Maternity Care in California: Opportunities for Collaboration and Transparency

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California Maternity Overview (2013)

- ~475,000 annual births (1/8 of all US births) in ~260 maternity hospitals
- Nearly 50% of births are paid for by Medi-Cal
- Race/Ethnicity: Hispanic 49.1%, White 27.6%, Asian/PI 15%, and Af Am 5.7%
- 22.7% of women start pregnancy with BMI >30 (obese)
- 40% are having their first birth
- 33.2% total Cesarean rate, similar to the US (more details on this later)

*(Preliminary data from CMQCC, pending final statistics from the Department of Public Health)*
Important Maternity Issues for California

- High rates of early elective deliveries
- High rates of low-risk, first-birth Cesarean-sections
- Limited access and low rates of vaginal birth after Cesarean (VBAC)
- High rates of serious maternal complications (and death) from hemorrhage and preeclampsia
- All measures are significantly worse for African American women
What Is CMQCC?

- Multi-stakeholder and multi-disciplinary organization dedicated to improving maternity care in California. Our collaborators include:
  - State agencies: CDPH, DHCS (Medi-Cal), OSHPD
  - Providers: OB/GYN, Nurses, Midwives, Fam Prac
  - Hospitals: Cal Hospital Assoc, Hospital Quality Inst, hospital systems
  - Public: March of Dimes, Consumers Union, others
  - Health Plans, purchasers
  - Quality experts
What CMQCC Does

- Turn data into action!
- Maternal mortality reviews
  - Focus on safety opportunities
- Report and benchmark maternity quality measures for California hospitals
  - Use measures as a tool for improvement
- Quality improvement to scale:
  - Implementation projects targeting all 260 maternity hospitals
- Success requires collaboration
Changing Medical Practice

- Not easy to change practice patterns
- Need to break the status-quo, provide a reason to change
- Opportunities for collaboration: Lots to learn from nursing and midwifery practice
- Public reporting (transparency) is important but not enough
- Need multiple pressures from multiple angles (collaborative action)
- Let’s examine early elective delivery, a highly successful change in practice
Early Elective Delivery Success:

Target: <5%

Collaborative Action

- Provider Leaders
- Public Health Agenda
- Public Advocates
- Quality Measures
- Transparency
- Public Reporting
- Quality Improv. Toolkits
- Strong Evidence
- Baseline Rate = 13.5%
- Payment Incentives
Early Elective Delivery Success:

Collective Impact

- State at Target of 5%
- Provider Leaders
- Public Health Agenda
- Public Advocates
- Quality Measures
- Quality Improv. Toolkits
- Strong Evidence
- ~65% Reduction in CA!
- Payment Incentives
- Transparency

Required in some states, but not in California

~65% Reduction in CA!
CMQCC Maternal Data Center

- Mother/baby data from every CA hospital
  - Active members: Data are 45 days old
  - All others: Data are 9-15 months old
- Generate quality measures
  - Benchmarking, trend data
  - Tool for improvement, drill down analysis
- Transparency
  - Key hospital measures publically reported (CHART, CalQualityCare.org)
  - MD and midwife measures used internally
CMQCC Maternal Data Center

Discharge Diagnosis File (ICD9 codes)

Birth Certificate File (Clinical Data)

Upload every MONTH from active or every six months for all hospitals from OSHPD

Every MONTH: Upload electronic files for ALL CA births

CMQCC Data Center

CLINICAL DATA as needed for specific measures (electronic files or direct entry)

Immediately calculates all the measures

REPORTS
Benchmarks against other hospitals
Sub-measure reports
Analyses: Why is my rate high?

Support Data Improvement

Mantra: “If you use it, they will improve it.”
CMQCC Maternal Data Center

- Report on EVERY hospital in CA (except military)
  - >98% of births are in hospitals
- Data are only a few months old; not perfect, but great to drive quality improvement
- >30 performance measures, 14 data quality metrics, plus 20 hospital statistics including demographics
- Have not done birthing centers to date
  - Do not report to OSHPD and are very low volume
  - No reason that they could not report directly to CMDC, but need to identify hospital transfers
Unwarranted Variation Is Widespread

- **Every** measure shows large variation among hospitals and among providers
- Represent opportunities for improvement
  - Measures can be risk adjusted (where appropriate)
  - Peer comparison and peer pressure are very powerful
- Powerful argument for **transparency**
- **Collaborative** quality improvement is ideal to address large variation in care
Low-Risk First-Birth (Nulliparous Term Singleton Vertex) C-Section Rate
(Standard Cesarean rate: Joint Commission, LeapFrog, CMS)
Among 249 California Hospitals: 2011-2012 (CMQCC)

Extreme Hospital Level Variation!

Range: 10.0—75.8%
Median: 27.0%
Mean: 27.7%

National Target =23.9%

36% of CA hospitals meet national target

Pilot
Data-Driven Quality Initiative:
Nulliparous Term Singleton Vertex C-Sections

Pilot Hospital: PBGH / RWJ CS Collaborative

Keys for Success:
1. Evidence-based QI plan based on rapid-cycle data
2. Local leadership
3. Hospital-provider alignment
4. Modest incentives (shared savings)

National Target for NTSV CS = 23.9%

QI Project Started: Jan 16

NTSV CS Rate
Approach for Reducing NTSV Cesarean Birth:

Collaborative Action

- Provider Leaders
- Public Health Agenda
- Public Advocates
- Quality Measures
- Public Reporting
- Quality Improvement Toolkits
- Strong Evidence
- Payment Incentives
Approach for Reducing NTSV Cesarean Birth:

Collective Impact

- Provider Leaders
- Public Health Agenda
- CMQCC Projects
- Quality Measures
- Public Reporting

Transparency

- Public Advocates
- Quality Improv. Toolkits
- Strong Evidence
- Payment Incentives

↓CB
CalSIM: Maternity

- **Collaboration** between purchasers, plans, and providers around quality/cost=value
- **Transparency** of metrics (CMDC capture and report)
  - NTSV (first-birth) CS, VBAC rates, and Early Elective Del
  - Unexpected newborn complications (balancing metric)
- Implement CMQCC quality improvement project and toolkit for NTSV Cesarean reduction
- **Key partners**
  - Purchasers: CalPERS, Cover California, PBGH, DHCS
  - Health plans
  - ACOG (OBs), AWHONN (nurses), ACNM (midwives), CDPH regional programs
Maternal Mortality

- California Pregnancy-Associated Mortality Reviews
  - Under the auspices of the CDPH (Title V funding)
  - Identify both the leading causes of maternal mortality and the improvement opportunities

- Statewide QI projects for maternal safety
  - Obstetric Hemorrhage and Preeclampsia Initiatives
  - Multi-disciplinary (MD, nurses, midwives)
  - Many organization partners!
  - Roll out to EVERY CA hospital and provider
  - Collaboration is critical

- Significant improvements are already being seen
Conclusions

- Mother and baby outcomes are improving, but plenty still to work on!
- Important role for collaborative action
  - Engaging all disciplines
  - Engaging many organizations
- Collaborations require “constant gardening”
- We wish to thank the state agencies that are working on these projects with us and CHCF, and the CDC, which is funding the California Maternal Data Center