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A systematic approach towards the development of a set of quality indicators for public reporting in community-based maternity care

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ABSTRACT

Objective: to demonstrate the process and outcome of a systematic approach towards the development of a set of quality indicators for public reporting on quality of community-based maternity care.
Design and setting: a four-stepped approach was adopted. Firstly, we defined key elements of community-based maternity care, by performing a systematic search on care guidelines/ standards. Secondly, the literature was searched for existing indicators for maternity care, which were subsequently categorised according to the key elements and systematically selected on suitability of public presentation. The emerging set of indicators suitable for public reporting was presented to five health-care professionals using a Delphi technique (step 3). Based on the comments of the professionals, the set was adjusted and subsequently presented to the health-care consumers (a sample of pregnant women) in step four to test its validity, after which the final set was composed.
Participants: health-care professionals in the field of maternity care and pregnant women.
Findings: key elements of community-based maternity care were extracted from eight guidelines and care standards. We then extracted 10 documents with 223 indicators in total, from which 19 indicators covering the key elements were included in the first set and presented to experts. Based on their comments three indicators were deleted and four indicators were added to the set or slightly rephrased. These were subsequently judged by 13 pregnant women. Seventy-five per cent of the indicators were judged positively by them; no indicator was judged negatively. The set of indicators was thus left unchanged after this final step.
Key conclusions and implications for clinical practice: the systematic approach adopted in this study resulted in an indicator set that was considered valid by both maternity care professionals and pregnant women, and is likely to satisfy the essential requirements on clinimetric properties. The next step will be to pilot test the indicator set on feasibility in daily clinical practice and to refine the set when necessary. In the future, maternity care professionals may use the set to present the quality of care they provide and to define issues of improvement. Pregnant women may use the information to make a founded choice between maternity care professionals, which ultimately should result in improved safety and quality of maternity care as well as patient satisfaction. Although we focused on the Dutch, community-based maternity care system, the approach used may be extrapolated to other care processes and health-care systems. Extrapolation of the results itself (i.e. the indicator set) may need to be limited to systems with an emphasis on community-based maternity care.

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Introduction

To guarantee safe and high quality health care, the development of guidelines and quality indicators has grown exponentially during the last decade. Key stakeholders for quality indicators are physicians, for whom indicators serve as important monitoring and feedback instruments to increase standardisation and quality of care. Another important group of stakeholders are the health-care consumers. Especially for them, quality indicator scores need to be presented publicly. This public presentation serves two main goals: Firstly, it is meant to inform health-care consumers and to support them in making a rational choice between health-care professionals. Secondly, it is anticipated to stimulate health-care professionals to optimise the quality of care they deliver and to improve patient-centeredness of care. For public presentation to be valuable for consumers, it is necessary that they actually *do* have a choice between different health-care professionals.

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An example of a care domain in which patients do have choice is community-based maternity care, i.e. maternity care from a midwife or a primary care physician. Although in most Western countries giving birth is among the most common reasons for hospital admission, there is a substantial number of women receiving community-based midwifery care. By illustration, in the Netherlands 86% of the pregnant women start their pregnancy check-ups with community-based midwifery care professionals, about 50% of these women start labour at home, and about 75% of these women actually give birth at home (CBS Statline, 2007). This number has shown to be influenced by the midwife, in terms of her attitude towards home birth and cooperation with secondary care (Wiegers et al., 2000), but whether or not a woman receives pregnancy care *and* gives birth supervised by community-based midwifery care is especially based on the differentiation between physiology and pathology. Healthy pregnant women with an uncomplicated pregnancy are supervised by a midwife of their own choice (or by their GP), and they may subsequently choose where to give birth: At home or in a short stay hospital unit supervised by their own midwife or GP (Wiegers et al., 2008). In the event that complications arise or are to be expected, the woman is referred to hospital care, i.e. an obstetrician. This system of risk selection has shown to function properly, and seemed to result in only a small number of emergency referrals during labour (Amelink-Verburg et al., 2008).

The organisation of health care during pregnancy and labour in the Netherlands and in other countries with strong primary care systems, implies that, to a certain level, women can choose who they would like to deliver primary maternity care to them. In fact, women are more and more encouraged to take an active role in decision-making in maternity care (Brown et al., 2002; Lally et al., 2008). Public reporting on performance of the health-care professionals in this field can support women in making their decisions. For this to be valuable, it is important that the performance information is considered relevant by both the health-care professional and the pregnant women, especially when it concerns indicators for clinical care. Thus, for valid public presentation of quality indicators it is essential that both groups of stakeholders (the health-care professional and the pregnant women in this case) are involved in the development of these indicators. Several studies have shown that health-care consumers indeed are interested in quality-of-care information (Hibbard and Jewett, 1996; Longo and Everet, 2003; Boscarino and Adams, 2004; Cheng and Song, 2004), but the process of developing indicators for public reporting involving both groups of stakeholders has, as far as the authors are informed, not yet been described in medical literature.

We performed the present study to demonstrate the process and outcome of a systematic approach towards the development of a set of quality indicators for public reporting. The two major groups of stakeholders, i.e. health-care professionals and health-care consumers, were systematically involved in this study for validation of the indicator set. We explicitly focused on public reporting on clinical care, rather than on consumer experiences. For illustrations on the latter topic, the reader is referred to Delnoij et al. (2010) and Goberna-Tricas et al. 2011. Community-based maternity care in the Netherlands was chosen to illustrate the process we adopted, but in essence, it can easily be translated to other care processes as well. Generalisability of the specific outcome (i.e. the indicator set itself), however, may be limited to health-care systems with an emphasis on community-based maternity care.

Methods

We used a systematic approach for the development of a set of quality indicators for public reporting in community-based maternity care, in which the following steps were defined:

1. Definition of the key elements of community-based maternity care.
2. Selection of available quality indicators (representing maternity care and suitable for public reporting).
3. Validation among health-care professionals.
4. Validation among health-care consumers (pregnant women).

Step 1: definition of the key elements of primary maternity care

The aim of defining the key elements of community-based maternity care was to structure the focus of the ultimate set of indicators for public reporting. We searched the internet for guidelines and care standards, preferably originating from the Netherlands because of its strong emphasis on primary care. We included a broad search area scrutinising the internet using specific keywords: Pregnancy, labour, maternity care, midwifery, care standard, and protocol (in Dutch). We also intentionally explored the websites of specific professional institutions, i.e. the Royal Dutch Organization of Midwives (the KNOV), the Dutch General Practitioner Organization (the NHG), and the Dutch Society of Obstetrics and Gynecology (the NVOG), and specific websites with guidelines for health care (e.g. www.artsennet.nl/richtlijnen, www.artsenapotheker.nl/richtlijn), because these are important sources of scientific guideline and care standard development in the Netherlands. The professional institutions merely work complementary rather than developing separate guidelines on exactly the same topic. Furthermore, they have a strong scientific orientation with guideline development based on a solid scientific ground. As a result, contradictions in the guidelines were not to be expected and quality judgment of guidelines was considered not contributing to the validity of the current study. For each of the identified documents we screened the reference lists for new and relevant documents. We worked according to a saturation principle, which implies that the search was stopped when no more new information could be identified. The search was closed in November 2008.

The elements of community-based maternity care described in the guidelines were ordered chronologically into a framework, starting with the prenatal phase, towards the perinatal and postnatal phases. As women with serious conditions during pregnancy and labour are referred to an obstetrician in hospital care, we focused on care for women with uncomplicated pregnancy (i.e. *general care*). To illustrate the process of primary maternity care in case of (minor) complications, we selected three situations the care provider is expected to respond to; one in the prenatal period, one in the perinatal period, and one in the postnatal period. These *situations* were selected based on societal relevance in terms of prevalence and/ or impact and potential consequences. Based on this argumentation, we selected ‘persisting blood loss before 16 weeks gestation’ (prenatal phase), ‘pain during labour and birth’ (perinatal phase), and ‘emotional distress of the mother in the post partum phase’ (postnatal phase). Although pain is a natural physiological aspect of giving birth, about 80–90% of the women describe labour pain as serious to unbearable (Dickinson et al., 2003). Adequate education, information and support has shown to affect the actual use of analgesic medication of the women in labour (Janssen et al., 2007); therefore, pain during labour and birth is considered a situation to which the health-care professional should anticipate and respond to by means of information on pharmacological (such as epidural analgesia as used in hospital care) and non-pharmacological (such as transcutaneous electrical neurostimulation as used in community-based midwifery care) pain reduction techniques. Thus, for this study we restricted ourselves to guidelines and care standards addressing *general care* and those addressing *care concerning the three situations.*

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