Care Pathway

Prenatal Care

- Recommend content of visits or timing? OR silent on number of visits

- Adapted from Providence Health and Services (source) that use a care team consisting of "*certified nurse midwives anchor our team-based care model. They provide high-quality, family-centered care that's safe, compassionate, nurturing and empowering. Our nurse midwives see pregnancy and birth as normal, natural events – not medical conditions to be treated. They lead your care team, which also includes registered nurses, doulas, patient navigators and consulting obstetricians and pediatricians to provide a warm, personal approach to your pregnancy and birth – with the safety of a hospital delivery.*"
- Prenatal
    - 5-8 Weeks: Pre-OB Visit with a Patient Navigator
    - 10-12 Weeks: Visit with a Nurse Midwife
    - 15-18 Weeks: First Group Session
    - 21-22 Weeks: Visit With a Nurse Midwife
    - 26-28 Weeks: Second Group Session
    - 32 Weeks: Visit with a Nurse Midwife
    - 33-35 Weeks: Third Group Session
    - 36 or 37 Weeks: Visit with a Nurse Midwife
    - 37-39 Weeks: Fourth Group Session
    - 40 Weeks (as needed): Visit with a Nurse Midwife
    - 41+ Weeks (as needed): Visit with a Nurse Midwife

Labor Management and Delivery

- Standards for Scheduling Deliveries before the 39th week: Hospitals should implement a policy that limits scheduling deliveries before the 39th week and includes the following two components:
    1. The indication must be on The Joint Commission or the Washington State list used in the current elective delivery between 37 and 39 weeks Washington State Perinatal Collaborative/WSHA project; and
    2. For clinical situations not on the two lists noted in number one above, consultation must occur and agreement must be obtained that the clinical situation requires delivery.[1]
- Standards for Scheduling Elective Inductions between 39 and up to 41 weeks: Since no widely-accepted standard for elective inductions at or over 39 weeks exists, the Bree Collaborative recommends hospitals adopt a protocol similar to that of Swedish Medical

[1] If there is concurrence, the delivery would be considered medically necessary, not elective.

Center, Seattle and Magee-Women's Hospital, Pittsburgh including a patient education component:

1. The cervix must be favorable (Bishop score of 6 or greater) for an elective induction to be scheduled; and[2]
2. A consent form specific to the risk and benefits of induced compared with spontaneous labor has been signed by the patient.

- Labor and Delivery Guidelines for C-Sections: As mentioned previously, clear national guidelines do not currently exist for diagnosing labor arrest requiring C-section delivery. To fill this gap, OB experts on the Bree OB subgroup reviewed labor and delivery management literature and research studies, and recommend hospitals implement the following evidence-based guidelines and standards recommended by experts (denoted in parentheses below) until Washington State[3] or a national group like ACOG develops universally accepted labor and delivery management standards:
  - Admit only those spontaneously laboring women at term who present with no fetal or maternal compromise when the cervix is 4 centimeters or more dilated.
  - [1]
  - Allow first stage labor arrest cesarean (reassuring fetal and maternal status but lack of progress of labor) to be performed only in the active phase (equal to or more than 6 centimeters dilation).[2, 3]
  - Allow adequate time in the active phase (4 to 6 hours) with use of appropriate clinical interventions before making a diagnosis of active phase arrest.[4]
  - Allow sufficient time with appropriate clinical interventions in the 2nd stage before diagnosis of 2nd stage arrest or "failure to descend." [4, 5]

[2] France's national protocol advised a Bishop score of 5 or greater; Swedish's was greater than or equal to 6; and Magee-Women's Hospital's was at least 8 if first child or 6 for not first child (repeat birth).

[3] Washington Medicaid hired OHSU to develop labor and delivery management standards for Washington; draft standards are expected to be completed in summer or fall 2012.

[4] Zhang et al found that one-third of cesarean deliveries at the second stage were performed at less than 3 hours in nulliparous women (women who have never given birth to a viable, or live, infant), whereas, a quarter were performed at less than 2 hours in multiparous women (women who have given birth one or more times). This finding contradicts a 2003 ACOG guideline that defines arrest of descent as greater than 3 hours in nulliparous women with epidural analgesia and greater than 2 hours in multiparous women with epidural analgesia.

Postpartum Care

(adapted from ACOG Optimizing Postpartum Care)
At least two visits with additional visits as needed

- 3 weeks postpartum visit

- Additional comprehensive visit prior to 12 weeks postpartum
    - Assessment of mood and emotional well-being including screening with a validated tool for depression (e.g., PHQ-9), anxiety (e.g., GAD), tobacco use, substance use disorder,
    - Infant care and feeding
    - Sexuality including contraception (if needed) and discussing birth spacing
        - Same-day placement of long-acting reversible contraceptive, if desired
    - Sleep and fatigue
    - Physical recovery from birth
    - Chronic disease management (if needed)
    - Health maintenance
    - Identification of primary care provider to assume care after 12 weeks postpartum

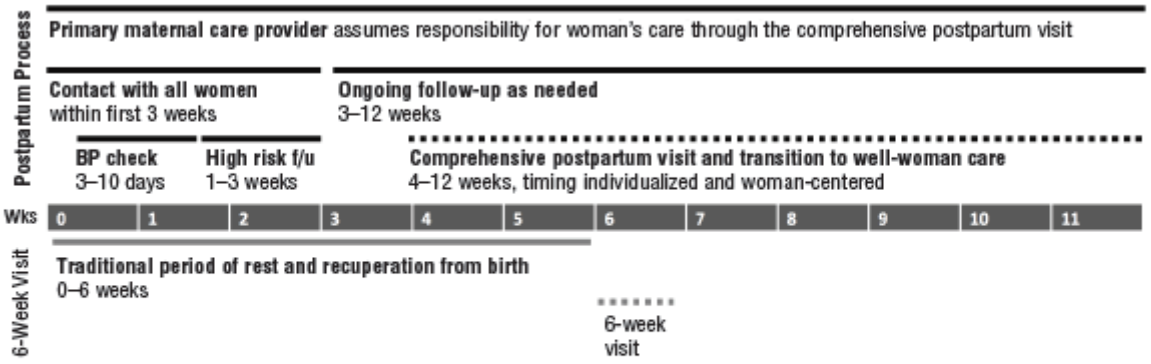

Figure 1. Proposed paradigm shift for postpartum visits. The American College of Obstetricians and Gynecologists' Presidential Task Force on Redefining the Postpartum Visit and the Committee on Obstetric Practice propose shifting the paradigm for postpartum care from a single 6-week visit (bottom) to a postpartum process (top). Abbreviations: BP, blood pressure; f/u, follow-up. ⇦

Quality Metrics

Maternity

- Source:
  - HIV Screening
  - Strep B screening
  - Gestational diabetes screening
  - Asymptomatic bacteriuria screening
  - Chlamydia screening
  - Tdap vaccination
- Source: HPC-LAN from Core Quality Measures Collaborative http://hcp-lan.org/workproducts/maternity-whitepaper-final.pdf and http://www.qualityforum.org/cqmc/
  - Frequency of ongoing prenatal care
  - Cervical cancer screening
  - Chlamydia screening and follow up
  - Incidence of episiotomy
  - Elective delivery for vaginal or cesarean at > =37 and < 39 weeks of gestation completed (PC-01)
  - Cesarean (nulliparous women with a term, singleton baby in a vertex position delivery by cesarean section, PC-02)
  - Antenatal steroids under certain conditions (PC-03)
  - Exclusive breast milk (PC-05)
- Source: HPC-LAN from CMS Medicaid and CHIP Child and Adult Core Measures for Maternity Care
  - PC-01: Elective delivery NQF 0469 – Endorsed
    This measure assesses patients with elective vaginal deliveries or elective cesarean births 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). PC-01: Elective Delivery is one of two measures in this set that have been reengineered as eCQMs and are included in the EHR Incentive Program and Hospital Inpatient Quality Reporting Program.
  - PC-02: Cesarean Section NQF 0471 – Endorsed
    Percentage of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth (C-section).
  - PC-03: Antenatal steroids NQF 0476 – Endorsed
    Percentage of Medicaid and CHIP enrolled women at risk of preterm delivery at 24 and <34 weeks gestation that received antenatal steroids prior to delivering preterm newborns.
  - Timeliness of Prenatal Care NQF 1517 – Not endorsed
  - Live births less than 2500 grams NQF 1382 – Endorsed

Percentage of live births that weighed less than 2,500 grams in the state during the reporting period.
Frequency of ongoing prenatal care NQF 1391 – Not endorsed

- Behavioral health risk assessment for pregnant women
  American Medical Association - PCPI
  Percentage of patients, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings at the first prenatal visit: screening for depression, alcohol use, tobacco use, drug use, and intimate partner violence.
- Postpartum contraceptive use among women ages 15-44
  Developmental measure (OPA/CDC)- NQF-29025
  The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period.

- Source: Washington State Common Measure Set, 2019 (PMCC Approved, December 2018) https://www.hca.wa.gov/assets/program/washington-state-common-measures-2019.pdf
  - Cesarean Birth (NTSV C-Section)
    The Joint Commission. This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean birth. This measure is part of a set of five nationally implemented measures that address perinatal care. This is PC-02.
  - Prenatal Care
    Washington State Department of Health. The percentage of women who receive first trimester prenatal care.
  - Unintended Pregnancies
    Washington State Department of Social and Health Services. Percentage of pregnancies that was unintended at the time of conception.
  - Mental Health Service Penetration (Broad Version)
    Washington State Department of Social and Health Services. The percentage of members with a mental health service need who received mental health services in the measurement year. Separate reporting for two age groups: 6-17 years and 18 years and older.
  - Substance Use Disorder Service Penetration
    Washington State Department of Social and Health Services. The percentage of members with a substance use disorder treatment need who received a substance use disorder treatment in the measurement year. Reported for Medicaid only. Separate reporting for two age groups: 12-17 years and 18 years and older Reported for Medicaid only.
  - Antidepressant Medication Management (AMM)
    National Committee for Quality Assurance. The percentage of members 18 years and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates reported: Effective Acute Phase Treatment and Effective Continuation Phase Treatment

  - Controlling High Blood Pressure (CBP)
    National Committee for Quality Assurance. The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled.

Pediatrics

- Source: HPC-LAN from CMS Medicaid and CHIP Child and Adult Core Measures for Maternity Care
  - Pediatric Central Linked Associated Bloodstream infections: neonatal ICU and pediatric ICU (CLABSI)
- Source: Washington State Common Measure Set, 2019 (PMCC Approved, December 2018) https://www.hca.wa.gov/assets/program/washington-state-common-measures-2019.pdf
  - Audiological Evaluation No Later Than 3 Months of Age
    Centers for Disease Control. The percentage of newborns who did not pass hearing screening and have an audiological evaluation no later than 3 months of age.
  - Childhood Immunization Status (CIS) Combination 10
    National Committee for Quality Assurance. The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTap); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday
  - Well Child Visits in the First Fifteen Months of Life (W15)
    National Committee for Quality Assurance. The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.

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Patient Population

Lower-Risk Bundle Exclusions

- HPC-LAN
  - Pre-existing health conditions, such as diabetes, hypertension, epilepsy, cancer, renal disease, obesity, advanced maternal age, and mental health conditions;
  - Lifestyle choices: Cigarette smoking, alcohol use and illegal drug use;
  - Previous pregnancy complications, such as genetic or congenital disorder, stillborn, preterm delivery; and
  - Pregnancy complications, which can also arise during the pregnancy and birth, such as: Multiple gestation, fetal growth restriction, prolonged premature rupture of membranes, or placenta abnormalities
  - *The maternity bundles in Tennessee are also adjusted based on a variety of factors, including risk and/or severity factors captured in recent claims data, such as early labor, preeclampsia/eclampsia, and behavioral health conditions* (page 59)
- Healthy People 2020
  - A low-risk female is defined as one with a full-term (at least 37 weeks since the first day of the last normal menstrual period [LMP]) singleton (not a multiple) pregnancy, with a vertex fetus (head facing in a downward position in the birth canal). A description of the primary measurement used to determine the fetus's gestational age, the interval between the first day of LMP and the birth, has been published by NCHS.
- NIH
  - Existing health conditions
    - High blood pressure
    - Polycystic ovary syndrome (PCOS)
    - Diabetes
    - Kidney disease
    - Autoimmune disease
    - Thyroid disease
    - Obesity (BMI>=30, 35, or 40)
    - HIV/AIDS
    - Zika infection
  - Age
    - Young age
    - First-time pregnancy after age 35 or 40
  - Lifestyle factors
    - Alcohol use
    - Tobacco use
    - Drug use
  - Conditions of pregnancy
    - Multiple gestation
    - Gestational diabetes
    - Preeclampsia and eclampsia
    - Previous preterm birth
    - Birth defects or genetic conditions in the fetus

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Codes

Global Obstetrical Package – CPT codes 59400 59510 59610 59618

Global obstetrical care includes antepartum care, delivery and postpartum care and is reported using the date of delivery as the date of service after all services are rendered by a provider from a solo practice or multiple providers within the same group practice.

Initial and subsequent histories
Physical examinations
Recording of weight, blood pressures, fetal heart tones
Routine chemical urinalysis
Monthly visits up to 28 weeks gestation
Biweekly visits up to 36 weeks gestation
Weekly visits until delivery
Hospital & observation care
Evaluations & management (E&M) services within 24 hours of delivery
Admission to hospital
Admit history & physical
Management of uncomplicated Labor
Placement of internal fetal and/or uterine monitors; fetal monitoring
Catheterization or catheter insertion
Perineum preparation
Injection of local anesthesia
Induction of labor/artificial rupture of membranes
Preoperative counseling for cesarean delivery, preparation of abdomen and abdominal incision
Delivery of fetus (vaginal or cesarean)
Delivery of placenta
Insertion of cervical dilator
Simple removal of cerclage (not under anesthesia)
Episiotomy and/or repair of first and second degree lacerations
Removal of sutures/staples
E&M services following delivery

[1] Main E et al. "Is there a useful cesarean birth measure? Assessment of the nulliparous term singleton vertex cesarean birth rate as a tool for obstetric quality improvement." *Am J Obstet Gynecol* 2006;194, 1644-52. (Level of Evidence: III)

[2] Zhang J, Tronendle J, Reddy UM, et al, for the Consortium on Safe Labor. "Contemporary cesarean delivery practice in the United States." *Am J Obstet Gynecol* 2010;203:326.e1-10. (Level of Evidence: III)

[3] Harper LM, Caughy AB, Odibo AO, et al. "Normal Progress of Induced Labor" *Obstet Gynecol* 2012;119:1113-8. (Level of Evidence: II-2)

[4] Rouse D, Owen J, Hauth J. "Active-Phase Labor Arrest: Oxytocin Augmentation for at Least 4 Hours." Obstetrics *&* *Gynecology* 1999;93:323-328. (Level of Evidence: II-3)

[5] Zhang J, Tronendle J, Reddy UM, et al, for the Consortium on Safe Labor. "Contemporary cesarean delivery practice in the United States." *Am J Obstet Gynecol* 2010;203:326.e1-10. (Level of Evidence: III)