.travis@leehealth.org

Jane: jane.james@msmc.com

- If you have a question, please enter it in the "Chat Box" or "Raise Your Hand" to be un-muted.
- We can only unmute you if you have dialed your Audio PIN (shown on the GoToWebinar side bar—enter you PIN plus #).
- Other questions: FPQC@health.usf.edu