The Joint Commission

Q&A

Joint Commission Accelerate PI Webinar-Clinical Transformation: Equitable Reduction of Cesarean Birth Rates

Live Webinar Broadcast 5/15/2024

Note: Please refer to the transcript for questions that were answered verbally during the live session.

Question	Answer
Are bishop scores monitored to reduce the NTSV rates?	Yes, they are monitored as a part of our overall reviews of the intrapartum labor course and indications for induction.
For measures, what sources were used for definitions for each metric if they were not TJC or CMS metrics?	Where possible, we followed standardized definitions from TJC, CMS, CDC, California Maternal Quality Care Collaborative (CMQCC) or New York Department of Health (NYDOH). For any definitions not available from these entities, we defined the measures as a collaborative group based on standard practice and documentation by providers.
What percentage of patients are induced and what guidelines are in place for induction?	We are currently adding data to our dashboard. As of now we allow elective inductions at 39 wks and follow standard ACOG guidelines for medically indicated deliveries.
For those who used the Labor Culture Survey, can you discuss your conclusions from the responses?	We are in the final phase of analyzing our data and sharing with our faculty and staff.
How have you standardized provider documentation for indications for CS ? Is it via the problem list- Delivery Summary- Drop downs in an Operative note? Or all of the above?	This is actually the next phase of our NTSV CS bundle which standardizes a preoperative note that focuses on patients safety and further clarify indications for intraoperative cesareans.
On the Outcome Slide 39. Curious if you identified any special cause variations that caused the uptick specifically for black and other races?	No, we have not but we are actively investigating this.
Have you incorporated these measures in the OPPE/FPPE process? How did you do it and is it working?	Yes, we incorporate into these evaluations.

What program does your system use for multi-disciplinary education and drills?	We utilize zoom platform to hold multi-disciplinary education sessions. For our drills, these are occurring in-situ n labor and delivery and occasionally within our simulation centers.
Can you talk more about the OCI? How is it calculated? Is there a national definition?	The OCI is a calculator that uses the patient comorbidites to predict the risk of a significant maternal morbidity as defined by the CDC. This was originally published by Bateman and expanded upon by Lenoard with more information well aggregated by the CMQCC : https://www.cmqcc.org/research/severe-maternal-morbidity/obstetric-comorbidity-scoring-system
How have you been able to keep staff motivated and accountable when your role out new checklists or workflows? I know you spoke on this briefly but would love to hear more.	We utilize several processes for our faculty and staff, including Grand Rounds and other large forums as well as small group unit-based education.
What Algorithm do you use to try and decrease the NTSV Cesarean Rate?	We don't currently have a specific algorithm but rather a multifaceted bundle as we discussed in the presentation.
You mentioned providing patient education on NTSV to prevent 'elective' requests for NTSV deliveries. Would you be willing to share the handout/flier you created?	These sources were taken from the CMQCC Vaginal Birth Toolkit.
Can you tell me how to access the VBAC calculator in Epic? New to Epic here	Vaginal Birth After Cesarean Calculator - mfmunetwork - portal (MFMU) (gwu.edu)
Would you be willing to share your cat II algorithm?	https://pubmed.ncbi.nlm.nih.gov/23628263/
Who provides provider coaching?	Senior member of our quality leadership team.
Who participates in the PP volunteer program?	Our health system has a robust volunteer services program and has worked with us to provide support to our postpartum patients.
Can you provide an example of the Labor and culture survey?	https://pubmed.ncbi.nlm.nih.gov/30407646/
Your team seems very comprehensive, and transparent- you mentioned data collectors, data analysts, project managers, I would imagine that you have a robust	Considering the move of much of the perinatal care measure collection from abstraction to eCQM, most organizations should have electronic data for these measures being built by your

informaticist team along with a close partnership between quality, coding, and physician leadership. What is your suggestion for external supports for organizations with fewer resources?	informatics/EHR teams. They should also be able to put that data into dashboards.
Are peanut balls an infection control concern or are they individual to each patient?	No, we reviewed the use of them with our infection control who gave us instructions for proper cleaning and handling.
With your peanut ball initiative, what types of staff education did you provide?	We provided in person training sessions for staff.
I believe that the most influential period for patients to decide on vaginal delivery vs c-section is during the prenatal visits. How did your sites do in this aspect?	We have been focused on optimizing EPIC to ensure that documentation regarding discussions related to trial of labor after cesarean and interapartum management.
What was the staff response to the racial data- was anyone resistance to accepting it or discussing contributing factors?	Thankfully, the staff was pleased to know their data and have it readily available.
Are you doing any multidisciplinary fetal strip review to find opportunities? if so how is it conducted?	We currently do not.
Of the interventions tried, do you have any idea about what intervention may have made the largest benefit?	Anecdotally, believe that the provider meetings and newsletters helped the most as these were the two things that were discussed most often on the labor floor.
What is your total annual delivery volume and how many OB MD's do you have? Do you report CNM NTSV rates as well or are they credited to the OB doing the CD?	We have currently have near 14,000 deliveries in our health system and we do track NTSV rates by all providers, including midwives.
Are the core equity measures dashboard available in Epic for your physicians or how do the physicians view it?	The dashboards are not available in Epic - largely because we need to combine a number of data sources outside of Epic to build our robust OB/GYN dataset. Physicians have access to the dashboards via Mount Sinai's tableau server. They are able to log in with their Mount Sinai credentials.

Why was there an increase in C/S with commercial payor group? Do we have any ideas?	We are unsure but we know that our Medicaid population is taken care of primarily by a laborist group while the commercially insured patients are taken care of by on-call physician groups. We suspect the difference in workflows and post-call obligations probably affect provider decision making. But again, this is just a hypothesis that requires further investigation and not likely the only cause.
What meaningful clinician level quality measures best reflect individual performance? Have you looked at TOLAC success rate as a balancing measure to VBAC rate?	We are reviewing TOLAC success rates, and utilize this a part of our overall quality measure related to VBAC.
Would Mount Sinai be willing to share their nurse-driven Peanut Ball competency and protocol?	Please email us for further information.
We are a Critical Access Hospital with OB/Gyns and delivering Family Practice. We deliver over 300 births per year. Our closest tertiary centers are 90 minutes away. What would a reasonable goal or target benchmark for cesearean sections would you recommend?	This is an important and difficult question to answer but it should take into account the comorbidity burden of your population and CS rates of your contemporaneous partners while balancing the neonatal outcomes which can typically be measured using PC-06.
Thank you for a wonderfully informative presentation. The dashboards are very helpful. What have you done to engage providers in your efforts?	We utilize the newsletter and individual provider meetings.
Could you provide the education that was presented to providers on NTSV reduction?	We created standardized PowerPoints using published mean and median values for correct diagnosis of failed labor. This is currently the subject of a research project, so we are unable to share the slides.
Can you dive more into any qualitative analysis or root-cause analysis you completed after analyzing the quantitative data? e.g., chart reviews, patient focus groups, etc.	This is a critically important aspect of our review, and it does include chart abstraction, internal debriefs, and RCAs, as indicated.
Do you compare your data to birth certificate data for accuracy?	No, we do not compare it.

Can you discuss the postpartum volunteer program more? Slide 41	We created the postpartum volunteer program in collaboration with our volunteer services department. Our volunteers visited our postpartum patients and provided the NYS Birth Equity Improvement Project PREM survey. They have also been involved with patient education related our postpartum education resources. It has been very beneficial.
Do you offer Elective Primary C/S's? If not, how do you present this decision to patients while still respecting a patients right to choose?	Yes we offer elective primary CS as we believe in a patients right to choose. We just ensure proper counseling and providers understand that these patients will increase their individual NTSV CS rate.
Can you talk more about not using the VBAC calculator. How were providers educated to counsel their TOLAC patients?	We have created provider videos on proper TOLAC counseling that we plan to disseminate soon to our department. We have also created standardized note templates on TOLAC counseling.
Has "other races" provided insight on disparities?	We utilize self-reporting for race/ethnicity and the tracking of our percentages for the "other" category does provide valuable information to our team.