Learning Objectives (slide 2)
Upon completion you will:
1. Identify methods to track and report labor and cesarean measures.
2. Discuss strategies to improving the use of data to drive cesarean reduction and
3. Review performance measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies

Reporting and Systems Learning ~ Every birth facility (slide 3)
The 4th domain of the Safe Reduction of Primary C/S: Supporting Intended Vaginal Births Safety Bundle is Reporting and Systems Learning for every birth facility. This domain, with 2 key elements:
1. Tracking and reporting labor and cesarean measures
2. The second element requires an organization to track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety.

1. Track and report labor and cesarean measures in sufficient detail to: (slide 4)
As just mentioned, the first key strategy in the Reporting domain is to create the ability to track and report labor and cesarean measures in sufficient detail to:
- Compare to similar institutions
- To conduct case reviews and system analysis to drive care improvement and to;
- Assess individual provider performance

Approaches to reporting and systems learning (slide 5)
A key approach for successful quality improvement project implementation, including cesarean reduction, is the use of data to help drive change. Achieving the goal of reducing preventable cesarean births will depend on accurate and timely measures provided to clinicians and organizations about the care provided to their patients. We know that you cannot change what you cannot measure. The goal of data monitoring is not to have an overwhelming burden but, to have enough data for comparison to others, conduct peer review and compare provider performances. In the response domain for the cesarean bundle will review the barriers and strategies to accomplish cesarean reduction goals and provide a brief description of current measures that are currently in use or have been proposed.

Barriers to using data (slide 6)
The CMQCC Task Force identified six main implementation barriers to using data to drive cesarean reduction.
1. Lack of awareness of the scope of the issue by providers and the public
2. Lack of transparency
3. Poor data quality
4. Lack of actionable data related to cesarean births
5. Data burden
6. Need for new measures to drive quality improvement

Awareness (slide 7)
Literature has indicated a lack of awareness and knowledge about the extraordinary variation in cesarean rates among hospitals and individual providers by the public and providers alike. This lack of awareness has failed to create the burning platform necessary to change the current “status quo.” Key drivers identified for the lack of awareness include:
- Not being identified as a compelling or important issue
- Difficulty in gaining access to the data and the
- Data is not often publicly available
- Lack of public understanding on why cesarean prevention is important by purchasers, health plans, hospitals, and providers and
- Having old data, the data is not timely in the hospital setting and public reporting

Transparency (slide 8)
Transparency within a healthcare organization of hospital-level data is essential to quality improvement for cesarean reduction. Many hospitals face a lack of transparency about their own outcomes, what quality initiatives other departments are taking on and what lessons other departments have learned from their quality-improvement efforts. Improved public transparency on outcomes is also needed. Public transparency improves consumer knowledge of available quality providers, thereby harnessing the power of consumer decision making to create a positive feedback cycle where quality is both created through transparency and sought out as a result of transparency. Patients must frequently rely on the provider’s self-descriptions — “I never do unnecessary cesareans” or “My rate is below others in this facility” — without having access to evidence that could confirm or contradict those assertions.

Provider strategies to drive cesareans reduction (slide 9)
Key Strategies for Using Data to Drive Reduction in Cesareans have been identified. These include:
- Provide timely data to providers in a persuasive manner using display tools, background information, benchmarks, historical data, and broader outcome data (such as infant outcomes and maternal morbidity measures)
- Present comparative data in a manner that demonstrates a sense of urgency
- Present identical measures across multiple levels - MD/practice group / hospital, region or state
- Presenting attainable goals by showing that other similar providers have already reached the goal
and by targeting or “Packaging” the data for the audience - data can be supplemented by patient stories, not just graphs and figures

**Trusting data quality** (slide 10)
Physicians need to know that they can trust the data, where it came from and how accurate it is. Provider level data is an essential tool for helping physicians understand exactly how their performance compares to industry benchmarks. Incorporating data into healthcare practice is an evolutionary journey with issues such as appropriate provider attribution, especially in facilities that have residents, midwives or family medicine physicians who perform vaginal births with covering obstetricians performing the cesarean deliveries. By creating and using data tools and strategies to assist providers to understand their cesarean rates and be Comfortable with and trust the quality of the data will help providers understand where improvement opportunities lie.

2. **Track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety** (slide 11)
The second key strategy of the response domain is to track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety. For data and information to work effectively as a driver of improvement, it must not only be clear and accurate, but also delivered in a manner that can be used to create action.

For example, the traditional Primary Cesarean Delivery Rate measured by hospitals may inform the organization that its rate is elevated but does not pinpoint why and, in turn, fails to identify strategies for improvement based upon that data. Additionally, data provided is not usually not risk adjusted, and are therefore open to the response: “My practice (or hospital) takes care of more high risk patients and that accounts for our higher rate.” This often-heard sentiment has undermined many quality improvement efforts in the past.

**Performance measures** (slide 12)
Performance measures used in quality improvement are commonly divided into categories:

- **Outcome measures:**
- **Process measures:**
- **Structure measures and**
- **Balancing Measures:**

Cesarean rates do not fall neatly into any of these categories. Thus, organizations must ensure that the data resulting from measurement activities is accurate. Accurate measurement strategies will help organizational and clinical leadership identify changes needed to make improvements, as well as understand progress towards the goal of reducing avoidable cesarean births. AIM has each of these measures outlined to support the Safe Reduction of Primary Cesarean Births and Supporting Intended Vaginal Births.
**Outcome measures** (slide 13)

Outcome metrics measure the results of health care and generally are measures of death, injury, complications or disabilities. Examples of outcome measures for reduction of cesarean births may include any of the metrics outlined on this slide.

- Total Cesarean Birth Rate
- Primary Cesarean Birth Rate
- Repeat Cesarean Birth Rate
- Complication rate following cesarean birth
- Joint Commission PC-02: NTSV Cesarean Birth Rate
- AHRQ IQI 34: VBAC Rate
- AIM: C/S Delivery Rate among NTSV Population after Labor Induction
- AIM: Severe Maternal Morbidity Rate

**Process measures** (slide 14)

Process measures measure how services are provided or whether an activity proven to benefit outcomes was performed. Examples of process measures might include the percentage of

- Provider and Staff Education on the cesarean bundle achieved
- Compliance rate to the AIM Cesarean Bundle elements
- or number of Multidisciplinary Case Reviews for C/S Bundle elements such as
  - Labor Dystocia or Failure to Progress
  - Failed induction of labor
  - and Fetal Distress or non-reassuring Fetal Heart Pattern

**Structure measures** (slide 15)

Structure measures captures the organization’s capacity and the conditions in which care is provided by looking at factors such as an organization’s staff, facilities, or health IT systems. Additional examples include the adoption of policies, procedures, guidelines and algorithms that support intended vaginal birth

**Balancing measures** (slide 16)

In any quality improvement program, it is important to be vigilant for unintended consequences whereby unexpected harm might appear as a result of the project. These are called balancing measures. Typical balancing measures used for projects to support vaginal birth and reduce cesareans might include neonatal outcomes such as the NQF metric for Term Unexpected Newborn Complications or by monitoring the rate of third and fourth degree lacerations to illustrate that more vaginal births are not creating more maternal morbidity.

**Summary** (slide 17)
In summary, the fourth domain of the Safe Reduction of Primary Cesarean Births: Supporting Intended Vaginal Births Safety Bundle is Recognition and prevention— for every patient and contains 3 key elements:

1. Tracking and report labor and cesarean measures in sufficient detail to: 1) compare to similar institutions, 2) conduct case review and system analysis to drive care improvement, and 3) assess individual provider performance.

2. Tracking appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety.

3. Strategies to improving the use of data to drive cesarean reduction include:
   - Providing awareness of the scope of the issue to providers and the public
   - Enhance data transparency
   - Improve the quality and timeliness of data and to
   - Develop reliable measures to drive quality improvement that providers can trust

**Resources and References: Safe Reduction of Primary C/S: Supporting Intended Vaginal Births Safety Bundle** (slide 18)

With every AIM eLearning Module you will be provided with links to resources and materials that will support the development of your teams journey to impact change. Please download these resources using the link at the top of this page before leaving the each of the eLearning modules.

**AIM program contact** (slide 19)

Please contact AIM directly with any questions on the materials provided or how we can better support your needs.