U.S. Hospitals Held Accountable for C-Section Rates

Posted by Rebecca on Jan 23, 2013 in News and Updates | 19 comments

By Rebecca Dekker, PhD, RN, APRN of www.evidencebasedbirth.com

Back in December, we shared some big news! We found out that starting in January 2014, the Joint Commission will require U.S. hospitals with more than 1,100 births per year to work towards reducing the C-section rate in first-time moms. Our hope is that this article will help you understand the importance of this news for the health of moms and babies all over the U.S.

What are the basics of the new requirement?

Starting in 2014, hospitals who are accredited by the Joint Commission will be required to publicly report on 5 outcomes, known as the “perinatal core measure” set. These outcomes include:

1. Decreasing the early elective birth rate (before 39 weeks)
2. Decreasing the C-section rate in low risk women (first-time moms with a single baby who is head-down at term)
3. Increasing the use of prenatal steroids for babies who are born pre-term
4. Reducing bloodstream infections in newborns
5. Increasing exclusive breastfeeding rates during hospitalization

In this blog article, we are going to be focusing on the 2nd core measure, which is lowering the C-section rate in first-time moms. To find out more about the perinatal core measure set, we talked with Celeste G. Milton MPH, BSN, RN, the project lead for perinatal core measures at the Joint Commission.

What is the Joint Commission?

The Joint Commission (formerly known as JCAHO) is an independent, non-profit organization that accredits and certifies more than 20,000 health care organizations and programs in the United States, including 4,500 hospitals. The mission of the Joint Commission is to continuously improve health care for the public by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

The Joint Commission carries out periodic, unannounced site visits at all hospitals that they accredit. During these visits, the Joint Commission makes sure that hospitals are complying with evidence-based standards and improving the quality of care that they are delivering. On-site evaluations typically occur every 1.5-3 years and many of the findings are publicly available on the internet.
Joint Commission accreditation is important because hospitals that have been accredited by the Joint Commission are eligible for reimbursement from Medicare and Medicaid. In other words, if hospitals don’t get accredited, they don’t get paid.

How was the new requirement developed?

In 2007, the Joint Commission decided to replace the old perinatal requirements with a new set of evidence-based measures. At the same time, the National Quality Forum launched a perinatal care project, which resulted in the endorsement of 17 perinatal measures.

After reading the 17 new measures, the Joint Commission put together an advisory panel made up of experts. The panel included neonatologists, obstetricians, certified nurse midwives, and labor and delivery nurses. The experts reviewed the 17 perinatal measures, and out of those 17 they selected 5 to make up the Joint Commission’s new perinatal core measures: early elective delivery rates, first-time mom C-section rates, prenatal steroids given for preterm birth, bloodstream infections in newborns, and breastfeeding.

The new perinatal core measures were ready for hospitals to use in the fall of 2009, and data collection began in April 2010. However, very few hospitals chose to adopt the measures because, the measures were optional. In fact only 160 hospitals—out of thousands—voluntarily adopted the perinatal core measures.

Why did they decide to make the perinatal core measures mandatory?

In the past 2 years, the U.S.’s C-section rates began to get serious national attention. The Joint Commission was encouraged by several different stakeholder groups to make the perinatal core measures mandatory. These groups included the American Congress of Obstetricians and Gynecologists, the Association of Women’s Health, Obstetric, and Neonatal Nurses, the American College of Nurse Midwives, the American Academy of Pediatricians, and the Society for Maternal-Fetal Medicine.

In November 2012, the board of commissioners of the Joint Commission announced that the perinatal core measure set would now be mandatory for hospitals with more than 1,100 births per year, starting January 1st, 2014. This is the first time in history that the Joint Commission has required a core measure set to be mandatory for a specific type of situation—in this case, any kind of a hospital with more than 1,100 births per year.

To read the full description and rationale for the perinatal core measures, click here (Click PC-01, 02, 03, 04, or 05 to see each of the 5 measures). To specifically view the C-section measure, click here.

Why did the Joint Commission decide it is important to lower C-section rates?

In their rationale, the Joint Commission wrote, “The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean section rates… There are no data that higher rates improve any outcomes, yet C-section rates continue to rise. Some hospitals now have C-section rates over 50%.”

Why did the Joint Commission decide hospitals should lower the C-section rate in first-time moms?

The thing about first-time moms is that there are clear-cut quality improvement activities that can prevent preventable C-sections in these women. For example, a large number of preventable C-
sections occur because more than 40% of all first-time moms have their labor induced. When medications are used to force labor, a first-time mom doubles her chance of having an unplanned C-section. Another common practice that contributes to high rates of preventable C-sections is admitting women to the hospital when they are still in very early labor. Finally, a substantial number of unplanned C-sections are due to physicians mislabeling a woman’s labor as “failure to progress”—a term that research says is more aptly named “failure to wait.”

Basically, it boils down to the fact that physician and hospital practice patterns—not pregnant women’s conditions or their diagnoses—are the major reason for differences in C-section rates among hospitals. According to the Joint Commission, it’s time for hospitals and care providers to look at their practice, and see what they can do to prevent preventable Cesareans.

What does the Joint Commission mean when they say the desired outcome is “a decrease” in the C-section rate?

According to Ms. Milton at the Joint Commission, there is no specific C-section rate that hospitals need to attain. The Joint Commission does not set benchmarks or quotas.

Instead, each hospital will receive a quarterly performance report with their hospital’s C-section rate compared to a desired target range. The target range will vary from quarter to quarter, depending on the national performance of all the hospitals reporting the perinatal measures. The Joint Commission anticipates that the target range for the C-section will lower (lower = better) over time.

If hospitals do not decrease in their C-section rate, would they lose their accreditation?

The Joint Commission is not requiring any kind of specific rate that the hospitals need to reach—there is no “one-size-fits-all” rate. So hospitals will not necessarily lose their accreditation if they don’t see a specific decrease in their C-section rates.

However, the new perinatal core measure requirement puts pressure on hospitals—for the first time—to monitor, publicly report, and evaluate their C-section rates. As Ms. Milton said, “The goal here is to get hospitals to look at their practice and get an idea of where their rates are, and to figure out if they do need to make changes.”

Will this put women who legitimately need first-time C-sections at risk?

When asked about this concern, Ms. Milton said there are no set rates for any of the perinatal measures. There are no quotas. Thus the new perinatal core measure requirement should not put women at risk for not receiving a necessary C-section.

“People are not quite grasping what we are doing here,” she said. “We are trying to get people to look at their practice. If your Cesarean rate is 50%, I would say that this is probably something you want to look at. You can at least be aware of what your rate is, and see if there are performance improvement measures you can put into place to make a difference.”

If someone continues to have concerns about this issue, Ms. Milton recommends reading the white paper from the California Maternal Quality Care Collaborative.

When will we be able to view hospitals’ performance on the perinatal measure?
Moms and families will be able to see and compare hospitals’ early elective delivery and breastfeeding rates at www.qualitycheck.org starting in 2013. During the first year, the publicly reported rates will come from the 160 hospitals that are already using the perinatal core measure. In 2014, the website will include the hospitals with more than 1,100 births that are required to take part in the perinatal core measures.

C-section rates may take a little bit longer than the other measures to become publicly available—this is because the C-section rates will be risk-adjusted. Risk adjustment means that the Joint Commission will use a statistical method to control for the fact that some hospitals have a higher percentage of high-risk women. This will allow the public to compare C-section rates between hospitals in a more equal fashion.

Will smaller hospitals eventually be held to the same standard?

In their press release, the Joint Commission suggested that smaller hospitals may eventually have to comply with the perinatal core measures. However, Ms. Milton said that although there is talk about doing this, this is not something that has been officially decided.

So what’s the bottom line for women and their families?

Sometime in 2014, women and their families will be able to see risk-adjusted C-section rates for all hospitals with more than 1,100 births per year. There are no quotas or limits on C-sections, so this new requirement will not hurt women who require C-sections. For the first time, hospitals in the U.S. will be motivated to look at their practice and see what they can do to prevent preventable C-sections in first-time moms.