Perinatal Metrics Reported on Cal Hospital Compare

FAQs

What is happening?
On January 18, 2018, hospital-level perinatal performance measures for calendar year 2016 will be publicly released on www.CalHospitalCompare.org — a healthcare consumer website governed by a diverse set of stakeholders including consumers, purchasers, health plans and hospitals. Given the heightened statewide interest in perinatal quality, the release may receive significant press attention.

In addition, Secretary Diana Dooley will acknowledge hospitals that have met or surpassed the 23.9% Healthy People 2020 NTSV C-Section Target Rate. Details will be announced across multiple channels, including the California Hospital Association’s electronic daily, CHA News. A certificate of acknowledgement will be mailed to hospital CEOs.

How will my hospital be represented?
Performance scores for all California hospitals currently offering maternity services were emailed to hospital contacts via the Hospital Quality Institute, including CEOs. Your hospital can be found by searching on hospital name or facility OSHPD ID.

Which measures are being reported?
The measures are based on nationally-endorsed specifications and include:
- Cesarean Birth Rate among Low-Risk First Births—Nulliparous, Term, Singleton, Vertex (NTSV)
- Episiotomy Rate
- VBAC Rate

Where does the data come from?
The rates are based on publicly-available data for calendar year 2016 from the Office of Statewide Health Planning and Development (OSHPD) and the California Department of Public Health-Vital Records. The California Maternal Quality Care Collaborative (CMQCC) linked and reviewed these state data sets for completeness and calculated the measures based on nationally-endorsed measure specifications. The performance categories are based on scoring algorithms developed by Cal Hospital Compare (formerly, the California Hospital Assessment Reporting Taskforce) with methodological and analytic support from Truven Health Analytics, an IBM Company. For more information, see Methodology and Measure Specifications below.

Why publicly report perinatal measures?
Consumers and stakeholders statewide have observed concerning trends in maternity services, including rising rates of maternal morbidity, ever increasing utilization of the cesarean procedure, and dramatic variation in obstetric practices across hospitals. For example, low-risk, first birth C-section rates vary from 11% to 79% across California hospitals. In a state with nearly 475,000 births annually, collaborating stakeholders seek to reverse these trends and optimize the quality of care provided to mothers and newborns.

Who is involved?
Collaborating stakeholders include quality improvement organizations, purchasers and foundations. See the full list below.

What can my hospital do to improve perinatal care?
CMQCC will be hosting a webinar for all hospitals interested in learning about opportunities to improve care for their mothers and newborns—including new initiatives on Supporting Vaginal Birth and Reducing C-sections. The meeting takes place on January 25 from 12:00-1:00pm PST and dial-in details are below:

Meeting URL: https://stanford.zoom.us/j/513475209
Dial: +1 650 724 9799 (US, Canada, Caribbean Toll) or +1 833 302 1536 (US, Canada, Caribbean Toll Free)
Meeting ID: 513 475 209
Collaborating Stakeholders

**Hospital Quality Institute (HQI)**
The Hospital Quality Institute (HQI) is the patient safety and improvement organization, created by California hospital associations, that strategically aligns measures and initiatives to eliminate defects in care to achieve zero harm; optimize clinical effectiveness; and improve the experience of care for each person and for populations served. It operates the nation's largest Patient Safety Organization (PSO) and the California Hospital Improvement Innovation Network in partnership with Healthcare Services Advisory Group (HSAG). HQI is a trusted source for data management and reporting.

**California Maternal Quality Care Collaborative (CMQCC)**
CMQCC is a not-for-profit, multi-stakeholder collaborative dedicated to ending preventable morbidity, mortality and racial disparities in California maternity care using data-driven, evidence-based approaches. CMQCC’s stakeholders include representatives across California’s provider, payer and public health communities, including American College of Obstetricians and Gynecologists District IX, the California Hospital Association and the California Department of Public Health. CMQCC is based at Stanford University School of Medicine.

**Cal Hospital Compare**
Cal Hospital Compare (formerly the California Hospital Assessment and Reporting Taskforce) strives to improve the quality of care delivered in California by objectively reporting the performance of California hospitals. As a non-profit organization governed by a diverse set of stakeholders including consumers, purchasers, health plans and hospitals and working with Truven Health Analytics, an IBM Company, to analyze complex data, Cal Hospital Compare supports consumer choice and public accountability.

**California HealthCare Foundation (CHCF)**
CHCF is leading the way to better care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford. [www.chcf.org](http://www.chcf.org)

**Pacific Business Group on Health (PBGH)**
PBGH is a non-profit business coalition focused on improving the quality and affordability of health care. The group represents 60 large health care purchaser members with more than 10 million employees, retirees and dependents in California. PBGH’s approach is to use the influence and concentrated power of our Member organizations to test and scale healthcare innovation across the U.S.

**California Perinatal Quality Care Collaborative (CPQCC)**
CPQCC’s 130 member hospitals care for over 90 percent of California neonates requiring neonatal intensive care. CPQCC is committed to improving the quality of care to California’s mothers and our most vulnerable infants. An action arm of the California Association of Neonatologists and a regional member of the Vermont-Oxford Network, CPQCC thrives as a result of the commitment and input of its diverse stakeholders, including the California Children’s Services and the California Division of Maternal, Child, and Adolescent Health. Its highly effective perinatal outcomes reports and quality improvement activities have provided a national model for regional perinatal quality improvement.
Measures

Measurement timeframe
The measurement period for the maternity measures listed below (NTSV C-Sections, Episiotomies, and VBACs) is **January 1, 2016 - December 31, 2016**. The “VBAC Routinely Available Survey” was conducted by the HQI in the fall of 2017. These measurement periods will be posted to [www.CalHospitalCompare.org](http://www.CalHospitalCompare.org) along with the updated 2016 maternity data on January 18, 2017.

Cesarean Birth Rate among Low-Risk First Births—Nulliparous, Term, Singleton, Vertex (NTSV)
The number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean.

**CalHospitalCompare.org Description:** The percentage of Cesarean section deliveries among mothers whose pregnancies were nulliparous, term, singleton and vertex (NTSV) — which means the delivery of a single baby [versus twins or triplets] in a head-down position after 37 weeks gestational age to mothers having their first baby. In such "low-risk" pregnancies, C-sections should be avoided to reduce post-surgical infections and other complications and improve overall health outcomes for both mother and baby. A lower percentage is usually better and hospitals with an NTSV C-section rate above 23.9% are performing Cesareans outside the target goal set by Healthy People 2020. Hospitals that serve as referral centers for high-risk pregnancies, those with intensive care units for very sick babies, and those serving mothers who have not had the benefit of prenatal care may appropriately have higher C-section rates. A woman who prefers a vaginal birth should look for a hospital with a low C-section rate. She should discuss this concern with her maternity care provider.

**Data Source:** Inpatient Discharge Data from Office of Statewide Health Planning and Development (OSHPD), 2016 linked to Birth Certificate Data from California Department of Public Health-Vital Records, 2016

**Denominator Statement:** Nulliparous patients delivered of a live term singleton newborn in vertex position, excluding those with:
- ICD-9/-10 Diagnosis Codes for multiple gestations and other presentation, as defined in Joint Commission Specifications Manual (v2016A) Appendix A: Table 11.09.
- Gestational Age < 37 weeks (Birth Certificate)
- Any prior births over 20 weeks gestation (Birth Certificate)

**Numerator Statement:** Denominator cases with ICD-9/-10 code for cesarean section as defined in Joint Commission Specifications Manual (v2016A): Appendix A, Table 11.06.

**Measure Sets/Endorsers:** National Quality Forum (0471), the Joint Commission (PC-02), Healthy People 2020.

Episiotomy Rate
Percentage of vaginal births (excluding those with shoulder dystocia) in which an episiotomy is performed.

**CalHospitalCompare.org Description:** An episiotomy is a surgical cut in the vaginal opening to make more space for the birth of a baby. It was once a routine procedure; however, many recent studies show that this cut does not make the birth easier and may lead to more frequent and worse tears and may result in short- and long-term harm in women. Providers and hospitals aim to do fewer episiotomies. In general, a lower rate is better.

**Data Source:** Inpatient Discharge Data from Office of Statewide Health Planning and Development (OSHPD), 2016 linked to Birth Certificate Data from California Department of Public Health-Vital Records, 2016

**Denominator Statement:** All vaginal births excluding those with an ICD-9/-10 code for shoulder dystocia.

**Numerator Statement:** Denominator cases with episiotomy procedures (as defined by ICD-9/-10 codes within the National Quality Forum specifications).

**Measure Sets/Endorsers:** National Quality Forum (NQF 0470)
**Vaginal Birth After Cesarean (VBAC) Rate**
Vaginal births per 1,000 deliveries among women with one or more previous Cesarean deliveries.

*CalHospitalCompare.org Description:* A vaginal birth after Cesarean section (VBAC) occurs when a woman who has had a prior C-section gives birth to a new baby vaginally (that is, without needing a C-section). Maternity providers have found that many women who have had a prior C-section do not need to deliver all future babies by C-section. This measure shows how often vaginal births among women with a prior C-section occur at this facility.

*Data Source:* Inpatient Discharge Data from Office of Statewide Health Planning and Development (OSHPD), 2016 linked to Birth Certificate Data from California Department of Public Health-Vital Records, 2016

*Denominator Statement:* All deliveries with ICD-9/-10 diagnosis codes for previous Cesarean delivery.

*Numerator Statement:* Denominator cases delivered vaginally in current delivery

*Measure Sets/Endorsers:* Agency for HealthCare Research and Quality: Inpatient Quality Indicators #34 (IQI #34).

**VBAC Routinely Available**

*Data Source:* Hospital Quality Institute Survey, Fall 2017

*CalHospitalCompare.org Description:* Some hospitals will not provide “vaginal birth after C-section” (VBAC), usually because they do not have the necessary medical personnel needed to respond immediately for an emergent C-section, according to ACOG guidelines. This measure, collected from a survey by the Hospital Quality Institute, can help consumers understand whether a facility routinely offers a trial of labor for vaginal birth after prior C-section.
Cal Hospital Compare classifies each hospital with patients at risk for a measure into one of five performance categories: Superior, Above Average, Average, Below Average, and Poor (pictured below). For some measures, it is difficult to discriminate between the top two categories and between the bottom two categories. For those measures, Cal Hospital Compare eliminates the Superior and Poor performance categories, resulting in a three-category classification: Above Average, Average, and Below Average.

A hospital’s “true” score is the score that we would observe on the basis of a very large (infinite) sample of patients at risk. The distribution of true scores is estimated statistically using the distribution of observed hospital scores and accounting for the imprecision of the observed scores owing to the fact that they are estimated from relatively small samples of patients at risk.

The five performance categories are defined by four score thresholds set as the 10th, 25th, 75th, and 90th percentiles of the distribution of “true” hospital scores. For three performance categories, the score thresholds are defined by the 25th and 75th percentiles of the distribution of “true” hospital scores.

Finally, for each hospital, Cal Hospital Compare estimates a distribution of possible “true” scores for that hospital. Cal Hospital Compare classifies each hospital on the basis of the median “true” score estimated for that hospital. This ensures that the estimated probability is less than 50% that a hospital’s “true” rate actually falls into a higher or lower performance category than the one to which it is assigned. There are no pre-determined or absolute targets used in the scoring process; Cal Hospital Compare’s categories show how a hospital rates against its California peers.

### Cal Hospital Compare Five Category Rating Key

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUPERIOR</strong></td>
<td>Provider performed well above average compared to other providers on this measure.</td>
</tr>
<tr>
<td><strong>ABOVE AVERAGE</strong></td>
<td>Provider performed better than average compared to other providers on this measure.</td>
</tr>
<tr>
<td><strong>AVERAGE</strong></td>
<td>Providers performed within the average range compared to other providers on this measure.</td>
</tr>
<tr>
<td><strong>BELOW AVERAGE</strong></td>
<td>Provider performed worse than average compared to other providers on this measure.</td>
</tr>
<tr>
<td><strong>POOR</strong></td>
<td>Provider performed well below average compared to other providers on this measure.</td>
</tr>
<tr>
<td><strong>NOT RATED</strong></td>
<td>Provider performance has not been rated because there is not sufficient data.</td>
</tr>
</tbody>
</table>