Promoting Primary Vaginal Deliveries Initiative

Lessons Learned from Implementing an Induction Policy

PROVIDE Collaborative Session Webinar
Partnering to Improve Health Care Quality for Mothers and Babies
Welcome!

• Please join by telephone to enter your Audio PIN on your phone or we will be unable to un-mute you for discussion.

• If you have a question, please enter it in the Question box or Raise your hand to be un-muted.

• This webinar is being recorded.

• Please provide feedback on our post-webinar survey.
Webinar Agenda
February 8, 2018

 PROVIDE Announcements

 Lessons Learned from Implementing an Induction Policy
   The Team at Tampa General Hospital
   The Team at Sacred Heart Hospital Pensacola

 Questions/Comments
Reminders

Data Collection or Submission Questions?
Estefania Rubio, Data Analyst erubio1@health.usf.edu

Clinical Questions? Interested in a Grand Rounds presentation or on-site consultation?
Annette Phelps annettephelps.ap@gmail.com

Not sure where to send your question?
FPQC@health.usf.edu
Session Topics

• State of the FPQC
• Reducing Health Disparities through Shared Decision Making
• Optimizing Physician Engagement
• Partnering with Patients and Families
• Neonatal Abstinence Syndrome
• Customization vs. Standardization of Care
• The Cesarean Epidemic
• Optimizing Enteral Nutrition for Preterm Infants
• Contraceptive Choice Counseling
• The ARRIVE Trial (39 Week Inductions study)
• Healthy Start Coalitions and Hospital QI
• Birth Certificate Accuracy and Perinatal Indicators
• PROVIDE
Early Bird Registration ends March 31!

Neel Shah, MD, MPP
Harvard’s Ariadne Labs
*System Complexity and the Cesarean Epidemic*

Heather Kaplan, MD, MSCE
Ohio Perinatal Quality Collaborative
*Neonatal Abstinence Syndrome*

Tara Bristol Rouse, MA
Perinatal Quality Collaborative of North Carolina
*Partnering with Patients & Families to Transform QI*

Ann Borders, MD
Illinois Perinatal Quality Collaborative
*Optimizing Physician Engagement in QI*

Maya Balakrishnan, MD, CSSBB
Florida Perinatal Quality Collaborative
*Customization Versus Standardization of Care*

Karen Harris, MD
ACOG District XII
*Reducing Health Disparities through Shared Decision Making*
Lessons Learned from Implementing an Induction Policy

Tampa General Hospital PROVIDE Team

Karen Bruder
Sherri Badia
Pat Barry
Frances Manali

Partnering to Improve Health Care Quality for Mothers and Babies
## ACOG Standard Definitions

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
</tr>
</thead>
</table>
| **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 6 cm |
| **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 |
Cervical dilation at intrapartum cesarean delivery among women attempting vaginal delivery by parity, onset of labor (induced vs spontaneous onset), previous uterine scar in singleton gestations.


**Finding:** More than 50% of induced nullips are <6 cm at CS.
Induction of labor algorithm
(adapted from Obstetric Care Consensus, Safe Prevention of the Primary Cesarean Delivery, March, 2014, Number 1)

Cervical ripening
- Mechanical (foley bulb or Cook ripening catheter)
- Prostaglandin (prostaglandin E2 or misoprostol with or without mechanical)
- Repeat if unfavorable

Favorable Cervix
(Bishop’s score)
- Nulliparous
  - Early labor (3 to 6 cm)
    - Median 3.9 h
    - 95% 17.7 h
  - Multiparous (informational only)
    - Median 2.2
    - 95% 10.7 h
- Consider cesarean delivery for active labor arrest when at least 6 cm and:
  - 4 hours: no cervical change & adequate contractions
  - 6 hours: no cervical change & inadequate contractions
(Maternal-fetal conditions permitting)
- (Zhang Obstet Gynecol 2010;116:1281-7 and Spong Obstet Gynecol 2012;120:1181-93)

Oxytocin induction
- Titrating slowly using lowest effective dose to achieve regular contractions and cervical change
- Consider amniotomy when labor progresses slower than 95% (see box for normal labor)

Bishop’s Score Calculation
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<th>3</th>
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<td>0</td>
<td>1 - 2</td>
<td>3 - 4</td>
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<tr>
<td>Effacement, %</td>
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<td>Medium</td>
<td>Soft</td>
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<td>Position</td>
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<td>Anterior</td>
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Maternal or fetal indications for delivery
(ACOG Committee Opinion, No. 560, 2013)
- As per ACOG recommendations, perform induction of labor before 41 weeks when a maternal or fetal indication exists. When none exists, proceed with a favorable cervical exam.

Obstetric Issues
- Premature rupture of membranes
- Pregnancy at or beyond 41 weeks
- Pregnancy between 39 and 41 weeks with favorable cervix

Maternal Issues
- Essential hypertension
- Diabetes mellitus
- Gestational Hypertension

Fetal Issues
- Growth restriction, singleton or multiple
- Multiple gestation
- Oligohydramnios

This is a simplified table adapted for this algorithm. Please see accompanying companion checklist for additional indications for delivery.

If labor does not occur and delivery indicated

Choice 1
- Consider discharge home if:
  - Contractions are minimal intensity
  - intact fetal membranes
  - Stable maternal and fetal condition
  - Reschedule within 24 to 48 hours, if needed

Choice 2
- Trial of oxytocin

Partnering to Improve Health Care Quality for Mothers and Babies
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<tr>
<th>Parameter</th>
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<th>5 - 6</th>
<th>≥ 80</th>
<th>≥ +1</th>
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<td>60 - 70</td>
<td>≥ 80</td>
<td>≥ +1</td>
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<td>Station (-3 to +3)</td>
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ACOG Patient Safety Checklist No. 5; December, 2011
According to the ACOG, induce labor prior to 41 weeks when a maternal-fetal indication exists. When none exists, proceed with a favorable cervical exam.

- **Favorable Cervix (Bishop’s score)**
  - Nulliparity ≥ 8
  - Multiparity ≥ 6

**Cervical ripening**
- Mechanical (foley bulb or Cook ripening catheter)
- Prostaglandin (prostaglandin E2 or misoprostol with or without mechanical)
- Repeat if unfavorable

**Nulliparous**
- Early labor (3 to 6 cm)
  - Median 3.9 h
  - 95% 17.7 h

**Multiparous**
- Median 2.2 h
- 95% 10.7 h

- Consider cesarean delivery for active labor arrest when at least 6 cm and:
  - 4 hours: no cervical change & adequate contractions,
  - 6 hours: no cervical change & inadequate contractions

*(Maternal-fetal conditions permitting)*

Zhang Obstet Gynecol 2010;116:1281-7 and Spong Obstet Gynecol 2012;120:1181-93

**Oxytocin induction**
- Titrate slowly using lowest effective dose to achieve regular contractions and cervical change
- Consider amniotomy when labor progresses slower than 95% (see box for normal labor)

**Consider cesarean delivery for failed induction of labor when:**
- Latent labor (< 6 cm) exceeds 24 hours
  - and preferably
- At least 12 - 18 hours of oxytocin administration following amniotomy

*(Maternal-fetal conditions permitting)*

If labor does not occur and delivery indicated
Bishop's score unfavorable after at least 2 ripening attempts, consider either:

Choice 1

Consider discharge home if:
- Contractions are minimal intensity
- Intact fetal membranes
- Stable maternal and fetal condition

Reschedule within 24 to 48 hours, if needed

Choice 2

Trial of oxytocin
PROVIDE
(Promoting Primary Vaginal Deliveries)

Baseline Report
Initiative-wide

Data Source: NTSV Cesarean Audits

Partnering to Improve Health Care Quality for Mothers and Babies
OVERALL ASSESSMENT
45 HOSPITALS
Overall 1: Percent of All NTSV Cesarean Deliveries Performed by Category During Baseline

- Induction: 34%
- Dystocia: 21%
- FHR concern: 30%
- Other: 14%
Overall 3: Percent of NTSV Cesarean Deliveries Performed Not Meeting Criteria by Category during Baseline

- Induction: 40%
- Dystocia: 29%
- FHR Concerns: 19%
- Other: 12%
I-3a. Percent of NTSV Cesarean Deliveries with Induction by Cervix Dilation at Delivery

Baseline (nR=662)

- Unknown: 3%
- < 6 cm: 54%
- 6-9 cm: 31%
- 10 cm: 12%

Partnering to Improve Health Care Quality for Mothers and Babies
I-4: Percent of Cesarean Deliveries with Induction that Did Not Meet ACOG/SMFM Criteria by Cervical Dilatation

Baseline (nR=662)

- Unknown: 3%
- <6 cm: 40%
- 6-9 cm: 10%
- 10 cm: 7%
- Met: 40%
I-8: Percent of NTSV Cesarean Deliveries with Induction by Bishop Score Agreement at Time of Induction between Provider and Hospital Record

Baseline (nR=662)

- Missing: 61%
- Provider < Record: 7%
- Provider > Record: 6%
- Agree: 26%
I-10: Percent of All NTSV Cesarean Deliveries with Induction and a Bishop Score <8 with Cervical Ripening Agent Used
Labor Induction Checklist

For Obstetrical and Medically Necessary Induction of Labor:

- Confirm gestational age (The need to deliver at a gestational age less than 39 weeks is dependent on severity of condition)
- Confirm one of the following indications
  - 41+0 weeks
  - Abruptio placenta
  - Preeclampsia
  - Gestational HTN
  - GDM
  - PROM
  - Fetal Demise
  - Coagulopathy/Thrombophilia
  - Pulmonary disease
  - Chorioamnionitis
  - Unstable Lie
  - Other Fetal compromise
  - IUGR
  - Isoimmunization
  - Fetal malformation
  - Multiples w/ complications
  - Twins w/o complication

- If other indication, confirm necessity for induction with perinatology:

  □ Other:
  ___ Perinatology consult obtained and agrees with plan:
  ____________________________________________________________
  (consultant name)
Labor Induction Checklist

For Elective Induction of Labor

- Ensure patient will be 39 weeks gestation or greater at time of induction
- Confirm gravity and parity of patient
- Be aware of reason that elective induction is planned
  - Patient or obstetrician choice
  - Risk of rapid labor
  - Distance from hospital
  - Psychosocial indications

- Confirm favorable cervix by Bishops score (See table)
  - Bishop’s score >= 8 for nullipara
  - Bishop’s score >= 6 for multipara

<table>
<thead>
<tr>
<th>Parameter</th>
<th>0</th>
<th>1 - 2</th>
<th>3 - 4</th>
<th>5 - 6</th>
</tr>
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<tbody>
<tr>
<td>Dilation (cm)</td>
<td>0</td>
<td></td>
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</tr>
<tr>
<td>Effacement, %</td>
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<td>40 - 50</td>
<td>60 - 70</td>
<td>&gt;= 80</td>
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<td>-1, 0</td>
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<td></td>
</tr>
</tbody>
</table>

ACOG Patient Safety Checklist No. 5; December, 2011
Labor Induction Checklist

For all Inductions:
- Provide patient with written educational material on induction of labor
- Obtain signed induction of labor education form
- Remind patient to call Labor and Delivery (or designee) prior to leaving home on the day of the induction

References:
ACOG Committee Opinion, No.560, 2013
Induction of Labor

Tampa General Hospital
Sherri Badia, Nurse Manager Labor and Delivery
Frances Manali, Nurse Clinician Labor and Delivery
Karen Bruder, MD, Physician Champion, former Chief of OB/GYN

Partnering to Improve Health Care Quality
for Mothers and Babies
Tampa General Hospital
5,875 Deliveries
Level III NICU
Tampa, Florida
Induction of Labor Team Formed in 2010

Team members
- Labor and Delivery Nurse Manager
- Labor and Delivery Nurse Clinicians (similar to assistant nurse manager role)
- Private practice MDs
- Residency service MDs
- CNM
- Perinatal CNS
Why was the team formed?

- FHR Tracing issues were often associated with use of oxytocin
- Perception of Nurses and Providers that there were ongoing “Pit wars”
- Desire to improve communication and standardization, and decrease risk associated with use of oxytocin
- Desire to develop protocols that were evidence based
Initial Steps

- Reviewed what we had in place
- Performed a Literature search
- Reviewed ACOG and AWHONN Resources
- Surveyed area hospitals for community practice
- Review of TGH data reflected we were meeting the Elective Delivery at 39 weeks or greater at least 95% of the time
What we accomplished related to Induction/Augmentation of Labor

- Cervical Ripening, Induction/Augmentation of Labor policy and order set developed by Interdisciplinary Committee and approved by TGH OB/Gyn Department
- Education of all Providers and Staff related to policy and management of oxytocin
- Decreased number of elective deliveries less than 39 weeks gestation to 0%
Induction of Labor Booking Process in Place Prior to Revisions

- Paper Calendar was used to schedule inductions
- Inductions were booked by L&D Unit Coordinators
- Set time slots were available
- No oversite for Gestational age or indication
- Elective inductions did not require ripe bishop score
- Providers would occasionally send patients in without an induction appointment
First Induction Booking Form

TGH Induction of Labor Booking Form

Patient Name:
DOB:
Pt Phone:
Provider:
Provider office CONTACT number:
Provider office FAX number:
Requested date/week for induction:
Gestational age now:
EDC:

Indications for induction

Medical

☐ Abruptio placenta
☐ Chorioamnionitis
☐ Fetal demise
☐ Hypertension
☐ Premature rupture of membranes
☐ Postterm pregnancy
☐ Diabetes mellitus
☐ Renal disease
☐ Chronic pulmonary disease
☐ Chronic hypertension
☐ Fetal compromise:
☐ Other:

Elective

☐ 36 weeks or more at time of induction
☐ Fetal lung maturity established (Amnio)

Indications:

☐ Risk of rapid labor
☐ Desire to leave hospital
☐ Psychosocial indications
☐ Other:

Does this patient have any specific issues/reasons related to the scheduling of this induction?

Please fax this completed form along with the prenatal records to 813-844-1668.

This completed form and the prenatal records will be reviewed by a Labor and Delivery Staff Member. Your office will be notified of the scheduled induction date and time.

<table>
<thead>
<tr>
<th>Induction Date:</th>
<th>Time to arrive at hospital:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduled by:</td>
<td></td>
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</tbody>
</table>

Please remind the patient to call 813-844-7122 prior to leaving home on the day of the scheduled induction.

Partnering to Improve Health Care Quality for Mothers and Babies
Elective Induction Had to be at least 39 weeks

Elective
39 weeks or more at time of induction
OR
☐ Fetal lung maturity established (Amnio)

Indications
☐ Risk of rapid labor
☐ Distance from hospital
☐ Psychosocial indications
☐ Other:
Areas of policy that were of concern with this form/process

- Booking of Inductions using Booking form #L2004 not consistently used
- Elective Induction Scheduling
  - Could be scheduled weeks ahead, possibly taking up needed slots for medically indicated inductions
  - Bishop Score not required
Evolving Process: Revised Booking Form

Bishop Score greater than 6 one of the indications, but not required

- Elective 39 weeks or more at time of induction
- Fetal lung maturity established (Amnio)

Indications:
- Risk of rapid labor
- Distance from hospital
- Psychosocial indications
- Other:
- Bishop Score greater than 6
- Evaluation for induction
Latest Version of Booking Form

Induction of Labor Booking Form

Patient Name: ___________________________
DOB: ___________________________
Pt. Phone: ___________________________
Provider: ___________________________
Provider office CONTACT number: ___________________________
Provider office FAX number: ___________________________
Requested date/week for induction: ___________________________
Gestational age now: ___________________________
EDC: ___________________________

Indication for Induction

Medical
- Abruptio placenta
- Chorioamnionitis
- Fetal demise
- Gestational Hypertension
- Chronic hypertension
- Preeclampsia/eclampsia
- Premature rupture of membranes
- Postterm pregnancy
- Diabetes mellitus
- Renal disease
- Chronic pulmonary disease
- Fetal compromise
- Other: ___________________________

Elective (May be up to 7 days prior to requested date)
AND
- Bishop Score 10 or greater for a Primipara
- Bishop Score 6 or greater for a Multipara

Bishop Score | Total Score
-------------|-------------
0            | 0           | Cephalic | 1 |
1            | 3           | Breech   | 5 |
2            | 6           | Midpelvis| 10 |
3            | 9           | Anterior | 15 |

Indications:
- Risk of rapid labor
- Distance from hospital
- Psychosocial indications
- Other: ___________________________

Does this patient have any specific issues/needs related to the scheduling of this induction?  □ Yes □ No
If yes, explain: ___________________________

Please fax this completed form along with the prenatal records to (813) 844-1668, if prenatal records not available in Epic.

This completed form and the prenatal records will be reviewed by a Labor and Delivery Staff Member. Your office will be notified of the scheduled induction date and time. If the patient needs to be informed of the date and time during this visit, please call the L&D Scheduling Line at (813) 844-6627.

Induction date: ___________________________
Time to arrive at hospital: ___________________________
Scheduled by: ___________________________
Referred to Dept. Chair/Chief: ___________________________

Please remind patient to call (813) 844-7122 prior to leaving home on day of scheduled induction.
Elective Induction Requirements: Hard Stop

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<th>Dilution</th>
<th>Effacement</th>
<th>Station</th>
<th>Consistency</th>
<th>Position</th>
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<td>0-30%</td>
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<td>Medium</td>
<td>Midposition</td>
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<td>2</td>
<td>3 - 4</td>
<td>60-70%</td>
<td>-1.0</td>
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<td>Anterior</td>
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<tr>
<td>3</td>
<td>5 - 6</td>
<td>80%</td>
<td>+1, +2</td>
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Indications:
- Risk of rapid labor
- Distance from hospital
- Psychosocial indications
- Other:
Why require a Bishop Score of 8 for Elective Inductions?
Intermountain Health Care CS Rates by Bishop Score

Cesarean Section Rates By Bishop Score

Elective Inductions in First-Time Moms 2001-2006
(Data from 6,721 Intermountain Healthcare patients)

Percent C-Sections

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<td>13.3%</td>
<td>13.4%</td>
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<td>Nine</td>
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Intermountain Healthcare

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Elective Induction Risk with Unripe Bishop Score

Concerns

- Increased risk of morbidity
- Decreased patient satisfaction
- Increased length of stay
- Increased utilization of beds, nursing staff and providers in postpartum
Concerns Related to Stricter Guidelines

- Patient, family pressure to be induced at 39 weeks (or on a specific date)
- Fairness in scheduling process—providers concerned that individual providers would take all the slots
- Concern that patients may want to deliver at a facility with less strict guidelines
Getting Buy In

- Physician Champions presented recommendations at monthly Perinatal Best Practice committee
  - Presented revised policy, induction booking form and patient education booklet
  - Obtained feedback
  - Received Maternal Fetal Medicine Physician support and approval
  - Provider to provider education about best practices
  - Nursing and Administration support for best practices
- Final plan taken to TGH OB/Gyn Department meeting
  - Approval obtained to make this TGH policy
LABOR Day Party Held to Kick Off New Process September 2012

COME CELEBRATE:
L&D’s Success & Future Opportunities with
LABOR INDUCTIONS
Wednesday, September 5th
L&D Conference Room K4008
AT 10:00am

BRUNCH will be served in a BEACHY atmosphere!!
Initial Induction Booking Process

- Prenatal care site given booking forms and patient education booklets
- Site would fill out information on form
- PNC site would Fax form and Prenatal Record to dedicated line in Nurse clinician office
- Clinician would review information, select date and time, fax info back to PNC site.
Process Evaluation

- Process was time consuming for Nurse Clinicians, who had additional clinical and administrative duties.
- PNC sites complained about not getting quick responses to inform patients with a 24 hour turn around time.
- Decision made to assign task to trained OB Data abstractors (non-nurses).
- List of approved indications approved by MFM utilized.
- If there was a question about whether an indication was appropriate-referred to MFM for final decision.
Developed Labor Induction Patient Education Booklet To Be Given to all Scheduled Inductions

Obtained written permission from Intermountain Health to use their graphs in our booklet
How Has This Process Worked?

- Many Providers felt that it took the pressure off of them from the patient perspective since it was a TGH policy.
- Data abstractors call or email Nurse Clinicians if a provider is asking to induce a patient without meeting the criteria.
- MFM contacted if indicated to obtain final decision.
PROVIDE
(Promoting Primary vaginal Deliveries)

TGH Baseline Report

Partnering to Improve Health Care Quality
for Mothers and Babies
Overall 1: Percent of All Cesarean Deliveries Performed by Category During Baseline

- Induction: 17%
- Dystocia: 15%
- FHR Concerns: 60%
- Other: 8%
Overall 2: Percent of All Cesarean Deliveries Performed that Met Criteria During Baseline

- 71% Yes
- 29% No
Overall 3: Percent of Cesarean Deliveries Performed Not Meeting Criteria by Category during Baseline

- 81% (FHR Concerns)
- 19% (Other, Induction, Dystocia)
I-8: Percent of NTSV Cesarean Deliveries with Induction by Bishop Score Agreement at Time of Induction between Provider and Hospital Record

![Bar chart showing percent agreement between provider and hospital record. The chart indicates 90% agreement and 10% disagreement.](chart.png)
I-10: Percent of All NTSV Cesarean Deliveries with Induction and a Bishop Score <8 with Cervical Ripening Agent Used
Previous Standard L&D H&P (Epic)
Changes to Standard L&D Admission H&P (Epic)

Abdomen: (pregnancy, gestational age: 31 weeks)
- FHT: Baseline ***, Accelerations: {DESC, PRESENT/ABSENT: 17923}, {DEC, NO/MILD/MOD/MARKED: 15%} variability, Category {Roman # IV 19040}
- Toco: contractions every [NUMBERS TO TEN: 20-26] (TIME, SECOND/MINUTE W/PLURALS: 19177), {DESC, regular/irreg: 14644}
- Presentation: {fetal pos: 14550} by ***, Estimated Fetal Weight: ***, Extremities: (EXTREMITIES EXAM: 30117150), Reflexes (Exam, reflexes: 19581)
- Sterile: normal vaginal mucosa, (presence/absence: 19608) of blood, Cervix: (cervix: 315964, "normal appearing cervix without discharge or lesions")
- Speculum exam: pooling, (gen poss neg 315643) ferning, (gen poss neg: 315643) nitrazine, KOH/Wet prep: (presence/absence: 19608) of BV, 
- (presence/absence: 19608) of yeast, (presence/absence: 19608) of Trichomonas

Cervix:
- Dilation: {NUMBERS 0-10 WILDCARD - AMB: 20610 cm}
- Effacement: {Ob effacement: 14523}
- Station: {station: 14562}
- Consistency: {firm/med/soft: 14583}
- Position: {post/mid/ant: 14884}
- Bishop Score: {NUMBERS 0-10 WILDCARD - AMB: 20610}

<table>
<thead>
<tr>
<th>Cervical Exam</th>
<th>Points</th>
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<tr>
<td></td>
<td>0</td>
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<tr>
<td>Dilation</td>
<td>Closed</td>
</tr>
<tr>
<td>Effacement (%)</td>
<td>0-30</td>
</tr>
<tr>
<td>Station</td>
<td>-3</td>
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<tr>
<td>Consistency</td>
<td>Firm</td>
</tr>
<tr>
<td>Position</td>
<td>Posterior</td>
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<tr>
<td>Total Score</td>
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Change to OB Rounding documentation
Bishop score calculator

<table>
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<tr>
<th>Bishop Score</th>
<th>Cervical Position</th>
<th>Cervical Consistency</th>
<th>Dilatation (cm)</th>
<th>Effacement (%)</th>
<th>Fetal Station</th>
<th>Bishop Score</th>
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<tbody>
<tr>
<td></td>
<td>0 = posterior</td>
<td>0 = firm</td>
<td>0 = closed/0 cm</td>
<td>0 =0-10%</td>
<td>0 = 1-4</td>
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<tr>
<td></td>
<td>1 = middle</td>
<td>1 = medium</td>
<td>1 = 1 cm</td>
<td>1 =0-50%</td>
<td>1 = 1-3</td>
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<tr>
<td></td>
<td>2 = anterior</td>
<td>2 = soft</td>
<td>2 = 2 cm</td>
<td>2 =50-70%</td>
<td>2 = 2-4</td>
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<tr>
<td></td>
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<td></td>
<td>3 = 3 cm</td>
<td>3 = greater than 80%</td>
<td>3 = 3-6</td>
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<td></td>
<td></td>
<td>4 = 4 cm</td>
<td></td>
<td>3 = 6-7</td>
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<td></td>
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<td>5 = 5 cm</td>
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<td>3 = 6-7</td>
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<td>6 = 6 cm</td>
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<td>3 = 8-9</td>
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<td>7 = 7 cm</td>
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<td>3 = 10</td>
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<td>9 = 9 cm</td>
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<td>10 = 10 cm</td>
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</tbody>
</table>
Sacred Heart Hospital Pensacola Experience

Dr Joe Peterson SHHS PROVIDE Lead
Erica Bottom RN, MSN PROVIDE Lead
Julie DeCesare, MD FPQC PROVIDE Lead

Partnering to Improve Health Care Quality for Mothers and Babies
Comments?
Questions?
http://health.usf.edu/publichealth/chiles/fpqc/provide/toolbox
Thank you!

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