Massachusetts
Perinatal Quality Collaborative

MA Perinatal Quality Collaborative
Advisory Committee Minutes
August 7th 2013, 1-2pm

Attendees: Glenn Markenson, Bonnie Glass, Jeff Ecker, Fifi Diop, Audra Robertson, Mark Manning, Dale Magee, Munish Gupta, Faye Weir, Alexis Travis, Monica Le (Attending for Linda Clayton).

39 Weeks:

- Glenn stated that we have a plan for making outreach to outliers/those who have high rate of early elective deliveries as reported by the Leap Frog Group, but limited time has made it difficult to follow-up with all of them. Glenn shared that he has talked to staff at Mercy hospital, but wants to connect with Anna Jacques. Bonnie said she knows the nurse manager at Anna Jacques and suggested we provide a toolkit that they can use to address the problem. Faye agreed and suggested that we put the information in context. She shared that she was surprised about South Shore Hospital's rate and went back to discuss it with QI staff at the hospital. On review, they found errors in the data and talked about how they collected the data.
  Glenn shared that Tufts, BWH, and Pittsfield have corrected their rate, but there are a list of hospitals with high rates that we haven't reached yet including: Heywood (38%), Holyoke, and Lawrence. Bonnie mentioned Charlene Torrisi is the Nurse Manager at Anna Jacques. Bonnie will investigate who could help with the rate at Lawrence General Hospital and will talk to Darcy about it.
- Alexis shared the approach that some chapters in the March of Dimes have used, by going out and visiting with key personnel in various institutions and sharing information about the March of Dimes 39 week toolkit, which is available for free online through the prematurity prevention network. She suggested that we could go out and do face to face visits in order to provide information and assistance. Glenn agreed that the personal touch helps. (See Atul Gwande's Annals of Medicine article in July 29, 2013, The New Yorker, pp 36-46)
- Monica asked if there is a more comprehensive way to look at the data. Glenn responded that the data is tabulated by the Leap Frog Group. Bonnie agreed that it is important to keep track and follow-up, possibly resurvey.
- Alexis asked if anyone knows when this year's data will be published by Leap Frog and whether we should wait until the new rates are published. Glenn responded that we should continue to make contact with the hospitals that have problems and we can update our data when the new rates are out. Bonnie volunteered to assist in reaching out to the hospitals we haven't reached yet.

Hemorrhage:

- Glenn told the group about a presentation Bonnie and Glenn gave at the MA ACOG meeting, reviewing what the MPQC has done to date around maternal hemorrhage. Bonnie shared that she hasn't heard any direct feedback yet, however 2 more providers volunteered to join the consulting team as a result of hearing the presentation. The 2 volunteers are David Kramer, DO from a practice in Lincoln and Michele Helgeson, CNM from Harvard Pilgrim.
- Bonnie outlined the next steps for the hemorrhage project would be to re-survey institutions, by sending out a formal introductory letter and a new survey to the physician leader and nurse

leader of each institution and following up. Bonnie asked Fifi if Bathul, (an intern at DPH) is still available to help with the work, Fifi informed the group that Batul has completed her internship but there may be other interns that could help.

- Glenn mentioned that he has been developing a toolkit for maternal hemorrhage at Baystate that he hopes to share with other institutions through the MPQC. Bonnie responded that she thinks this will add value and we could put it on the website. Glenn asked Alexis if we still have the other protocols that various members of the advisory committee had submitted previously. Alexis responded that we have them and we can find a space on the website to have information on Maternal Hemorrhage.
- Glenn asked the group how we will measure success in this project. Mark responded that the simplest way would be to record the number of hospitals with an established, usable protocol before and after the intervention. He added that the hardest part is measuring the impact on patient outcomes because maternal death due to hemorrhage is so rare, so we could ask a qualitative question and use some sort of scale e.g. did the protocol make a difference. Glenn suggested we should set up a group call in between this call and our next call to discuss, the group agreed.
- Mark shared that every time there is a maternal hemorrhage at UMass Memorial in Worcester they clinical team meets with the blood bank pathologist and anesthesiologist. They focus on the process to see if anything can be done differently. Bonnie agreed that the process is an important measure, responded that the UMass process is a great practice and could have helped prevent the 6 women that died last year. She added that is would be helpful if they shared the summary of the reviews, although we don't always catch all of the near misses. Mark said he will invite the blood banking pathologist at UMass to participate in the hemorrhage call.
- Jeff suggested 3 metrics:
    1. Whether or not there is an OB hemorrhage team at each site and does it have a blood bank person as part of it.
    2. Track the number of times the protocol is activated at each institution.
    3. Agree on elements that are essential to be in each protocol and assess where each protocol contains those essential elements. Jeff stated this could include specific lessons e.g. you shouldn't give red blood cells without other components (not just packed cells)

  The group agreed and will continue the conversation on the hemorrhage subcommittee call.

Birth Certificate:

- The group continued the discussion on the fields that we would like to add to the birth certificate. Glenn summarized that we had previously agreed to add 3 fields (1) Vaccinations – Flu and Tdap, (2) Progesterone after prior preterm birth, and (3) Has there been an early elective induction prior to 39 weeks.
- Glenn queried whether or not the third field on early elective induction should be added, he shared that the MA ACOG didn't like the third measure because the term "elective" is not always well understood. Dale responded that we could add a checklist for that item and have recommended criteria for early elective delivery rather than the term itself. Glenn said that is kind of what we do now. Fifi agreed. Dale stated that we need to improve the accuracy of these boxes. Jeff shared that he feels strongly about including early elective deliveries on the birth certificate and asked who is responsible for checking it. Fifi said that the birth certificate clerk looks through it. Faye stated that it will be difficult to improve the accuracy because we have the EHR and paper-based systems and no accurate process for transferring the data. Glenn asked if it would be possible to educate the clerks. Jeff responded that we need to indicate that early elective delivery means with no medical indication. He shared that many times the rate of early elective deliveries is over estimated because complications are not noted, so we need providers to indicate it is an early elective delivery.

- Glenn asked the group if we start tracking early elective deliveries do we think people will do a better job at improving the accuracy. Jeff responded that it would be like the Leap Frog data. Dale agreed and stated he thinks people pay more attention to Leap Frog than the Birth Certificate.
- Glenn stated for the measure on vaccinations would could simply ask "did you receive these vaccination during pregnancy?' and asked where this would go. Fifi replied that it goes on the hospital worksheet not the patient worksheet.
- Glenn mentioned that for the measure about progesterone we had narrowed it down to "did you receive progesterone". Dale suggested that we put this field in the prenatal procedures section of the birth certificate. He explained that there is a box above for preterm labor in a previous pregnancy and preterm birth in a current pregnancy so it would fit well there.
- The group returned to discuss the issue of adding early elective deliveries. Faye said she had now qualms about having early elective deliveries on the birth certificate because it adds accountability if there are other indications, so we have to say early elective deliveries before 39 weeks. Dale shared that there are other fields that have low accuracy rates therefore one more box won't increase accuracy; we could use Leapfrog to do that. Glenn suggested that if we publicize it they will respond. Fifi shared that most issues with accuracy are on the patient worksheet, the hospital worksheet is more accurate so we are using that. Dale stated that if it leads to more training for hospital staff he is for adding the field. Munish stated that although he has not been as involved with this, he agrees with the approach.
- Alexis asked the group about training the birth certificate registrars as we had discussed on a previous call and stated that she feels the training should be parallel to adding the field. The training could be part of an MPQC summit or a separate meeting. Fifi responded that the birth certificate registrar training might be helpful to go over definitions of terms such as "induction". Glenn stated that he thinks it is reasonable to put early elective deliveries in the birth certificate and provide training. Bonnie agreed and stated she feels strongly that a portion of this needs to be education of birth certificate registrars and pursue adding the fields. Fifi said we can do the education while we are adding the fields. Dale added we should find out now the quarterly birth certificate report is completed. Glenn summarized that we will go ahead and add all three fields that we have discussed; Fifi will update the birth certificate, track outcomes and publish the data on the website.

Progesterone:

- Audra gave a summary of where we are with the progesterone project, she shared that she had reached out to MassHealth (Dr Jeffrey) about what clinical data they have on who receives progesterone and demographics. She has developed a 1 page abstract to submit in support of our request for data from the All payers claims database (see 1 page abstract attached). The purpose is to link patient outcomes to billing information and track the system to see why progesterone is being used and answer certain questions that we have.
- Fifi stated that the All payers claims data spans from 2009-2011 and now includes MassHealth data. The data comes from pharmacies, claims data by drug name and diagnostic codes etc. From that we can figure out if the woman had a prior preterm birth. Fifi shared that unfortunately data from 2012 and 2013 is not available. Audra responded that the data would be helpful, because 2011 is the time that most people were using progesterone. Fifi said she would send out information on the All payers claims database. Audra asked what the turn around time is for a request for data. Fifi responded that it depends but it doesn't take long.

Obstetrical Outcomes Data Pilot Project:

- Mark gave a brief update on the obstetrical data pilot project. He stated that on time reports have been received from 40-50% of hospitals so far, usually around one week after the end of the month. He shared that some institutions are working on IRB approval and several are about to

dump a heap of data into the system, including Baystate. Mark and Matt will be looking at data from May to August.

- So far there has been no major challenges, the only difficulty has been getting the time of the risk managers. Mark explained that large academic centers have researchers and QI people doing the reporting, but the smaller ones have the risk managers doing it. Matt and Mark are trying to work around this issue and will assess at the end of the first 5 months, hopefully learn if it works and if it does roll it out across the state.
- Mark asked the group if everyone knows about REDCap (Research electronic data capture) an online database system that people can use to access data from multiple sites. He stated most of the academic institutions know about it and it is something we could use. Munish shared that NEOQIC has been using REDCap for their State NAS project. He stated that they use a local version and it would be doable to use it for this project too, but it is project specific – each project requires its own agreement.

Meeting Adjourned:

- Glenn stated that unless anyone had any pressing items we would adjourn the meeting due the time and we will discuss the other agenda items on the next call.

Action Items:

- Bonnie to work on reaching the hospitals with high Leap Frog Rates that we haven't reached yet.
- Alexis to provide information on the 39 Week toolkit for communication with hospitals who still have a high Leap Frog Rate.
- Alexis to add hemorrhage protocols and toolkit information to the MPQC Website
- Bonnie and Alexis to work together to schedule a group call for the hemorrhage subcommittee prior to the next advisory committee call.
- Mark to invite the UMass Blood banking pathologist to join the maternal hemorrhage call and participate in the subcommittee.
- Fifi to incorporate new fields and language discussed on the call into the birth certificate.
- Mark and Matt to continue to assess data from the pilot project and investigate whether REDCap should be used for the project.

The next call is scheduled for 1-2pm, September 11th

Conference Call #1.800.411.7650

Participant Code-139774#

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