Transforming Maternity Care Blueprint for Action
Performance Measurement and Leveraging of Results

This document presents the content of the Transforming Maternity Care Blueprint for Action that addresses one of eleven critical focus areas. The complete Blueprint for Action can be accessed at http://transform.childbirthconnection.org/blueprint

Problems

Lack of nationally endorsed maternity care performance measures
The National Quality Forum (NQF) is a consensus-based entity that fosters performance measurement. Although the NQF has endorsed 24 measures that apply to maternity care, significant gaps remain for numerous crucial maternity topics. The generic Consumer Assessment of Healthcare Providers and Systems (CAHPS) facility, provider, and health plan surveys do not adequately address important dimensions of maternity care quality.

A comprehensive set of nationally endorsed maternity care performance measures is needed to assess patient experience, outcomes, and other dimensions of quality across the full episode of maternity care and in the various settings where care is received.

Problems with availability of performance measurement data
Many measures of interest for improving maternity care quality cannot be implemented currently because the data needed for measurement are not routinely and systematically collected, and collection would impose an undue burden. The current coding system was designed for billing and has shortcomings when used for performance measurement.

Problems with performance data reporting and use
Public reporting of currently endorsed performance measures is inadequate. Large-scale reporting of maternity care performance has been very limited. Reporting interfaces are not user friendly and comparison at the health professional level is virtually unavailable. The Centers for Medicare and Medicaid Services (CMS) has one of the best-developed public reporting programs through its Hospital Compare websites, but these are Medicare focused, limited to data on hospitals, and do not include maternity care. There is wide variation in performance reporting among states.

Currently endorsed maternity measures focus especially on facilities. This makes it hard to encourage clinician accountability and to help women choose caregivers wisely. Clinicians and facilities generally lack reliable and trusted feedback about their own performance, or the performance of other clinicians and facilities, which can foster quality improvement.

Current maternity measures are not stratified by race/ethnicity, insurance status, socioeconomic status, and language to aid in measuring and reducing disparities, and none directly assess disparities. Many are not risk adjusted, making interpretation of comparisons difficult.
For key measures such as cesarean section and VBAC rates, there is controversy about appropriate threshold rates. *Healthy People 2010* has established target cesarean and VBAC rates, and the United Nations recommends a cesarean rate range of 5% to 15%. However, the national cesarean rate reached 31.8% in 2007, and maternity professionals frequently reject targets or ranges. Some reporting systems exclude cesarean rates entirely on the grounds that an optimal rate is not known. Despite the need to move toward an optimal range and reduce harm and expense associated with current trends, existing reporting systems do not give childbearing women and other stakeholders needed guidance.

Childbearing women have not been actively engaged in defining maternity measures that are of greatest interest to them or in testing existing performance reporting systems, which greatly reduces the likelihood that they will see, understand, and use reporting systems.

**System Goals**

- A robust, comprehensive system for performance measurement and reporting with mechanisms for ongoing monitoring and refinement improves the quality and outcomes of maternity care.
- Performance measurement and reporting are grounded in best evidence.
- Measures are widely applicable and balanced across key criteria. Measures employ appropriate design and analytic methods to ensure fair comparisons of performance and illuminate disparities in risk, outcomes, and health care delivery across populations.
- There is broad stakeholder participation in the development, implementation, and reporting of maternity care performance measures.

**Major Recommendations and Action Steps**

1. Fill gaps to attain a comprehensive set of high-quality national consensus measures to assess processes, outcomes, and value of maternity care; care coordination; and experiences of women and families.
   - Support development, testing, and refinement of priority measures to submit to the NQF.
   - Address crucial topical gaps, which include informed decision making, VBAC, comfort measures and pain relief, serious perineal tears, postpartum hospital practices that impact attachment and breastfeeding, and persistent physical and emotional problems that arise in the postpartum period. Include measures of undisturbed, physiologic childbirth, including adaptation of the U.K. “Normal Birth” measure to the United States, to foster appropriate care for low-risk women.
   - Extend quality improvement provisions of the Child Health Insurance Program Reauthorization Act (CHIPRA) of 2009 to childbearing women and newborns covered by Medicaid and CHIP. This model includes processes for identifying priority maternity care performance measures, building the performance reporting infrastructure, improving and expanding the original measures, assessing and reporting progress, and developing a model electronic health record (EHR) format.
   - Develop and implement CAHPS Maternity adaptations of the generic CAHPS Provider, Health Facility and Health Plan surveys to facilitate measurement and reporting on the range of maternity care providers, settings, and care experiences, including pain/comfort and medication use.
• Stratify measures that have been endorsed by the NQF by race/ethnicity, socioeconomic status, insurance, and language, consistent with guidance in NQF’s National Voluntary Consensus Standards for Ambulatory Care: Part 2 report (NFQ, 2009), which describes methods to address health care disparities that could be adopted for perinatal measures.

• Create an ongoing structure and process for identifying consumer advocates with leadership potential and provide them with training and ongoing support to maximize their effectiveness as participants in the performance measurement process, following the model of the National Breast Cancer Coalition’s Project LEAD.

2. Improve availability and ease of collection of standardized maternity care data, both to encourage high-quality clinical care and to allow performance measurement and comparison.

• Establish a uniform dataset of maternity care variables and a standard data dictionary. Include items needed for provision of high-quality clinical care and its coordination across sites and professionals, as well as data needed to fill in priority gaps in existing maternity care performance measures. Work in concert with those identifying and developing priority measures. Obtain input from the American Association of Birth Centers and Midwives Alliance of North America, who have made extensive progress on developing uniform maternity datasets.

• Ensure harmonization of the uniform maternity care dataset with federal mandates regarding development of EHRs and interoperable health IT systems to limit collection burden.

• Bring National Center for Health Statistics and state representatives together to review the contents of the U.S. Standard Certificate of Live Birth. Evaluate its potential contribution to maternity care performance measurement and priority modifications for that purpose, and its relationship to evolving health IT. Carry out state pilot studies to test ways to optimize integration of birth certificate data, other available data, and health IT for performance measurement and other aims.

• In the short term, improve the availability and collection of administrative billing data to measure quality of care and reward performance in critical areas of clinical care. Engage the American Medical Association to convene a multi-stakeholder group to review Current Procedure Terminology (CPT) codes for maternity care. Ensure coding modifications to facilitate claims-based identification of individual prenatal visits, induced labor, scheduled cesarean sections, mothers’ parity, and gestational age of the newborn.

• Eliminate confusion caused by current fragmented data collection and nonstandardized reporting by various payors. Establish uniform requirements for maternity care data collection by providers and facilities. Create a national data registry that is administered and housed by a government or private national quality improvement entity.

3. Create and implement a national system for public reporting of maternity care data to all relevant stakeholders so that it can be leveraged to improve maternity care.

• Identify a core subset of national consensus measures for rapid reporting. Include intrapartum hospital care in this initial set, because measures addressing this phase of care are already endorsed and it is about five times as costly as the prenatal and postpartum segments and poses many opportunities for quality improvement.
• Determine the most efficient, effective performance reporting interfaces, and mechanisms, for all stakeholders. Performance reporting is needed for health professionals and facilities (to learn and compare own performance with peers), for consumers (to make informed choices), for public and private purchasers (for value-based purchasing), for policy makers (for oversight and need for policy action), and for researchers (diverse aims).

• Begin implementation with pilots to identify barriers to wholesale implementation that may result due to administrative variation across and within systems, and scale up to a standard, systemic reporting program.

• Extend CHIPRA quality improvement provisions related to health IT development and dissemination to childbearing women and newborns to support public reporting and assessment. Involve the target user groups in developing and testing the relevant interface(s), especially Medicaid programs in which systematic data analysis across all 50 states is particularly challenging.

• Explore ways for health systems to report performance data compiled from de-identified vital statistics and hospital discharge data to clinicians and hospitals, to provide feedback on their performance so that they can improve their systems of care.

• Ensure collection and reporting of standardized performance data for providers of out-of-hospital childbirth care, even if not fully electronic, to assess quality and serve as a benchmark for appropriate, physiologic care for low-risk childbearing women.

• Learn about best reporting practices from successful programs such as the Northern New England Perinatal Quality Improvement Network (NNEPQIN) or the European Union’s PERISTAT project.

• As an interim step until a national registry can be developed and implemented, call upon payors to report performance measurement data to providers in a uniform format so that feedback from payors as well as from facility discharge data enables action to improve outcomes of care.

4. Use reported maternity care performance data to develop initiatives that foster improvement in the quality and value of maternity care at each level and throughout the system.

• Encourage the development of state or regional quality collaboratives that bring hospitals, clinicians, consumers, and payors together to share ideas, pilot projects, and develop and carry out quality improvement initiatives. Engage existing quality collaboratives to provide consultation and guidance to start-up groups.

• Create demonstration projects sponsored by health plans and state and local health departments to test the impact of performance measures on pay for performance (P4P), audit and feedback, public reporting, and other quality improvement strategies.

• Encourage all entities responsible for certification and recertification of maternity care professionals to adopt quality measures for maintenance of certification similar to the exemplary Performance Improvement Modules of the American Board of Internal Medicine. Call on the National Committee for Quality Assurance and The Joint Commission to use maternity performance measurement in accreditation and certification programs.

• Create mechanisms for sharing and benchmarking clinician-level best practice data. Learn from current models such as the well-established NNEPQIN and their
OBNET birth registry to identify strategies for benchmarking to support quality improvement.

- Engage a quality improvement organization, academic institution, or other suitable entity to develop and publicize an inventory of maternity care quality improvement reports and of systematic reviews that assess the effectiveness of quality improvement strategies. Make a comparative analysis of existing programs using audit and feedback and other quality improvement strategies.
- Use performance data to generate a quality improvement and comparative effectiveness research agenda for maternity care.

Lead Responsibilities
Maternity care measures should be developed collaboratively with input as relevant from public and private purchasers, all clinical specialties, all types of maternity care delivery settings, consumers and advocates, quality collaboratives, researchers, and measurement experts.

Institutional, technical, and financial support for the measure development, implementation, and reporting processes should be provided by health care delivery systems, payor-purchaser groups, clinicians and health professional organizations, quality collaboratives and organizations, health IT organizations, researchers, government agencies, private foundations, and consumers and advocates.

Reference