Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates at Start of Project

Before the process of unblinding NTSV cesarean rates begins, it is important for teams to have a baseline understanding of their underlying practices. This can be determined through an examination of the drivers for primary cesarean rates, followed by a chart review of a sample to assess how well the providers follow the national ACOG guidelines for Failure to Progress and other key primary cesarean indications. Ongoing monthly review for consistency with guidelines is also quite useful (recognizing that not every case will follow the guidelines perfectly). The Readiness Assessment and Structure Measures Checklist will assist with this baseline review. Success of the project hinges upon system improvements that support providers in reducing individual rates.

The Readiness Assessment, Structure Measures Checklist (both are found in the Implementation Guide), and Chart Audit Tool are all located on the collaborative resources page at https://www.cmqcc.org/projects/toolkit-and-collaborative-support-vaginal-birth-and-reduce-primarycesareans/
collaborative

1. Educate & Inform:
    - Confirm physician champion on board and that he/she will be notifying other physicians of the plan to reveal rates
    - Reveal BLINDED baseline rates to each physician e.g. via letter, email, etc
    - Physician champion to notify physicians, e.g. at Quality or Department meeting, special cesarean reduction info session, or via email, of future intent to share unmasked individual NTSV cesarean rates (provide timeline!)
    - Key discussion points to include in letter, email, or at info session:
        - ✓ Each physician has an individual responsibility to the success of the project
        - ✓ This aspect of the project has proven to be one of the most important steps and will yield the most results
        - ✓ The process is not meant to be punitive, e.g. will not be used for "profiling" or credentialing. Rather, the data will foster improvement. Though when other steps have been less productive, some hospitals have used these data for the Joint Commission mandated: Ongoing Physician Performance Evaluation (OPPE).
        - ✓ The project's goal is not only to target specific changes in practice, but also to improve the systems that support each physician in being successful
        - ✓ Physicians should discuss with the project leader if they are opposed to unblinding of physician rates
        - ✓ Reiterate factors that will be considered when interpreting physician data (see Table 1 below)

Table 1: Common Considerations with Provider-Level Rates

Problem	Effect	Solution
Low Volume	Low volume often leads to an increase in variation of the results, possibly causing significant swings in the individual provider rates	Point out these concerns with low volume leading to possibly wrong conclusions, consider making the sampling interval longer (e.g. 12 months instead of 3 to 6 months)
Provider backing up other types of providers who cannot perform cesareans	Many care systems require OBGYNs to backup midwives, Family Practice, etc. which inflates the individual OB's cesarean rates.	There are a couple of approaches to correct this issue: 1) a new feature in the Data Center is the identification of the Labor Provider for all births. Hospitals can now recalculate all the provider stats using the labor provider rather than the delivery provider. This is a relatively easy process but requires manual entry on case-by-case basis. 2) Otherwise, consider "group rates" (combining the OB with the midwife practice, if that makes sense) for a collective evaluation.
Provider is held responsible for decisions of others: long labors that are held over from the prior shift or where counselling in the office precludes the current provider from achieving vaginal delivery (elective cesarean; lowered expectations on the part of the patient as to length of labor etc)	This can raise the rate of an individual OB where there are cases they feel could have potentially avoided cesarean.	This is part and parcel of group practice. Most of the time, this can be ameliorated by providers in the group discussing their practice differences and these data can jumpstart that process. Cases often balance out between shift changes over the long haul. Emphasize the use of "group rates" (easily set up) so that the individual provider doesn't bear the full responsibility.
Clerical entry errors in the birth certificate data or coding leading to wrong procedure or attributed provider.	Fortunately, these are uncommon and random, however with small denominators can be significant to individual providers.	Provide feedback loop for detected errors to correct the data (or reassign the provider). The Data Center has easy tools to accomplish this.

2. Identify and activate champions

• Current physician champion should seek out like-minded physicians who will co-carry the torch and speak up in support of unblinded data at the scheduled information session. These should include:

- ✓ Structural leaders such as OB Dept Chair, Medical Directors, Chair of Patient Safety Committee, other relevant committee Chairs
- ✓ Early adopter MDs who are well-respected and trusted

Month 2

1. Share BLINDED rates of all physicians e.g. via chart at department meeting, via email, or post in doctor's lounge

2. Distribute personal rates (or personal key) to each individual physician to allow comparison to the BLINDED rates of entire cohort

3. Identify and work with the outliers
   - ✓ Chart review for outliers to determine: How consistent are they with ACOG dystocia guidelines? What can they work on? What tools could they benefit from?
   - ✓ Physician Champion to meet with and review this information with outlier physicians

4. Identify and work with resistant physicians
   - ✓ Physician Champion to communicate candidly and honestly to build trust: What is the resistant physician worried about? How can you as the champion and team make this process easier?
   - ✓ Are there resistant physicians who would benefit from a discussion with a CMQCC MD mentor? If so, contact your team mentors or clinical lead

Month 3

1. Share BLINDED rates of all physicians (2nd time)

2. Distribute personal rates to each individual physician with a comparison to the BLINDED rates of entire cohort (2nd time)

3. Expect lots of questions and concerns about validity of individual rates. Be sure to reiterate the factors that should be considered when interpreting physician data (see Table 1 above)

Month 4

1. Share in writing UNBLINDED rates of all physician GROUPS in a Department meeting. Make it low key initially.

4. There is often great variation within groups. At this point, UNBLINDED individual rates would be shared only within each group, with the expectation that next time individual rates will be unblinded between groups for all to see and compare

4. If "group rates" do not apply to your facility where only individual practitioners practice, you would now UNBLIND individual physician rates for those physicians open to individual unblinding (for this to be successful, Physician Champion, Department Chairs, and Early Adopters must vocalize support for unblinding)

Month 5-6

1. If not already done, share UNBLINDED rates of individual physicians. This is done after trust has been built with the data. After a round or two, the individual rates can be shared more openly but not truly publicly. Share via department meeting, posted in doctor's lounge, and/or send via email etc. They should not be shared publicly as the data is not perfect. Providers do not like to be outliers (useful for us to help drive change) but they also do not like to be publically "shamed." It is only respectful to provide plenty of notice and opportunity to improve.

Troubleshooting / FAQs

1. What do we do if we are at the point of unblinding the data and we still have one or a few adamantly against it?

ANSWER: In general, this is actually rare in occurrence, but at some point it is necessary to proceed. Physician leaders should have firm conversations that unblinding is going to occur and that the rates will stay within the department. Often it is helpful to remind the providers that current public pressure is progressing to the point where, as these provider rates are derived from publically reported data, sooner or later these rates will be publically available to patients and payers. Therefore it is better to go along with this semi-public openness and work on obtaining appropriate rates (and improving the quality of the data).

2. What about the Kaiser model (or other laborist models), where some physician rates don't reflect true attribution?

ANSWER: In models where providers work as a team, often better to have them consider improvement as a team and have open discussions about solutions at their department meetings. For example: Is everyone supporting breech version? Is someone consistently delaying the cesarean section to the next shift or admitting patients in latent phase?
The Maternal Data Center now also has the ability to track "labor provider." This requires a little extra manual data entry on a case-by-case basis (and close tracking by each hospital as to who was the actual "labor provider" for each patient), but will greatly improve the ability to track NTSV rates in institutions where attribution is difficult to sort out.
Additionally, the hospitals in the collaborative have the ability to track consistency with ACOG guidelines for diagnosis of labor dystocia. For those who desire a proxy measure for provider improvement, provider-level data for "consistency with guidelines" is available through the data center, but does take some additional chart review and sorting. To do this:

- From the hospital landing page, click on the measure "NTSV Spontaneous Labor Arrest/CPD: Consistency with Guidelines." This will display the hospital trend via a run chart.
- Use the drop-down menu to adjust the time period, and then click on the data point in the run chart to drill-down to the patient level. This will give a list of cases.
- Click on Provider ID to sort.

3. How frequently should we share provider level data?

ANSWER: There is a balance to be had here. Monthly data analysis rarely provides providers with sufficient sample size to be meaningful (and can "numb" the providers to the data) but annual data release removes the immediacy of the issue. A good medium is to provide quarterly provider level data with annual un-blinded release. Department level data can be shared monthly unless the facility is quite small, as you would do in any QI project.

5. Don't forget to pair the NTSV Rates and progress with the Balancing Measures!

ANSWER: The pairing has been very helpful with advancing acceptance of the project. But be careful about sample sizes here as well! Small samples (a doctor or even a single month for the entire department) can be misleading. We recommend reporting these quarterly unless you work in a very large department. Trend lines and comparisons are easily found in the Data Center.

Reference: Institute for Health Care Improvement. *Engaging Physicians in a Shared Quality Agenda*. Retrieved from: http://www.ihi.org/resources/Pages/IHIWhitePapers/EngagingPhysiciansWhitePaper.asp