2021 Performance Measures

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Objective

• Review 2021 Performance Measures
• Introduce 2021 Quality Improvement Initiatives (QII)
• Declaration
## 2021 Scorecard Measure 4

<table>
<thead>
<tr>
<th>Performance Measure: Quality Improvement Initiative (QII)</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>QII Choice 1: Early Labor Admission Screening Checklist</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>QII Choice 2: Supporting Labor Progress</td>
<td></td>
</tr>
<tr>
<td>Scores ≥ 90 points on selected QII</td>
<td>40</td>
</tr>
<tr>
<td>Scores 75-89 points on selected QII</td>
<td>35</td>
</tr>
<tr>
<td>Scores 50-74 points on selected QII</td>
<td>25</td>
</tr>
<tr>
<td>Scores 1-49 points on selected QII</td>
<td>10</td>
</tr>
<tr>
<td>No implementation</td>
<td>0</td>
</tr>
</tbody>
</table>

- 2021 will be our first year with a performance based scorecard measure
- Measure 4 of the scorecard is designated for performance and is worth a total of 40 points out of the 100 point scorecard for 2021
- Gradually over several years, the amount of points designated to performance will increase to 70 points.
- To meet measure 4 of the scorecard, each hospital will need to select a QII choice to work for 2021
- The number of points earned on the project correlates to a number of points on the scorecard.
So what are the choices?

Early Labor Admission Screening Checklist
OR
Supporting Labor Progress
QI Implementation Choice 1

Early Labor Admission Screening Checklist

Measure hospital’s utilization of checklist at triage visits to reduce the number of women admitted <4cm

Goals
1. Increase use of checklist that supports outpatient management with cervical dilation <4cm & reduce the number of women admitted in early spontaneous labor without indication.
2. Review the indications for early admission to optimize strategies for labor management for these patients
Why did OBI select as a choice?

• In a rapid review of unadjusted 2019 OBI data*, 37% of women who presented to triage in spontaneous labor with intact membranes and had a cervical exam were admitted with less than 4cm dilation.

• The women who were admitted at less than 4cm dilation had a 60% increase in risk of cesarean delivery than those who were admitted at 4 cm or greater dilation.

• Checklist has been a core part of OBI since the collaborative started (Option A) so now it is time to measure!

*based on 30% sample of OBI participating hospitals 2019 NTSV delivery volume.
QII 1: Implementation Goals

<table>
<thead>
<tr>
<th>PROCESS MEASURE</th>
<th>HOW IT WILL BE MEASURED</th>
<th>TIME FRAME</th>
<th>POINTS AVAILABLE</th>
</tr>
</thead>
</table>
| A The screening checklist is used in 80% of NTSV triage visits presenting for labor evaluation. Each labor evaluation will be counted in the denominator. (See Appendix A for minimum Checklist requirements) | A per case question will be added to the Workstation for patients admitted in spontaneous labor <4cm and for patients with a triage visit within 72 hours of labor admission. | March 1, 2021 – October 31, 2021 delivery dates | ≥80%: 40 pts  
70-79%: 30 pts  
60-69%: 20 pts  
50-59%: 10 pts  
<50%: 0 pts |
| B Conduct quarterly multidisciplinary team meetings to discuss project progress, including data related to this measure. Two of these quarterly meetings must involve disseminating relevant OBI data and implementation progress with the maternity care team (i.e. using a grand rounds format for these meetings, early and mid-year preferred to help kick off your project and inform the full maternity care team of project progress). | Sites will submit agendas and rosters for a total of 4 meetings to OBI Coordinating Center by December 31, 2021. | January 1, 2021 – December 31, 2021 | 4 mtgs: 30 Pts  
3 mtgs: 20 pts  
2 mtgs: 10 pts |
| C Submit program implementation progress reports quarterly. Include specific barriers to checklist uptake if target goals are not being met. | OBI Workstation Program Progress Reports submitted by quarterly deadlines. | January – December 2021 Quarterly | 4 reports: 30 Pts  
3 reports: 20 pts  
2 reports: 10 pts |
### QII 1: Process Measure A: Cases Included

<table>
<thead>
<tr>
<th>Target population</th>
<th>Inclusion criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NTSV cases who are admitted in spontaneous labor with or without rupture of membranes</td>
</tr>
</tbody>
</table>

**Exclusion criteria:**
Admission for induction of labor OR Planned cesareans

**Numerator:**
- Triage visit that resulted in labor admission where cervical dilation was $<4\text{cm}$ with documentation of checklist use **OR**
- Triage visit for labor evaluation (that did not result in admission) within 72 hours of labor admission with documentation of checklist use

**Denominator:**
- Triage visit that resulted in labor admission where cervical dilation was $<4\text{cm}$ meeting above inclusion/exclusion criteria **OR**
- Triage visit for labor evaluation (that did not result in admission) within 72 hours of labor admission meeting above inclusion/exclusion criteria
Minimum Checklist Requirements

Appendix A: Minimum Required Admission Screening Checklist Elements

At a minimum the checklist must include the following criteria, but additional site specific items may be added:

- Reassuring fetal testing
- Normal Blood Pressure
- Gestational age ≥ 37 weeks**
- Vertex
- No prior uterine scars (myomectomy or cesarean delivery) **
- Intact membranes
- No significant maternal or fetal disease
- Cervical dilation < 4 cm* and effacement < 80%
- Labor Partnership Reviewed if available
- Support person available
  - If no support person or inadequate support, attempt to identify support for labor (Doula, extra support from labor nurse, social worker, volunteer, etc.)
- Coping with contractions

* Note: special circumstances such as severe fatigue, multiple triage visits, prolonged latent phase, and difficulty coping may warrant admission before 4cm.

** Women with gestations ≥41 weeks or prior cesarean delivery may require additional assessment and evaluation. These are not absolute contraindications and require individualized clinical decision making.
Goal
Increase the number of cases where a standardized process is used regarding CD decision making for dystocia to reduce the number of NTSV Cesarean Deliveries not meeting criteria for arrest disorders and failed induction as defined by ACOG and SMFM.
Why did OBI select as an option?

- The criteria for labor dystocia in labor as defined by ACOG/SMFM were not met in 52% of NTSV cesarean deliveries (CD) performed in Michigan maternity hospitals in 2019 (OBI Workstation) with:
  - 62% of CD performed for \textit{latent phase arrest} did not meet criteria
  - 24% of CD performed for \textit{active phase arrest} did not meet criteria
  - 65% of CD performed \textit{arrest of descent} did not meet criteria

- For failed induction of labor, 60% did not meet ACOG/SMFM criteria

- ACOG/SMFM guidelines have been a core part of OBI since the collaborative started (Option B) so now it is time to measure!
# QII 2: Implementation Goals

## QI Implementation Goals:
Implement the following process measure for review cesarean births performed for arrest disorders for the NTSV patient population:

<table>
<thead>
<tr>
<th>PROCESS MEASURE</th>
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<th>TIME FRAME</th>
<th>POINTS AVAILABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A NTSV Cesarean Deliveries performed for dystocia are reviewed using a standardized process to determine if ACOG/SMFM criteria for the diagnosis are met. The review should include evidence that ACOG guidelines have been met or the indication to deviate from guidelines is documented. Select one of the review options outlined in <strong>Table 2</strong>. (Refer to Appendix B for template option and necessary review components)</td>
<td>The proportion of NTSV CDs for dystocia that were reviewed using the standardized process.</td>
<td>March 1, 2021 – October 31, 2021 delivery dates</td>
<td>&gt;80%: 40 pts 70-79%: 30 pts 60-69%: 20 pts 50-59%: 10 pts &lt;50%: 0 pts</td>
</tr>
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<td>B Conduct quarterly multidisciplinary team meetings to discuss project progress, including data related to this measure. Two of these quarterly meetings must involve disseminating relevant OBI data and implementation progress with the full maternity care team (i.e. using a grand rounds format for these meetings, early and mid-year preferred to help kick off your project and inform the full maternity care team of project progress).</td>
<td>Sites will submit agendas and rosters for a total of 4 meetings to OBI Coordinating Center by December 31, 2021.</td>
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<td>C Submit program implementation progress reports quarterly. Include specific barriers to checklist uptake if target goals are not being met.</td>
<td>OBI Workstation Program Progress Reports submitted by quarterly deadlines.</td>
<td>January – December 2021 Quarterly</td>
<td>4 reports: 30pts 3 reports: 20 pts 2 reports: 10 pts</td>
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</tbody>
</table>

**TOTAL** 100
### QII 2: Process Measure A: Cases Included

<table>
<thead>
<tr>
<th>Target population</th>
<th>Inclusion criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NTSV cases where a cesarean Delivery (CD) was performed for <em>one</em> of the following primary indications:</td>
</tr>
<tr>
<td></td>
<td>• Failed Induction</td>
</tr>
<tr>
<td></td>
<td>• Latent Phase Arrest</td>
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<tr>
<td></td>
<td>• Active Phase Arrest</td>
</tr>
<tr>
<td></td>
<td>• Arrest of Descent</td>
</tr>
</tbody>
</table>

**Exclusion criteria:**
- Planned Cesarean Delivery without Labor
- Cesarean Deliveries undertaken for reasons other than the primary indications outlined above

**Numerator:**
- NTSV CDs undertaken for a primary indication of Failed Induction, Latent Phase Arrest, Active Phase Arrest, OR Arrest of Descent that were reviewed by one of the processes outlined below.

**Denominator:**
- NTSV CDs undertaken for a primary indication of Failed Induction, Latent Phase Arrest, Active Phase Arrest, OR Arrest of Descent
## QII 2: Process Measure A Review Options

### Table 2: Supporting Labor Progress Review Options

<table>
<thead>
<tr>
<th>Review Option (select one)</th>
<th>Reporting Criteria</th>
</tr>
</thead>
</table>
| **OPTION 1**  
Incorporate a standardized, evidence-based, pre-cesarean checklist into the EMR or make available within the Medical Record to be utilized for review of labor dystocia or failed induction cases. | Data element will be added to Workstation for collection by CDA. |
| **OPTION 2**  
- Conduct regular cesarean delivery review committee meetings or similar (e.g. quality improvement or peer review committee) that reviews all primary cesarean births performed for labor dystocia or failed induction and provides necessary feedback to the team involved in care.  
- For each meeting, document how many cases were reviewed with each case linked to the **OBI case ID**, date of meeting, opportunities or themes for improvement identified, general findings, and comments. A template will be provided. | - Complete the OBI template (spreadsheet) or local version and submit to OBI. This report will be compared to the number of CD cases performed for an arrest disorder abstracted in the workstation to ensure a complete number of cases are reviewed. |
What choice is best for our hospital?

• Discuss each choice with your hospital team

• Compare QI data to processes at your hospital
  ➢ QII Choice 1
    – Drill down into reasons for early admissions, are these modifiable?
    – Is there a standardized decision making process for admission?
  ➢ QII Choice 2
    – Compliance with ACOG/SMFM labor dystocia guidelines?
    – Is there a standardized universal cesarean delivery review process or checklist?
Declaration of QII Choice

• Declare your site’s QII choice by **Wednesday, December 16th, 2020**
  - QII Choice 1 or 2
  - For QII Choice 2, review option 1 or 2

• Declaration form:
  [https://umich.qualtrics.com/jfe/form/SV_eDKIdQdg0bkBY5n](https://umich.qualtrics.com/jfe/form/SV_eDKIdQdg0bkBY5n)

• **PDF** of Form (printable)
2021 QII Goals and Deadlines

**OBI 2021 QII Goals**

- **Dec 16, 2020**: Submit program options declaration form
- **March 31, 2021**: Q1 Program Progress deadline
- **Sept 30, 2021**: Q3 Program Progress deadline
- **Dec 31, 2021**: Q4 Program Progress and meetings documentation deadline

- **March 1, 2021**: Data measurement period begins
- **June 30, 2021**: Q2 Program Progress deadline
- **Oct 31, 2021**: Data collections ends
2021 QII Quarterly Team Meetings

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLAN AND ENGAGE</td>
<td>IMPLEMENTATION CHECK IN</td>
<td>IMPLEMENTATION CHECK IN</td>
<td>SUSTAIN</td>
</tr>
<tr>
<td><strong>Form your project team, review current processes and relevant data, create and share implementation plan with maternity care team.</strong></td>
<td><strong>Review results with team and make process changes as needed.</strong></td>
<td><strong>Review results with team and make process changes as needed.</strong></td>
<td><strong>Celebrate progress to date, make plan to sustain improvements. Continue to refine as needed.</strong></td>
</tr>
<tr>
<td>JAN-MARCH 2021</td>
<td>APRIL-JUNE 2021</td>
<td>JULY-SEPT 2021</td>
<td>OCT-DEC 2021</td>
</tr>
</tbody>
</table>
Questions and Resources

• Website: https://www.obstetricsinitiative.org/quality-improvement-implementation

• Email: OBICustomerSupport@med.umich.edu