Tennessee Initiative for Perinatal Quality Care

Promotion of Safe Vaginal Delivery (PVD)

EMR Data Guide *(REVISED 6/26/2023)*

This document is designed to accompany the "Measures" section of the project "Toolkit". It contains more specific data definitions, what data elements will need to be extracted from your EMR, and other details regarding data collection.

Target population

Nulliparous birthing patients with a term, singleton baby in a vertex presentation.

- **N**ulliparous = first delivery/birth or Para Zero
- **T**erm = ≥37 weeks gestation,
- **S**ingleton = no twins or beyond,
- **V**ertex position = Cephalic position; no breech or transverse positions.

This population is also known as the NTSV population.

DEFINITION OF "NULLIPAROUS"

There are multiple definitions of "nulliparous" when considering the NTSV population.

- ACOG defines nulliparous as a woman with a parity of zero, which translates to no (0) previous pregnancies reaching 20 weeks gestation regardless of the number of fetuses or outcomes.
- The Joint Commission's (TJC) Electronic Clinical Quality Measures (eCQM) logic for the Cesarean Birth measure[1] concludes that a patient is nulliparous when ONE of the following is true:
    1. Parity equals zero
    2. Gravidity equals one
    3. Preterm and Term births both equal zero.
- In the AIM Data Collection Plan, which TIPQC utilizes, the term is more loosely defined – "women who are having their first birth".
- In the TIPQC Project Toolkit (echoed above), nulliparous is defined as a patient's first delivery / birth or Para Zero. In this, "Para Zero" is similar to ACOG - no history of a previous pregnancy that reached at least 20 weeks gestation.

The definition specified by TJC eCQM also includes additional "exclusions" - inpatient hospitalizations for patients with abnormal presentation or placenta previa during the encounter.

On the surface, these definitions are very similar but there are nuances between them that could affect your data collection process – regardless of whether you are collecting data through manual chart review or via an EMR extraction. Your hospital may also be tracking and reporting NTSV cesarean birth rates to entities like TJC. *It is imperative that your team agrees upon how to define "nulliparous" for this project and the logic you will use to determine which patients meet the "inclusion criteria"*. This definition and logic may be what your hospital has already been using (outside of this TIPQC project). We (TIPQC) understand that there may be some deviations at individual participating hospitals. We ask that you be consistent internally for the whole project.

[1] https://ecqi.healthit.gov/ecqm/eh/2023/cms334v4#quicktabs-tab-tabs_measure-0 (2023). Parity: the number of pregnancies reaching 20 weeks gestation regardless of the number of fetuses or outcomes. Gravidity: the number of pregnancies, current and past, regardless of the pregnancy outcome. Preterm birth: The number of births ≥ 20 weeks and < 37 weeks gestation, regardless of outcome. Term birth: the number of births ≥ 37 weeks gestation, regardless of outcome.

Outcome measures

Frequency of collection & reporting: monthly

#1. Cesarean delivery rate among NTSV population

- Denominator = women with *live* births who are having their first birth ≥37 weeks gestation and have a singleton in vertex (Cephalic) position
- Numerator = among the denominator, all cases who had a cesarean birth

#2. Cesarean delivery rate among NTSV population after labor induction

- Denominator = women with *live* births who are having their first birth ≥37 weeks gestation and have a singleton in vertex (Cephalic) position *and with a labor induction*
- Numerator: among the denominator, all cases who had a cesarean birth

ACOG STANDARD LABOR DEFINITIONS[2]

Labor

- Uterine contractions resulting in cervical change (dilation and/or effacement)
- Phases:
  - *Latent phase* – from the onset of labor to the onset of the active phase
  - *Active phase* – accelerated cervical dilation typically beginning at 6cm

Augmentation of Labor

- The stimulation of uterine contractions using pharmacologic methods or artificial rupture of membranes to increase their frequency and/or *strength following the onset of spontaneous labor or contractions following spontaneous rupture of membranes*.
  - If labor has been started using any method of induction described below (including cervical ripening agents), then the term, Augmentation of Labor, should not be used.

Induction of Labor

- The use of pharmacological and/or mechanical methods to *initiate* labor *(Examples of methods include but are not limited to artificial rupture of membranes, balloons, oxytocin, prostaglandin, Laminaria, or other cervical ripening agents)*
  - Still applies even if any of the following are performed:
    - Unsuccessful attempts at initiating labor
    - Initiation of labor following *spontaneous ruptured membranes without contractions*

The following should also be noted:

- Induction of labor includes *all cases* with *any* of the following:
  - Cervical ripening using medications (e.g. prostaglandins including misoprostol)
  - Cervical ripening using mechanical methods (e.g. balloons or other cervical dilators)
  - Artificial rupture of membranes *before the onset of labor*
  - Oxytocin/Pitocin *before the onset of labor*. Note, if oxytocin is used in the setting of irregular contractions with intact membranes without cervical change, then it would be considered an Induction of Labor.
- Augmentation of labor occurs ONLY:
  - After the onset of *spontaneous labor, defined as contractions with cervical change*, or

[2] Menard MK, Main EK, Currigan SM. Executive Summary of the reVITALize Initiative: Standardizing Obstetric Data Definitions. Obstet Gynecol 2014 July; 124:150-3. CMQCC Link ("ACOG and ICD-10-PCS Coding Recommendations for Labor Inductions")

    - After *spontaneous rupture of membranes with contractions (with or without cervical change)*. Note, if there is spontaneous rupture of membranes and no contractions then administration of oxytocin is considered an induction of labor.
- "Induction" includes *both* elective *AND* medically indicated inductions.
- A birth would still be counted in the denominator counts for Outcome Measure #2 even if any of the following are performed:
    - Unsuccessful attempts at initiating labor.
    - The use of pharmacologic and/or mechanical methods to initiate labor following spontaneous ruptured membranes without contractions.
- Like the definition of nulliparous, *it is imperative that your team agrees upon the logic you will use to determine which patients meet the "labor induction" denominator for Outcome Measure #2*. As mentioned, we (TIPQC) understand that there may be some deviations at individual participating hospitals. We ask that you be consistent internally for the whole project.

Potential disparities across Structural & Social Determinants of Health (SSDOH):
Participating teams are asked to capture the "overall" numerator and denominator counts (in a given month) for *each* of the Outcome Measures as well as counts *disaggregated by the birthing patient's (1) race/ethnicity and (2) payor type*.

- **Race/ethnicity** is defined as Non-Hispanic (NH) White, NH Black, Hispanic
    - The denominator would translate to (for example) the number of NTSV patients who self-identified as White Non-Hispanic. The numerator would then count the number of these *White Non-Hispanic* women who had a cesarean birth.
    - If a woman's race/ethnicity is not one of these values or is missing in a medical record, the patient will be included in the "overall" numerator/denominator counts but excluded from the disaggregated counts.
- **Payor type** (insurance type / status) is defined as Medicaid (may include CHIP and Medicare); Private insurance; Other public insurance (may include military insurance, IHS, other state or federal source); or Uninsured (may include those who self-pay, are not charged for services, or another payer).

The following **EMR data elements** (*from the birthing patient's chart*) will be needed to tally the required overall and disaggregated denominator and numerator counts for each Outcome measure monthly:

- Admission Date
- Discharge Date
    - *IMPORTANT: The qualifying NTSV births in a given month should be based on the birthing patient's date of discharge (not their date of admission or delivery).*
- Race & ethnicity
- Payor / Insurance status / type
- Gravidity & Parity (*Obstetrical history*)
- Labor & Delivery encounter details, including
    - Gestational age
    - Position (eg, if Vertex position)
    - Presence of Abnormal Presentation or Placenta Previa
    - Indications of induction and/or augmentation
    - Delivery type (eg, Vaginal or Cesarean)
    - Delivery outcome (eg, Live birth)

Depending on your current EMR and your hospital's monthly delivery volume, your team may choose to collect the data from the relevant medical charts manually (ie, manual chart review) or via an EMR extraction / report. Your team should determine the process in which your team will collect and capture the outcome (and balancing) measures for this project.

- Are the needed data elements documented in your EMR? If yes,
  - Can a report be generated on the existing fields to provide the monthly counts you need?
  - Do the fields need to be revised to meet the suggested data fields?
- If the data is not currently captured in your EMR, how could you (manually) capture the needed data on each NTSV birth to then provide the monthly counts?

You may also choose to utilize **ICD-10 PCS codes**. The following are recommended ICD-10 codes for Outcome Measures #1 and #2.

- ***IMPORTANT*****:** *Your team's ability to extract data based on ICD-10 codes is directly related to the accuracy and validity of the ICD-10 values coded in a patient's chart. Your team may want to use this project as an opportunity to verify the accuracy of your coded values and to communicate with and educate your hospital's medical and coding staff on the appropriate coding values.*
- Links to other relevant references are denoted using footnotes.

ICD-10 CODING RECOMMENDATIONS FOR OUTCOME MEASURE #1[3]

Specifications Manual for Joint Commission National Quality Measures (v2021A1) - Perinatal Care Cesarean Birth Performance Measure (PC-02) – https://manual.jointcommission.org/releases/TJC2021A1/MIF0167.html

- Perinatal Care measure page: https://manual.jointcommission.org/releases/TJC2021A1/PerinatalCare.html
- Code Tables: https://manual.jointcommission.org/releases/TJC2021A1/AppendixATJC.html

	Included Population	Excluded Population
Denominator	Table 11.01.1: Delivery Table 11.08: Outcome of Delivery	Table 11.09: Multiple Gestations and Other Presentations
Numerator	Table 11.06: Cesarean Birth	N/A

If you hospital is participating in collection and submission of (2023) TJC eCQM measures, the following are links to the logic for the Cesarean Birth measure

- https://ecqi.healthit.gov/ecqm/eh/2023/cms334v4#quicktabs-tab-tabs_measure-0
- https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS334v4.html

ICD-10 PCS (PROCEDURE) CODING RECOMMENDATIONS FOR LABOR INDUCTION[4]

Description	ICD-10 Procedure (PCS) Code
Oxytocin/Pitocin (when used for Labor Induction)	**3E033VJ** – Induction of other hormone into peripheral vein, percutaneous approach
Cervical Ripening using cervical inserts or tablets with prostaglandins	**3E0P7GC** – Introduction of other therapeutic substance into female reproductive, via natural or artificial opening
Cervical Dilators using mechanical methods such as a balloon, digital exam or similar approach	**0U7C7ZZ** – Dilation of Cervix, Via Natural or Artificial Opening **0U7C7DZ** – Dilation of Cervix with Intraluminal Device, Via Natural or Artificial Opening

[3] https://manual.jointcommission.org/releases/TJC2021A1/MIF0167.html

[4] CMQCC Link ("ACOG and ICD-10-PCS Coding Recommendations for Labor Inductions")

Artificial Rupture of Membranes (AROM) (using a hook thru the cervix, not an amniocentesis)	**10907ZC** – Drainage of Amniotic Fluid, Therapeutic from Products of Conception, Via Natural or Artificial Opening IMPORTANT: This code makes no distinction between AROM for labor induction or AROM for labor augmentation. Currently, there is no way to identify a labor induction that was limited to AROM (with no oxytocin) but this is rare. Well over 95% of AROM are done to augment labor. *Accordingly, the presence of this code without any of the codes above would be very weak evidence for Induction of Labor and should be confirmed.*

ICD-10 CM (DIAGNOSIS) CODING RECOMMENDATIONS FOR FAILED INDUCTION[5]

Description	ICD-10 Diagnosis (CM) Code
Failed induction	**O61.0** – Failed medical induction of labor **O61.1** – Failed instrumental induction of labor **O61.8** – Other failed induction of labor **O61.9** – Failed induction of labor, unspecified

Balancing measures

Frequency of collection & reporting: monthly

#1. Percent of 5-minute APGAR scores ≤ 5 *among NTSV vaginal births*

- Denominator = women with live births who are having their first birth ≥37 weeks gestation and have a singleton in vertex (Cephalic) position
- Numerator = among the denominator, number of *vaginal* births with 5-minute APGAR score ≤ 5

#2 Percent maternal complications *among NTSV vaginal births*

- Denominator = women with live births who are having their first birth ≥37 weeks gestation and have a singleton in vertex (Cephalic) position
- Numerator = among the denominator, number of *vaginal* births *any* of the following complications
    - Chorioamnionitis
        - See table for list of recommended ICD-10 Codes
    - Postpartum Hemorrhage (over 1,000 mL EBL/QBL) with or without blood transfusion

NOTE: If both complications occurred for a specific NTSV vaginal birth, count the NTSV vaginal birth only once.

ICD-10 CM (DIAGNOSIS) CODING RECOMMENDATIONS FOR CHORIOAMNIONITIS

Description	ICD-10 Diagnosis (CM) Code
Chorioamnionitis, third trimester, not applicable or unspecified	O41.1230
Chorioamnionitis, unspecified trimester, not applicable or unspecified	O41.1290

[5] Main EK, Chang SC, Cheng YW, Rosenstein MG, Lagrew DC. Hospital-Level Variation in the Frequency of Cesarean Delivery Among Nulliparous Women Who Undergo Labor Induction. Obstet Gynecol. 2020 Dec;136(6):1179-1189. doi: 10.1097/AOG.0000000000004139. PMID: 33156193.

Process measures

Participating hospitals to report estimates of cumulative proportions in 10% increments (0-9%, 10-19%, 20-29%, 30-39%, 40-49%, 50-59%, 60-69%, 70-79%, 80-89%, 90-100%) at the end of every quarterly reporting period.

IMPORTANT: In the summer of 2023, AIM announced they would be releasing a revised version of their 'Safe Reduction of Primary Cesarean Birth' Safety Bundle, which was used as a foundation for the TIPQC PVD project. These revisions included changes to the *Process & Structure Measures* to be collected. AIM announced they would transition to the revised Process & Structure Measures starting with Q4 2023 reporting.

PREVIOUS TO BE DISCONTINUED AFTER Q3 2023	***REVISED TO BE ADDED AS OF Q4 2023***
1. Provider education: Cumulative proportion of *OB physicians and midwives* have completed (within the last 2 years) an education program on the ACOG/SMFM labor management guidelines that includes teaching on the 'Safe Reduction of Primary Cesarean Birth' bundle and the unit-standard protocol?	**1A. Provider education on safe support of labor and vaginal births:** Cumulative proportion of *OB physicians and midwives* has completed within the last 2 years an education program on **safe support of labor and vaginal births**? **1B. Provider education on respectful and equitable care:** Cumulative proportion of *OB physicians and midwives* has completed within the last 2 years an education program on **respectful and equitable care**?
2. Nursing education: Cumulative proportion of *OB nurses* have completed (within the last 2 years) an education program on the ACOG/SMFM labor management guidelines that includes teaching on the 'Safe Reduction of Primary Cesarean Birth' bundle and the unit-standard protocol?	**2A. Nursing education on safe support of labor and vaginal births:** Cumulative proportion of *OB nursing staff (including L&D and postpartum)* has completed within the last 2 years an education program on **safe support of labor and vaginal births**? **2B. Nursing education on respectful and equitable care:** Cumulative proportion of *OB nursing staff (including L&D and postpartum)* has completed within the last 2 years an education program on **respectful and equitable care**?

Structure measures

Participating hospitals to report the level of "completion" (from 1 = 'Not Started' to 5 = 'Fully In Place) of each Structure Measure at the end of every quarterly reporting period.

IMPORTANT: In the summer of 2023, AIM announced they would be releasing a revised version of their 'Safe Reduction of Primary Cesarean Birth' Safety Bundle, which was used as a foundation for the TIPQC PVD project. These revisions included changes to the *Process & Structure Measures* to be collected. AIM announced they would transition to the revised Process & Structure Measures starting with Q4 2023 reporting.

CURRENT TO BE DISCONTINUED AFTER Q3 2023	***REVISED TO BE ADDED AS OF Q4 2023***
1. Patient, family, & staff support: *Has your hospital developed OB specific resources and protocols to support patients, and family through an unexpected / traumatic Cesarean birth?*	**1A. Patient and Support Network Review of Cesarean Birth:** *Has your department established a standard process to review with patients and their support network on why they had a Cesarean birth?* **1B. Patient and Support Network Support After an Unexpected or Traumatic Cesarean Birth:** *Has your hospital developed OB-specific resources and protocols to support patients and their support network through an unexpected or traumatic Cesarean birth?** **An unexpected or traumatic Cesarean birth may differ for patients and their support networks but may include crash or emergency Cesarean births.*
2. Policy & Procedure: *Does your hospital have an up-to-date new labor guidelines policy and procedure (reviewed and updated in the last 2-3 years) that provides a unit-standard approach for providing labor support, freedom of movement, and management protocols for labor challenges?*	**2A. Unit Policy and Procedure:** *Does your hospital have an up-to-date labor guidelines, policies, and procedures (reviewed and updated in the last 2 years) that provide a unit-standard approach for providing labor support, freedom of movement, and addressing labor challenges?* **2B. Unit Policies and Procedures for Prioritizing Scheduled Inductions of Labor:** *Does your hospital have a prioritization policy, rubric and/or procedure for determining priority of scheduled inductions of labor and Cesarean births?*

CURRENT TO BE DISCONTINUED AFTER Q3 2023	***NEW TO BE ADDED AS OF Q4 2023***
3. EMR Integration: *Were any of the recommended tools for the 'Safe Reduction of Primary Cesarean Birth' bundle (i.e., order sets, protocols, and/or documentation) integrated into your hospital's Electronic Medical Record (EMR) system?*	**3. Labor Management Huddles:** *Has your department established huddles for communicating progression and support of labor that are inclusive of patients, their support networks, and the clinical team?*

CURRENT TO BE RETAINED AS IS
4. Multidisciplinary case reviews: *Has your hospital established a process to perform multidisciplinary bundle reviews on a random sample of 10-20 charts/monthly (depending on hospital size) for NTSV C/S?*

Additional Data Collection Details

Baseline data:
Participating hospitals will be asked to capture the outcome measures (overall denominator and numerator counts) for the *3* months (ie, quarter) prior to the project "start," which will provide an adequate estimate of their baseline cesarean delivery rates.

Data collection frequency & timeline:

Measures	Frequency	Timeline	
Outcome & Balancing	Monthly	Pilot teams: • Baseline: Nov – Dec 2022 • Active: Jan 2023 onward	Non-pilot teams: • Baseline: Mar – May 2023 • Active: Jun 2023 onward
Process & Structure	Quarterly	Pilot teams: • Q1 2023 onward • Will capture starting in Apr 2023	Non-pilot teams: • Q3 2023 onward • Will capture starting in Jun 2023

Data entry:
The defined Outcome, Balancing, Process, and Structure Measures will be collected using **REDCap** surveys. The surveys will be built and stored using the TDH TIPQC instance of REDCap. A unique survey link and response will be created for each participating hospital. Each participating hospital will be sent an email each month with their specific survey link and will be instructed to submit their Balancing Measures data (denominator and numerators counts).

Whether you collect your monthly data via manual chart review or EMR extraction, your hospital's monthly counts could easily be entered and stored *internally* using a Microsoft Excel spreadsheet using a similar layout to the following table, where D = denominator and N = numerator.

	Outcome Measure							
	Cesarean delivery rate among NTSV population							
	Overall		**NH White**		**NH Black**		**Hispanic**	
Month	**D**	**N**	**D**	**N**	**D**	**N**	**D**	**N**

For your convenience, **paper data collection instruments** to capture the specified monthly data are provided at the end of this guide. A paper data collection instrument is also provided to capture your team's quarterly measures.

Submission of data to AIM:
TIPQC will periodically enter the captured Outcome, Process, and Structure Measures in the AIM Data Center for each of the participating hospitals. The AIM Data Center is a secure online system used to capture data from every state participating in any of the AIM maternal safety bundles. The identity of each participating hospital is masked in the Data Center – only TIPQC and each participating hospital will know the identity of each masked hospital. Each participating hospital will be able to generate any number of reports in the Data Center on their data.

Additional Severe Maternal Morbidity (SMM) outcome measures are also required to be captured in the AIM Data Center for participation. This data will be calculated by the Tennessee Hospital Association (THA) for each participating hospital team using specific ICD-10 codes pulled from claims data. TIPQC will receive the tallied counts from THA (on a 2-quarter lag basis) and upload them into the AIM Data Center on behalf of each participating hospital. TIPQC will provide THA with the list of participating hospitals. The participating hospital teams have granted permission for THA to calculate the required measures and for TIPQC to submit the measures to the AIM Data Center. TIPQC will label each participating hospital teams' data with their masked identifier prior to uploading.

TIPQC Promotion of Safe Vaginal Delivery (PVD)

MONTHLY CAPTURE OF OUTCOME & BALANCING MEASURES

IMPORTANT: Please see the project "EMR Data Guide" for more detail on any of the following measures.

OUCTOME MEASURES

#1. Cesarean delivery rate among NTSV population

- Denominator = women with live births who are having their first birth ≥37 weeks gestation and have a singleton in vertex (Cephalic) position
- Numerator = among the denominator, all cases who had a cesarean birth

#2. Cesarean delivery rate among NTSV population *after labor induction*

- Denominator = women with live births who are having their first birth ≥37 weeks gestation and have a singleton in vertex (Cephalic) position *and with a labor induction*
- Numerator: among the denominator, all cases who had a cesarean birth

Potential disparities across Structural & Social Determinants of Health (SSDOH):

"Overall" numerator and denominator counts will be captured for each outcome measure as well as counts *disaggregated by birthing patient's (1) race/ethnicity and (2) insurance / payor type*.

- Birthing patient's race/ethnicity defined as Non-Hispanic (NH) White, NH Black, Hispanic
    - The denominator would translate to (for example), the number of NTSV women who self-identified as White Non-Hispanic. The numerator would then count the number of these *White Non-Hispanic* women who had a cesarean birth.
    - If a woman's race/ethnicity is not one of these values or is missing in her medical record, the woman will be included in the "overall" numerator/denominator counts but excluded from the disaggregated counts.
- Insurance / Payor type defined as Medicaid (may include CHIP and Medicare); Private insurance; Other public insurance (may include military insurance, IHS, other state or federal source); or Uninsured (may include those who self-pay, are not charged for services, or another payer).

#1. Cesarean delivery rate among NTSV population

→ Overall and disaggregated by birthing patient's race/ethnicity:

MONTH	Overall			NH White			NH Black			Hispanic		
(MM/YY)	N	D	%	N	D	%	N	D	%	N	D	%

→ Disaggregated by birthing patient's insurance / payor type:

MONTH	Medicaid			Private			Other Public			Uninsured		
(MM/YY)	N	D	%	N	D	%	N	D	%	N	D	%

#2. Cesarean delivery rate among NTSV population *after labor induction*

→ Overall and disaggregated by birthing patient's race/ethnicity:

MONTH	Overall			NH White			NH Black			Hispanic		
(MM/YY)	N	D	%	N	D	%	N	D	%	N	D	%

→ Disaggregated by birthing patient's insurance / payor type:

MONTH	Medicaid			Private			Other Public			Uninsured		
(MM/YY)	N	D	%	N	D	%	N	D	%	N	D	%

BALANCING MEASURES

#1. Percent of 5-minute APGAR scores ≤ 5 *among NTSV vaginal births*

- Denominator = women with live births who are having their first birth ≥37 weeks gestation and have a singleton in vertex (Cephalic) position
- Numerator = among the denominator, number of *vaginal* births with 5-minute APGAR score ≤ 5

#2 Percent maternal complications *among NTSV vaginal births*

- Denominator = women with live births who are having their first birth ≥37 weeks gestation and have a singleton in vertex (Cephalic) position
- Numerator = among the denominator, number of *vaginal* births any of the following complications
    - Chorioamnionitis
    - Postpartum Hemorrhage (over 1,000 mL ***E***BQ/***Q***BL) with or without blood transfusion

NOTE: If both complications occurred for a specific NTSV vaginal birth, count the NTSV vaginal birth only once.

MONTH (MM/YY)	BM #1			BM #2		
	N	D	%	N	D	%

TIPQC Promotion of Safe Vaginal Delivery (PVD)

QUARTERLY CAPTURE OF PROCESS & STRUCTURE MEASURES

NOTE: Please see the project "EMR Data Guide" for more detail on any of the following measures.

IMPORTANT: In the summer of 2023, AIM announced they would be releasing a revised version of their 'Safe Reduction of Primary Cesarean Birth' Safety Bundle, which was used as a foundation for the TIPQC PVD project. These revisions included changes to the Process & Structure Measures to be collected. AIM announced they would transition to the revised Process & Structure Measures starting with Q4 2023 reporting. This data collection instrument has been revised to reflect the plan discontinuations and additions.

PROCESS MEASURES

PREVIOUS TO BE DISCONTINUED AFTER Q3 2023)

1. Provider education: At the end of this reporting period, what cumulative proportion of *OB physicians and midwives* have completed (within the last 2 years) an education program on the ACOG/SMFM labor management guidelines that includes teaching on the 'Safe Reduction of Primary Cesarean Birth' bundle and the unit-standard protocol?

Q4 2022 (Oct – Dec)	Q1 2023 (Jan – Mar)	Q2 2023 (Apr – Jun)	Q3 2023 (Jul – Sep)
○ 0-9%	○ 0-9%	○ 0-9%	○ 0-9%
○ 10-19%	○ 10-19%	○ 10-19%	○ 10-19%
○ 20-29%	○ 20-29%	○ 20-29%	○ 20-29%
○ 30-39%	○ 30-39%	○ 30-39%	○ 30-39%
○ 40-49%	○ 40-49%	○ 40-49%	○ 40-49%
○ 50-59%	○ 50-59%	○ 50-59%	○ 50-59%
○ 60-69%	○ 60-69%	○ 60-69%	○ 60-69%
○ 70-79%	○ 70-79%	○ 70-79%	○ 70-79%
○ 80-89%	○ 80-89%	○ 80-89%	○ 80-89%
○ 90-100%	○ 90-100%	○ 90-100%	○ 90-100%

REVISED TO BE ADDED AS OF Q4 2023

1A. Provider education on safe support of labor and vaginal births: At the end of this reporting period, what cumulative proportion of *OB physicians and midwives* has completed within the last 2 years an education program on **safe support of labor and vaginal births**?

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
○ 0-9%	○ 0-9%	○ 0-9%	○ 0-9%
○ 10-19%	○ 10-19%	○ 10-19%	○ 10-19%
○ 20-29%	○ 20-29%	○ 20-29%	○ 20-29%
○ 30-39%	○ 30-39%	○ 30-39%	○ 30-39%
○ 40-49%	○ 40-49%	○ 40-49%	○ 40-49%
○ 50-59%	○ 50-59%	○ 50-59%	○ 50-59%
○ 60-69%	○ 60-69%	○ 60-69%	○ 60-69%
○ 70-79%	○ 70-79%	○ 70-79%	○ 70-79%
○ 80-89%	○ 80-89%	○ 80-89%	○ 80-89%
○ 90-100%	○ 90-100%	○ 90-100%	○ 90-100%

1B. Provider education on respectful and equitable care: At the end of this reporting period, what cumulative proportion of *OB physicians and midwives* has completed within the last 2 years an education program on **respectful and equitable care**?

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
○ 0-9%	○ 0-9%	○ 0-9%	○ 0-9%
○ 10-19%	○ 10-19%	○ 10-19%	○ 10-19%
○ 20-29%	○ 20-29%	○ 20-29%	○ 20-29%
○ 30-39%	○ 30-39%	○ 30-39%	○ 30-39%
○ 40-49%	○ 40-49%	○ 40-49%	○ 40-49%
○ 50-59%	○ 50-59%	○ 50-59%	○ 50-59%
○ 60-69%	○ 60-69%	○ 60-69%	○ 60-69%
○ 70-79%	○ 70-79%	○ 70-79%	○ 70-79%
○ 80-89%	○ 80-89%	○ 80-89%	○ 80-89%
○ 90-100%	○ 90-100%	○ 90-100%	○ 90-100%

PROCESS MEASURES, *continued*

PREVIOUS TO BE DISCONTINUED AFTER Q3 2023

2. Nursing education: At the end of this reporting period, what cumulative proportion of *OB nurses* have completed (within the last 2 years) an education program on the ACOG/SMFM labor management guidelines that includes teaching on the 'Safe Reduction of Primary Cesarean Birth' bundle and the unit-standard protocol?

Q4 2022 (Oct – Dec)	Q1 2023 (Jan – Mar)	Q2 2023 (Apr – Jun)	Q3 2023 (Jul – Sep)
○ 0-9%	○ 0-9%	○ 0-9%	○ 0-9%
○ 10-19%	○ 10-19%	○ 10-19%	○ 10-19%
○ 20-29%	○ 20-29%	○ 20-29%	○ 20-29%
○ 30-39%	○ 30-39%	○ 30-39%	○ 30-39%
○ 40-49%	○ 40-49%	○ 40-49%	○ 40-49%
○ 50-59%	○ 50-59%	○ 50-59%	○ 50-59%
○ 60-69%	○ 60-69%	○ 60-69%	○ 60-69%
○ 70-79%	○ 70-79%	○ 70-79%	○ 70-79%
○ 80-89%	○ 80-89%	○ 80-89%	○ 80-89%
○ 90-100%	○ 90-100%	○ 90-100%	○ 90-100%

REVISED TO BE ADDED AS OF Q4 2023

2A. Nursing education on safe support of labor and vaginal births: At the end of this reporting period, what cumulative proportion of *OB nursing staff (including L&D and postpartum)* has completed within the last 2 years an education program on **safe support of labor and vaginal births**?

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
○ 0-9%	○ 0-9%	○ 0-9%	○ 0-9%
○ 10-19%	○ 10-19%	○ 10-19%	○ 10-19%
○ 20-29%	○ 20-29%	○ 20-29%	○ 20-29%
○ 30-39%	○ 30-39%	○ 30-39%	○ 30-39%
○ 40-49%	○ 40-49%	○ 40-49%	○ 40-49%
○ 50-59%	○ 50-59%	○ 50-59%	○ 50-59%
○ 60-69%	○ 60-69%	○ 60-69%	○ 60-69%
○ 70-79%	○ 70-79%	○ 70-79%	○ 70-79%
○ 80-89%	○ 80-89%	○ 80-89%	○ 80-89%
○ 90-100%	○ 90-100%	○ 90-100%	○ 90-100%

2B. Nursing education on respectful and equitable care: At the end of this reporting period, what cumulative proportion of *OB nursing staff (including L&D and postpartum)* has completed within the last 2 years an education program on **respectful and equitable care**?

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
○ 0-9%	○ 0-9%	○ 0-9%	○ 0-9%
○ 10-19%	○ 10-19%	○ 10-19%	○ 10-19%
○ 20-29%	○ 20-29%	○ 20-29%	○ 20-29%
○ 30-39%	○ 30-39%	○ 30-39%	○ 30-39%
○ 40-49%	○ 40-49%	○ 40-49%	○ 40-49%
○ 50-59%	○ 50-59%	○ 50-59%	○ 50-59%
○ 60-69%	○ 60-69%	○ 60-69%	○ 60-69%
○ 70-79%	○ 70-79%	○ 70-79%	○ 70-79%
○ 80-89%	○ 80-89%	○ 80-89%	○ 80-89%
○ 90-100%	○ 90-100%	○ 90-100%	○ 90-100%

STRUCTUREMEASURES

At the end of this reporting period, what is the level of "completion" of each Structure Measure?

CURRENT TO BE DISCONTINUED AFTER Q3 2023

Patient, Family, & Staff Support

1A. *Has your hospital developed OB specific resources and protocols to support patients, and family through an unexpected / traumatic Cesarean birth?*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

1B. *Has your hospital introduced Principles of shared decision making?*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

REVISED TO BE ADDED AS OF Q4 2023

Support for Patients and Their Support Network

1A. Patient and Support Network Review of Cesarean Birth: *Has your department established a standard process to review with patients and their support network on why they had a Cesarean birth?*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

1B. Patient and Support Network Support After an Unexpected or Traumatic Cesarean Birth: *Has your hospital developed OB-specific resources and protocols to support patients and their support network through an unexpected or traumatic Cesarean birth?**

**An unexpected or traumatic Cesarean birth may differ for patients and their support networks but may include crash or emergency Cesarean births.*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

STRUCTUREMEASURES, *continued*

At the end of this reporting period, what is the level of "completion" of each Structure Measure?

CURRENT TO BE DISCONTINUED AFTER Q3 2023

2. Policy & Procedure: *Does your hospital have an up-to-date new labor guidelines policy and procedure (reviewed and updated in the last 2-3 years) that provides a unit-standard approach for providing labor support, freedom of movement, and management protocols for labor challenges?*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

REVISIONS TO BE ADDED AS OF Q4 2023

2A. Unit Policy and Procedure: *Does your hospital have an up-to-date labor guidelines, policies, and procedures (reviewed and updated in the last 2 years) that provide a unit-standard approach for providing labor support, freedom of movement, and addressing labor challenges?*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

2B. Unit Policies and Procedures for Prioritizing Scheduled Inductions of Labor: *Does your hospital have a prioritization policy, rubric and/or procedure for determining priority of scheduled inductions of labor and Cesarean births?*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

STRUCTUREMEASURES, *continued*

At the end of this reporting period, what is the level of "completion" of each Structure Measure?

CURRENT TO BE DISCONTINUED AFTER Q3 2023

3. EMR Integration: *Were any of the recommended tools for the 'Safe Reduction of Primary Cesarean Birth' bundle (i.e., order sets, protocols, and/or documentation) integrated into your hospital's Electronic Medical Record (EMR) system?*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

NEW TO BE ADDED AS OF Q4 2023

3. Labor Management Huddles: *Has your department established huddles for communicating progression and support of labor that are inclusive of patients, their support networks, and the clinical team?*

Q4 2023 (Oct – Dec)	Q1 2024 (Jan – Mar)	Q2 2024 (Apr – Jun)	Q3 2024 (Jul – Sep)
Not Started	*Not Started*	*Not Started*	*Not Started*
○ 1	○ 1	○ 1	○ 1
○ 2	○ 2	○ 2	○ 2
○ 3	○ 3	○ 3	○ 3
○ 4	○ 4	○ 4	○ 4
○ 5	○ 5	○ 5	○ 5
Fully In Place	*Fully In Place*	*Fully In Place*	*Fully In Place*

CURRENT TO BE RETAINED AS IS

4. Multidisciplinary case reviews: *Has your hospital established a process to perform multidisciplinary bundle reviews on a random sample of 10-20 charts/monthly (depending on hospital size) for NTSV C/S?*

Q4 2022 (Oct – Dec)	*Not Started*	○ 1	○ 2	○ 3	○ 4	○ 5	*Fully In Place*
Q1 2023 (Jan – Mar)	*Not Started*	○ 1	○ 2	○ 3	○ 4	○ 5	*Fully In Place*
Q2 2023 (Apr – Jun)	*Not Started*	○ 1	○ 2	○ 3	○ 4	○ 5	*Fully In Place*
Q3 2023 (Jul – Sep)	*Not Started*	○ 1	○ 2	○ 3	○ 4	○ 5	*Fully In Place*
Q4 2023 (Oct – Dec)	*Not Started*	○ 1	○ 2	○ 3	○ 4	○ 5	*Fully In Place*
Q1 2024 (Jan – Mar)	*Not Started*	○ 1	○ 2	○ 3	○ 4	○ 5	*Fully In Place*
Q2 2024 (Apr – Jun)	*Not Started*	○ 1	○ 2	○ 3	○ 4	○ 5	*Fully In Place*
Q3 2024 (Jul – Sep)	*Not Started*	○ 1	○ 2	○ 3	○ 4	○ 5	*Fully In Place*