



Commentary

Setting perinatal quality and safety goals: Should we strive for best outcomes?

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Introduction

The first step towards improving perinatal quality and safety are to identify where the problems are and develop the indicated solutions. However, there are a limited number of perinatal measures of quality and safety that are widely used, inhibiting opportunities for learning. There is also criticism that the current measures of quality and safety may not be tracking the most important elements of care, such as labour support for women (Reiger and Morton, 2010). For example, current quality measures in the USA focus primarily on medical procedures that are recorded in administrative data. As a measure developer, I recognise that these limitations exist, but hope that additional measures are developed and these initial measures will lead to more useful comparisons than those that have been tracked previously. In fact, measuring low-risk caesarean section rates has already led individual leaders in numerous countries to compare and scrutinise their own processes of care during labour in order to determine why their rates vary when compared with others (Main et al., 2004; Brennan et al., 2009). What to measure is an important topic to continue to debate and discuss. Measure developers should be challenged to measure what matters most.

Once a measure is developed, we also need to apply intensive scrutiny in the process of setting goals or targets for each measure used. There are two approaches currently being used in goal setting. The first approach is to set goals based on benchmark data and the current performance of the majority of clinicians. The second approach, or Six Sigma approach to strive for near perfection (only 3.4 defects per million opportunities), is to base goals on the needs of the population we are serving and strive to eliminate nearly all defects in the care that we provide (Eckes, 2003). My opinion is that health-care leaders can learn a lot from each other but should not be content with being average. Health-care leaders need to use the Six Sigma approach of striving for near perfection, and develop highly reliable organisations where the organisational processes are re-engineered such that catastrophes are avoided and best outcomes are consistently achieved (Weick and Sutcliffe, 2001). Let me explain further with two examples.

Example one: hospital quality measures and goals

I conducted research that included interviews with front-line nurse and doctor quality improvement (QI) project leaders (Bingham, 2009). Early in the research process, I identified a difference in how leaders set their goals. Most hospital front-line leaders chose their measures and set their goals based on the overall collective performance of hospital clinicians (hospital-based measurements), compared with other groups of clinicians at other hospitals. These leaders were content and stopped working towards making improvements once their hospital's collective data showed that they were performing at or a little better than average. However, there were two leaders who stood out from the others. These two leaders set their QI project goals by identifying best practices, and then worked diligently to change the behaviours of all clinicians and staff so that every woman who gave birth at their hospital had equal access to evidence-based care. These two leaders were not content unless all women had received care consistent with the latest quality and safety guidelines.

For example, one of the leaders who set a goal to ensure that all women had access to evidence-based care had one of the lowest hospital rates for episiotomy. However, this leader was concerned that there were two clinicians in this hospital whose episiotomy rates were too high. This leader was not comfortable with the 'average' low rate and considered this QI project as one of the least successful. This leader's goal was the best outcome for all women.

The other leader, focused on ensuring that all women had access to evidence-based care, started out the QI project with the lowest rates of low-risk first birth caesarean sections of all the hospitals in the group. However, the leader knew from the research that non-medically indicated inductions of labour led to unnecessary caesarean sections, particularly among first-time mothers. This leader worked diligently to track provider-specific induction and low-risk caesarean section rates, and was able to demonstrate that clinicians at this hospital who performed non-medically indicated inductions also had the highest rates of primary caesarean section. The leader then met with and presented these data to each individual clinician and with the staff as a whole. Together, they set a goal that no woman having their first infant at their hospital would have a non-medically indicated induction of

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labour. Many interesting details of how this leader tracked and ensured compliance among the team go beyond the scope of this commentary. However, the bottom-line result was that the rates of low-risk first birth caesarean sections were lowered even further. Eventually, every induction of labour that occurred without a medical indication was treated as a sentinel event and generated a root cause analysis process (Schuldt, 2010).

As this research illustrates, there are differences in how leaders set their quality and safety goals, and the goals they set clearly affect their behaviour as leaders. The majority of leaders set their goals based on comparisons with other clinicians. This type of goal setting is clinician-centred and focuses on current practice. The other leaders set their goals to ensure that all women who were cared for at their hospital had equal access to evidence-based care. These leaders set goals that were women-centred and focused on best outcomes.

Example two: determining quality measurement exclusions

Now let us shift to a debate currently unfolding in the USA. In Autumn 2008, the National Quality Forum (NQF) endorsed 17 measures of perinatal quality (NQF, 2009). After the perinatal measures were endorsed by NQF, The Joint Commission, the organisation in the USA primarily responsible for accrediting hospitals, selected five of these NQF measures to be part of their new set of perinatal care core measures. Exclusive breast-feeding rates of healthy term newborn babies, a quality measure that I helped develop in my role as Executive Director of the California Maternal Quality Care Collaborative (CMQCC), was one of these five NQF measures (The Joint Commission, 2009).

The two main questions to be answered when developing and promoting any measure are what, if any, are the exclusions that apply to the measure, and what are the goals or desired benchmark. For the NQF exclusive breast-feeding measure, we decided to keep it simple and have minimal exclusions. Initially, we argued that although we did not expect 100% of newborn babies to be exclusively breast fed, we thought it was important that all newborn babies be included in the denominator because the reasons not to breast feed are so few and should be tracked. We left the goal as open-ended. My thinking was that often we do not know what it is possible to achieve until we start trying. Ultimately, we made adjustments to the NQF measure and agreed on a few exclusions for the measurement specifications determined by the Joint Commission. Despite allowing some exclusions, CMQCC and the Joint Commission have received criticisms from clinicians who want more.

The most common request for exclusion is to eliminate from the denominator those infants whose mothers chose not to breast feed. Some hospital leaders and clinicians argue that they do not want to be judged and have their rates affected by women's choices around infant feeding. These arguments ignore the fact that clinician behaviours affect breast-feeding intention and women's self-efficacy regarding breast feeding (Taveras et al., 2004; Bartick et al., 2009). The argument is hospital- or clinician-centred. These leaders need to approach the measurement of quality as an opportunity to scrutinise (and change) how individual clinicians promote, support and protect breast feeding. When I meet with groups across the USA to explain the rationale

behind limiting exclusions on this measure, I work to help them shift their focus from 'looking good' to 'doing good'. Leaders need to be reminded that although not every woman will exclusively breast feed, we do not currently know what rates of exclusive breast feeding are possible. Rather than seeking multiple exclusions, we should track the reasons why exclusive breast feeding does not occur and then work to determine which of these elements we can impact and improve. Hiding the problems does not help us find solutions.

Conclusion

Solutions to the problems of quality and safety in maternity care are buried in the details, and these details need to be measured. With more data and feedback, targeted solutions to specific problems can be developed (Bingham and Main, 2010). One critical element when measuring, tracking and improving quality and safety is to set women- and infant-centred goals. We all want to look good, and feel good about the care we provide, but in order to do good we need to ensure that every woman has access to safe and healthy birth practices to ensure optimal outcomes. We need highly reliable health-care organisations (Weick and Sutcliffe, 2001). When setting quality and safety goals, we should strive for best outcomes. All women and newborn babies deserve equal access to the highest quality and the safest care. All women and newborn babies must be included as we set quality and safety goals.

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