

## 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  $\geq 37$  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)