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Coming Soon To a Hospital Near You: 17 Perinatal Quality Standards

The National Quality Forum has endorsed 17 perinatal standards to measure and improve quality of care. So what are these new measures and how might they change patient care. You are listening to a special focus on the future of medicine on ReachMD XM160, The Channel for Medical Professionals. I am Bruce Japsen, the healthcare reporter with the Chicago Tribune and with me today is Maureen Corry. She is the executive director of Childbirth Connection. Interval, Ms. Corry leads a National Not-For-Profit Organization founded in 1918 as the Maternity Center Association. As Childbirth Connection, the group promotes safe, effective, and satisfying evidence-based maternity care and is a voice for the needs and interest of childbearing families. Maureen has 30 years experience as a researcher, educator, advocate on maternal and infant health promotion and maternity care quality improvement. She joined Childbirth Connection as the executive director in 1995 and has played a leading role in positioning the group as a powerful and effective advocate for improving the quality of maternity care.

BRUCE JAPSEN:

Maureen Corry, welcome to ReachMD XM160, The Channel for Medical Professionals.

MAUREEN CORRY:

Thank you, Bruce. Nice to be here.

BRUCE JAPSEN:

Well, its good to have you again and I want to just say if you could tell us a little bit about the (**01:30**) Childbirth Connection and how these 17 perinatal standards came to be because I think you would probably agree there might a long time incoming and a lot of providers and consumers probably just don't know anything about them.

MAUREEN CORRY:

That's right. Well, first of all going back to Childbirth Connection, as you said, our mission is to promote safe, effective, and satisfying maternity care and about 2 years ago, we actually revised our mission statement to focus on our mission as improving the quality of maternity care through research, education, advocacy, and policy and it was about that time 2 years ago that we were paying a lot of attention about the national efforts, particularly out of Washington to improve the quality of healthcare in general and we were very impressed with the work of the National Quality Forum, who is very much involved in improving the quality of American Healthcare.

What they do is they set national priorities and goals for performance improvement and they endorse national consensus standards for measuring and public reporting on performance and then they promote the attainment of the national goals through education and outreach and we were struck by the excellent work that they had done, but we also recognized that there was a void in terms of maternity care meaning that there was no standardized consensus development process set of measures to evaluate the quality of perinatal care and there is an old saying that says you know, "What's not measured does not improve." So, we joined the National Quality Forum and at that time, we were one of the few voices (**03:00**) speaking on behalf of childbearing women and families and we got involved in the consumer council of the National Quality Forum and there are about 20 other national organizations that are part of that consumer council and again we were the only voice for childbearing women and families. Then one day we learnt that the Hospital Corporation of America had funded a new project at NQF to develop the national consensus standard set of perinatal care measures and I was fortunate to be nominated and chosen to be a co-chair of the National Perinatal Steering Committee and that committee met, its probably over a year ago now and typically what they do is they call for nominations from members of the Steering Committee and they choose a multidisciplinary group of people that represent all the stakeholders that care about the particular issue. In our case it was perinatal care and they send out a call to measure developers, people across the country that spend their lives developing performance measurement and testing them and reporting on them and measure developers submit various measures, in this case related to perinatal care for consideration by the Steering Committee and the Steering Committee seriously looks at each one of the measures that have been submitted by the measure developers and holds them up to a set of standards that are set by NQF and then decides among those measures that have been submitted which ones meet the NQF standards and which ones they recommend to (**04:30**) the Board of NQF to be endorsed.

BRUCE JAPSEN:

Well, and if you could, tell us, I mean this is very important because, you know, I have a 7-year-old daughter. Our listeners out there have children or thinking about children, and when you think about having a baby and thinking about the fact that they really are not a standard set of measures on how children are taken care of when they are born, it's sort of shocking, isn't it?

MAUREEN CORRY:

It really is. As a dad you probably know that there are over 4 million births per year. In fact, I think there were over 4.3 million last year and its hard to believe that with childbirth being a leading reason for hospital admission and childbirth-related procedures accounting for the 5 most common procedures in patients age 18 to 44, that there wouldn't be performance measures that look at the quality of perinatal care and I think people recognize that without having the appropriate information about performance at hospital levels, whether its at the national level or at the local regional levels that its going to be hard to really work to improve the quality of care because efforts are unfocused and there's no relevant standards for improving, so because there's been relatively few standardized measures in the field of perinatal, it was one of the reasons why NQF wanted to create this project and where the Hospital Corporation, who is apparently the largest integrated healthcare system in the US and has thousands and thousands of births wanted to support this project and its really important as you said especially for consumers because consumers can use performance results to compare (**06:00**) and choose among providers, care settings, and health plans, for example, and purchasers meaning employers and Medicaid programs, for example, can use their buying power and performance results to get better care for beneficiaries and better value for their investment if they have performance measures and standards to look at and in addition healthcare providers can use the results to improve their own practice.

BRUCE JAPSEN:

If you could give us an example of some of the things that are measured and how perhaps the consumer or even a medical care provider would find these measures?

MAUREEN CORRY:

Sure. You are correct, Bruce, what you just said and I think coming from a consumer perspective especially its really important if I were a woman, who is either contemplating pregnancy or pregnant and looking for a healthcare provider or birth setting, I would want to see how my options stand up to one another and have a way of evaluating them before I chose a birth setting or a caregiver. So its very very important and you know these new measure sets and perinatal care really take a leap forward for maternity care quality improvement. One of the things that's important to understand is that right now, performance measurement is voluntary meaning that the providers in the hospitals can decide whether or not they want to collect and report on the measures, but there are financial incentives involved for hospitals that do report on NQF endorsed measures.

BRUCE JAPSEN:

And that would be basically if the insurance company might pay them more if they go along with perinatal measures from the National Quality Forum.

MAUREEN CORRY:

I don't know specifically if its health insurance would pay them more, (**07:30**) but I know the center for Medicaid and Medicare does and really the Center for Medicare and Medicaid is driving a lot of this change in the right direction by trying incentives and payment to reporting of performance measurements, so right now its not like a woman could go online and get access to all this information and because these new perinatal measure set is new, its going to be a while before hospitals and providers and provider groups start reporting on it, but over time in theory, this information will be available for anybody to go on to their computers and find out and compare outcomes, you know for the measures that are set.

BRUCE JAPSEN:

And could you give us some examples of these 17 measures, like what are they measuring that they didn't measure before?

MAUREEN CORRY:

Well, I think for the sake of this conversation I will focus on the ones that have the most impact on the largest population of childbearing women. One of the most significant is looking at measuring elective delivery prior to a 39 weeks completed gestation and that's really important because as you know, the C-section rate is rising, its up to about 32% in the United States and their concerns about babies that are born have elective deliveries prior to 39 weeks because they are more likely to have health problems as a result of being born too soon, so its important that they are collecting this information and it would be helpful to women to look at the rates of elective delivery in different hospitals and care settings prior to 39 weeks in terms of making a decision about where to give birth. The (**09:00**) other one is the incidence of episiotomy and that means a number of vaginal deliveries with episiotomy performed and we know now from the best evidence that episiotomies can be harmful when performed if they are not medically necessary and it's pretty rare that they would be medically necessary. So in order to encourage providers not to perform episiotomies, it's really important to have this measure on episiotomy.

BRUCE JAPSEN:

For our listeners out there, what are your doctors, other medical care providers, and <_____> the key, what's coming here is the fact that

the quality measurement movement is not going away and in perinatal care, which Maureen Corry and her group, the Childbirth Connection is involved in, what we are seeing here is that there is more measurement, more efforts to get the doctors and hospitals to be measured and 17 measures in perinatal care, that's not anything to just guff at. Is it?

MAUREEN CORRY:

No, not at all. In fact as they said before, it's a major step forward for quality improvement in maternity care and you know, let me say, its not the end in <_____>, the NQF quality measures focused on the third trimester through hospital discharge. So there's still in need for measures in the prenatal period and in the postpartum period and I think NQF and other organizations will be looking at measure development to make sure that the whole continuum of maternity care is covered, but right now to start of with a set of 17 measures is (**10:30**) fabulous and it's a step in the right direction. It is not a step, it's a leap forward I think.

BRUCE JAPSEN:

And how long has this been in the works and perhaps if you could give us an idea or another example of what's being measured?

MAUREEN CORRY:

Sure. The project itself started last February. It was completed fairly quickly within 7 or 8 months because I think everybody felt the urgency to get the work done. Another measure that was endorsed and approved is the cesarean rate for low-risk first birth women and again as I said to you before, the 32% C-section rate in this country is quite high and is rising every year.

BRUCE JAPSEN:

And that's for anybody?

MAUREEN CORRY:

Ya. That includes, you know, both low-risk and high-risk women, but the reason why its important to know about cesarean rates for low risk first birth women is to help women make a decision about where they want to give birth because if you are a healthy childbearing woman and fortunately most job bearing women are healthy and most women want to avoid a C-section unless its absolutely medically necessary. So if I were pregnant and I wanted to avoid a C-section, I would want to look at and compare hospital cesarean rates for low-risk first birth women because that would give me an indicator of where am I to choose to give birth. So for example, I might choose a hospital with the lowest rate for cesarean low-risk women.

BRUCE JAPSEN:

With that, I would like to thank Maureen Corry who has been our guest. She is the executive director of the Childbirth Connection and we have been talking about something that will be coming to our hospital near you and other childbirth centers the effort to measure perinatal care (**12:00**) and for more information and to look for this coming, check out the quality forum website atwww.qualityforum.org.

My name is Bruce Japsen. I am at Chicago Tribune and I have been your host and Ms. Maureen Corry has joined us from the Childbirth Connections office in New York City. For information about this show or any other program, please visit our website at www.reachmd.com, which features our entire library through on-demand podcasts or call us toll free with your comments and suggestions at 888-639-6157 and I would like to thank you today for listening.

Thank you for listening to ReachMD on XM160 and this month's special series Focus on Future Medicine.

Welcome to Doctors Digest, a feature of ReachMD radio on XM160. Doctors Digest, bridging the gap between the business of medicine and the practice of medicine. A lot has been written about physician burnout. How to recognize the signs and symptoms and how to get back on track? What are the best courses to avoid burnout in the first place? Here's 5 tips from the experts: (1) Be clear about what you want. For example, if you were told early in your career you would need to do research and publish in order to succeed, decide whether research in publication really interests you. If not, set them aside and focus instead on direct patient care as a room calling. For some physicians, success means being an owner of partnered group. For others, it comes from working part time or changing jobs several times over the course of the career (13:30). Decide what you really want and go for it; (2) Try teaching or mentoring many physicians you teach whether the medical students or the residents, find that teaching helps them enjoy their careers. Teaching offers a chance to get back to the profession. It can also keep you up with changes in the profession as one expert points out – most medical schools and residency programs are begging for volunteers; (3) Get out of the office. Physicians who get out of town occasionally to attend meetings and network with their peers, claim they come home refreshed, invigorated, and eager to put what they have learnt into practice; (4) Stay positive. Don't surround yourself with people who have negative attitudes. One way to be positive is to focus on treating your patients the way you would want your own family treated rather than focusing on meeting job quotas. One doctor says thank you notes from his patients on a down day, he gets them out and reads them to remind himself of the value of his efforts; (5) Volunteer. Although physicians never seem to have enough free time, our studies show that about two-thirds of all survey doctors had participated in at least one public role in the past 3 years. Possibilities are endless. Coaching a kid Socrating, volunteering a church or temple, running for school board, helping out at a charity event. This is a great way to find a balance between work and life.

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