Recommendations for OBS Quality Measures in SIM

Participants: Amy Gagliardi, Mark DeFrancesco, MD

Dr. DeFrancesco and Amy Gagliardi met on 2/12 and 2/16/15 to discuss existing proposed OBS measures and potential new measures. Recommendations are as follows:

1) Recommendation to focus on quality of care measures rather than surgical; the following are measureable and meaningful.
   a) Include
      i) Line 65: Prenatal care (NQF 1517) - Entry into care measure (HEDIS)
      ii) Line 66: Prenatal frequency of care (NQF 1391) (often used as a proxy for quality) (HEDIS)
      iii) Line 67: Eliminate as this duplicates #65 above
   b) Exclude
      i) Line 162: Cesarean Rate
      ii) Line 163: Episiotomy
   c) Add new measure
      i) Elective delivery (NQF 0469) - This measure assesses patients with elective vaginal deliveries (that is, inductions not medically indicated) or elective cesarean sections at >= 37 and < 39 weeks of gestation completed. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding)

2) Possible new measure - consider adding annual GYN (Well Woman’s Visit) as measure
   a) For many women this is the only annual exam
      i) Many visit PCP only when sick rather than for an annual exam
      ii) Well woman visit often includes heart, lung, bloodwork (thyroid, lipids), lots of screenings
   b) Whatever should happen during a well women visit (currently being revamped) will be able to be measured on a 1,2 or 3 year cycle
   c) Measure well women visit as percentage of women (on providers or practice panel) who have had a well women visit. Denominator total number of women on panel

3) Consideration of other measures possibly in the future.
   a) Understand the importance of limiting measures to very few
   b) Look at CT Medicaid OB p4p measures as they have been vetted previously as evidenced based quality measures related to outcomes which are measurable.
   c) Revisited the 17-P measure for inclusion; agreed not to recommend 17-P as measure

4) Discussed appropriateness of including OB/GYNs in SIMS due to specialist status.
   a) Discussed how other specialists such as asthma might differ in regards to inclusion due to their frequency of interaction with PCPs (and co-management).
b) Acknowledged that whether OB/GYNs are considered Primary care or Specialists there exists a level of frequency of interactions between OB/GYNs, PCPs and sub-specialists.

c) Discussion on nature and frequency of interactions between OBs and PCPs and/or sub-specialists.

d) Noted the existing interaction between OB/GYNs and referrals to and from PCPs and sub-specialists.

e) Agreement that this will vary based on type of practice and practice style of provider

f) Medical practice is changing, forcing provider types to be more inclusive

g) National data suggesting perhaps up to 2/3 of women have established care with OB/GYN provider and self-refer for pregnancy care.

h) Noted that national data suggests approximately 50% of OB/GYNs self-identify as Primary care. This trend might grow as more ObGyns recognize the need to go “beyond the Pap and pelvic.”

i) Noted high percentage of Medicaid deliveries in CT. and that referral mode might differ between Medicaid and Privately insured women.

j) Amy G had a follow up conversation with an OB/GYN who self-defines as a specialist and reports frequent interactions with PCPs concerning her pregnant patients (referrals to – for instance exacerbation of asthma symptoms) and with less frequent interactions (referrals to) with sub-specialists (for instance preexisting (always) or gestational diabetes (sometimes) to endo)

5) Considered status of Value based plans/programs

a) Medicaid OB p4p discontinued

b) Some OBs might be involved in p4ps with plans but they might be GYN rather than OB related. Will need to clarify this point.

6) Attribution and ACO

a) Language around these issues need to be more clearly defined from an OB/GYN point of view.

b) Will need to understand better before transitioning to value based plans

c) While understanding there is no penalty associated with SIM some OB/GYN practices interested in nature of benefit

d) Perspective around this may differ depending on whether the OB/GYN practice is hospital based, community or regionally based or statewide.

e) As trends perhaps move towards use of more sub-specialists, the OB/GYN becomes hub for standard care, screenings, referrals and coordination of care

7) Agreement that SIM is about population health and broader than a specific discipline or practice

a) Agree on importance of including an OB quality measure(s) in SIM

b) Discuss OB as a bundled payment, how this might be a barrier, how this might be unbundled (as it can be in Medicaid