

Safely Reducing NTSV Cesareans – California Style

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Primary Cesarean Collaborative

Objectives and Disclosures

Objectives:

- Understand how California approached supporting vaginal birth and reducing primary cesarean sections
- List key QI elements from the Cesarean bundle
- Identify practical QI interventions to use on L&D

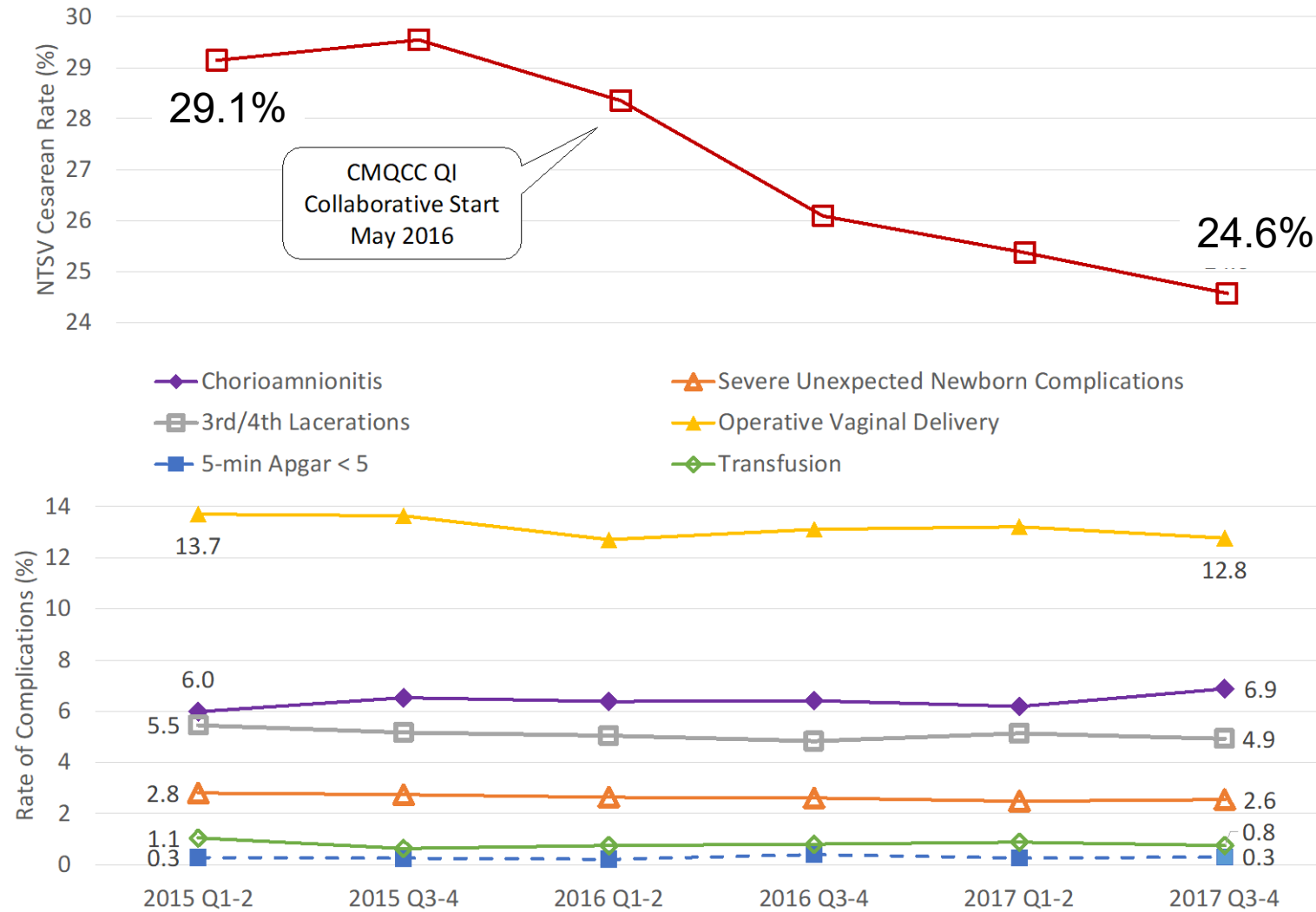
Disclosures

- Ms. Sakowski has no conflicts or disclosures to report

California Maternal Quality Care Collaborative - CMQCC

- Mission to end preventable morbidity, mortality and racial disparities in California maternity care
- Initial Funding from the California Dept. of Public Health
 - Rise in maternal mortality—needed study and action
 - Multidisciplinary Review Committee focused on potential improvement opportunities
 - Provided the foundation for Toolkits
- Further funding from CDC, CDPH, CHCF, RWJ, Yellow Chair & others
 - Formation of the Maternal Data Center
 - Collaborative programs
 - Supportive education and tools
- Multi-organization, multi-disciplinary partners and stakeholders

Trendlines for NTSV Cesarean and Safety Measures Rates (6 month blocks)




Supporting Vaginal Birth Collaborative Design: Coaching & Sharing

- 18 months
- Mentor lead
- Kick-off
- Site Visits
- CMQCC team
- SHARE
- Closing Celebration



KEY RESOURCES



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS


COMMITTEE OPINION

Number 687 • February 2017

Committee on Obstetric Practice
The American College of Nurse-Midwives and the Association of Women's Health, Obstetric and Neonatal Nurses endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, in collaboration with American College of Nurse-Midwives' liaison member Tekoa L. King, CNM, MPH, and College committee members Kurt R. Wharton, MD, Jeffrey L. Ecker, MD, and Joseph R. Wax, MD. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Approaches to Limit Intervention During Labor and Birth

ABSTRACT: Obstetrician-gynecologists, in collaboration with midwives, nurses, patients, and those who support them in labor, can help women meet their goals for labor and birth by using techniques that are associated with minimal interventions and high rates of patient satisfaction. Many common obstetric practices are of limited or uncertain benefit for low-risk women in spontaneous labor. For women who are in latent labor and are not admitted, a process of shared decision making is recommended. Admission during the latent phase of labor may be necessary for a variety of reasons. A pregnant woman with term premature rupture of membranes (also known as prelabor rupture of membranes) should be assessed, and the woman and her obstetrician-gynecologist or other obstetric care provider should make a plan for expectant management versus admission and induction. Data suggest that in women with normally progressing labor and no evidence of fetal distress, cesarean delivery is not necessary. The widespread use of continuous electronic fetal heart-rate monitoring is not necessary. Multiple nonpharmacologic techniques can be used to help women cope with labor pain. Women in spontaneously progressing labor do not require routine continuous infusion of intravenous fluids. For most women, no one position is proscribed. Nulliparous women who have an epidural and no indication for expedited delivery should be encouraged to have a period of rest for 1-2 hours before initiating pushing efforts. Obstetrician-gynecologist providers should be familiar with and consider using low-interventional approaches to the management of low-risk women in spontaneous labor.



COUNCIL ON PATIENT SAFETY
IN WOMEN'S HEALTH CARE
safe health care for every woman

SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

READINESS

Every Patient, Provider and Facility

- Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.


RECOGNITION AND PREVENTION

Every patient


- Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
- Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Use standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using NICHHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.

PATIENT SAFETY BUNDLE

Safe Reduction of Primary Cesarean Births



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

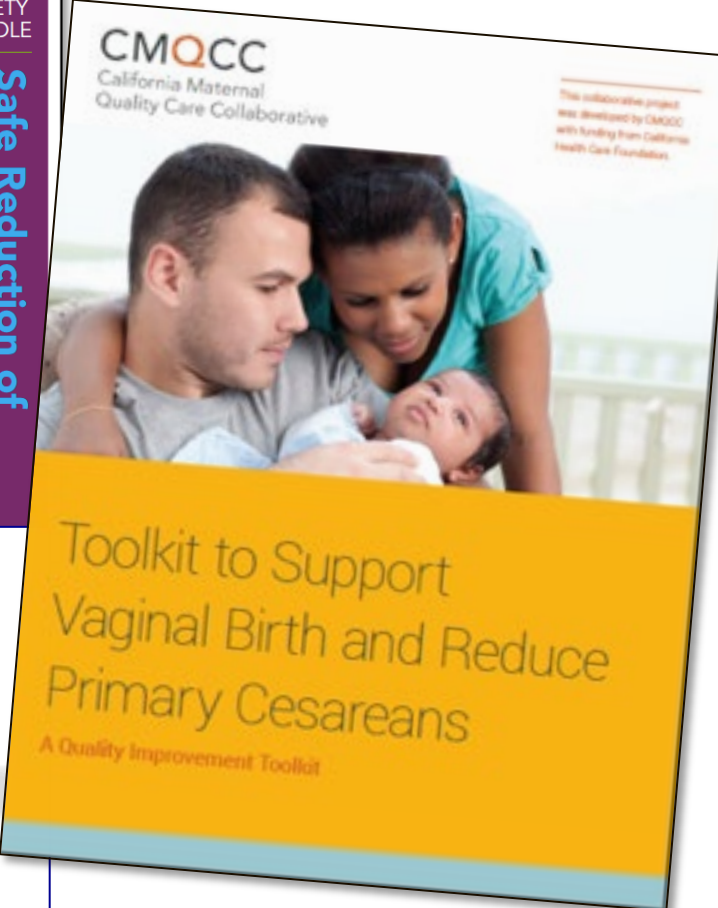


Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

Number 1 • March 2014

Safe Prevention of the Primary Cesarean Delivery



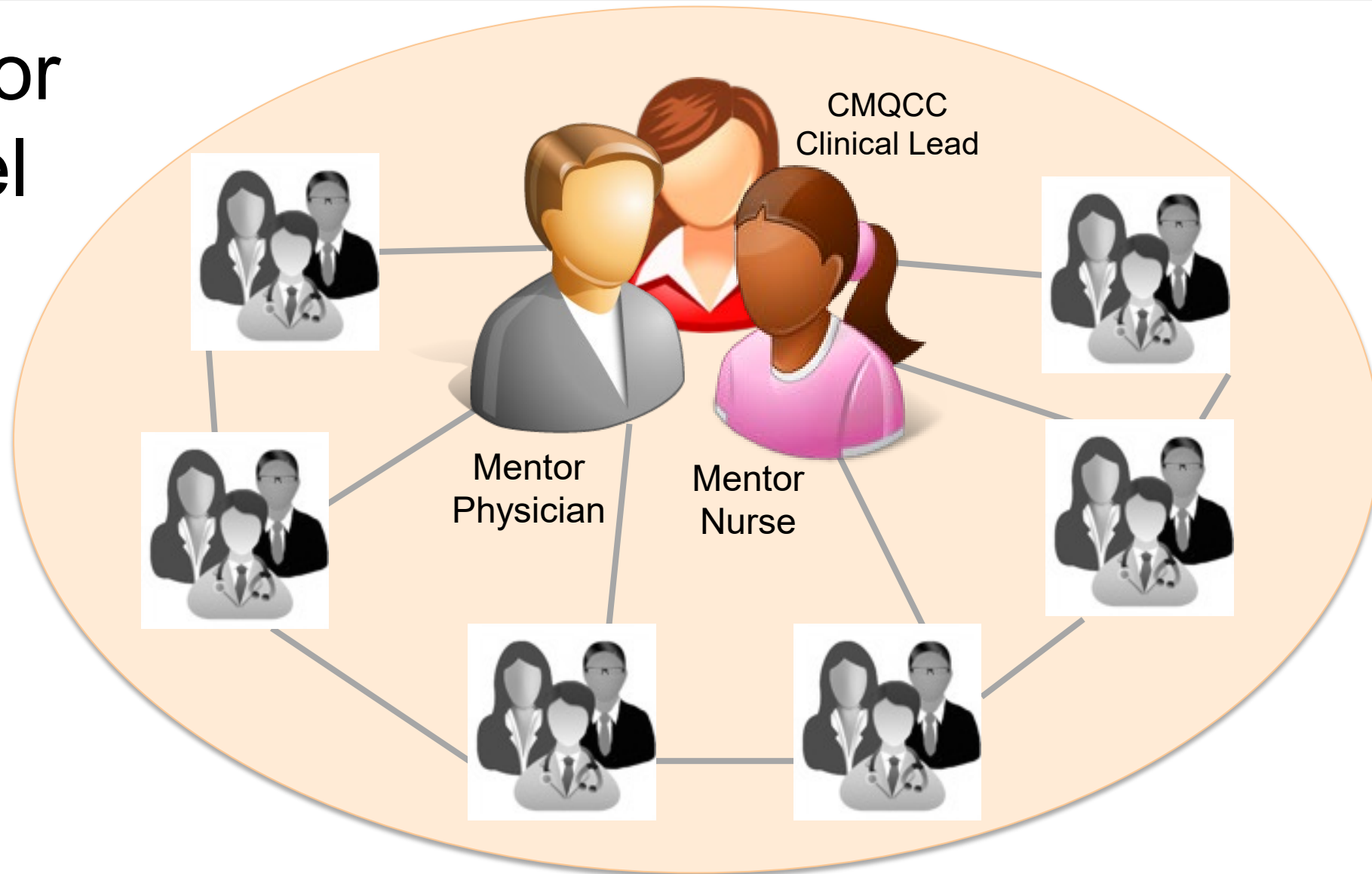
CMQCC
California Maternal Quality Care Collaborative

This collaborative project was developed by CMQCC with funding from California Health Care Foundations.

Toolkit to Support Vaginal Birth and Reduce Primary Cesareans
A Quality Improvement Toolkit

The Mentor Model

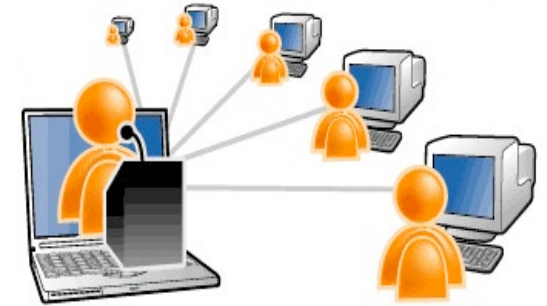
Mentor Model



Hospital Implementation Teams

Features of the Mentor Model

- In-person meetings
 - Kick-off
 - Closing Celebration
- Monthly web based meetings - focused attention
- Hospital site visit within first 3-6 months of collaborative start
- Mentor Guidance
- CMQCC Support



Key Activities for Monthly Meetings

- Present and discuss hospital level successes/challenges/concerns
- Celebrate accomplishments
- Share resources
- Supplemental Education
- Questions/Suggestions



What Did We Learn?

Lessons Learned

- This is not an easy project
- Build a strong team
- No one strategy will be effective
- Start with an easy win
- Identify areas of greatest impact
- Celebrate success!

COMMON QI ACTIVITIES:

- 1) Labor support techniques
- 2) Active phase guidelines
- 3) CS rate transparency
- 4) Latent phase guidelines
- 5) Induction guidelines
- 6) Techniques to reduce OP
- 7) Patient engagement
- 8) Unit culture/teamwork
- 9) Longer 2nd Stage

(in approximate order of use)

Hospital Quality Improvement Interventions, Statewide Policy Initiatives, and Rates of Cesarean Delivery for Nulliparous, Term, Singleton, Vertex Births in California

Melissa G. Rosenstein, MD, MAS; Shen-Chih Chang, MS, PhD; Christa Sakowski, MSN; Cathie Markow, RN, MBA; Stephanie Teleki, PhD; Lance Lang, MD; Julia Logan, MD, MPH; Valerie Cape, BSBA; Elliott K. Main, MD

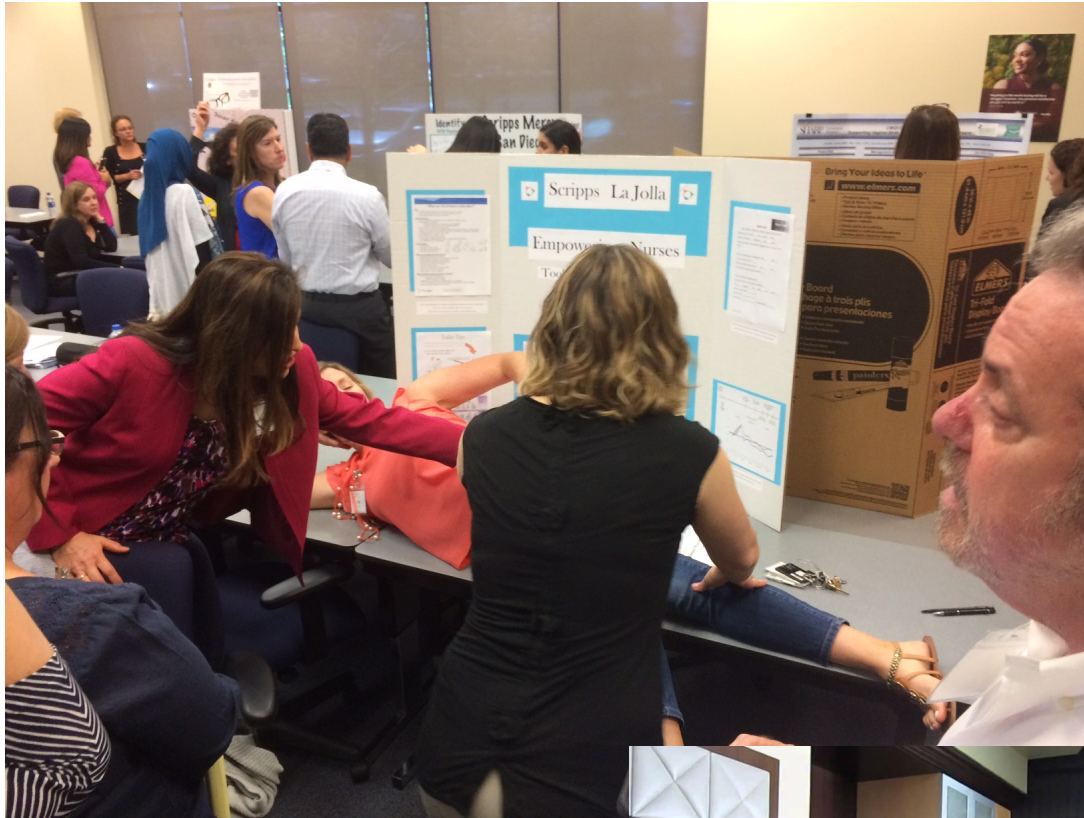
IMPORTANCE Safe reduction of the cesarean delivery rate is a national priority.

OBJECTIVE To evaluate the rates of cesarean delivery for nulliparous, term, singleton, vertex (NTSV) births in California in the context of a statewide multifaceted intervention designed to reduce the rates of cesarean delivery.

DESIGN, SETTING, AND PARTICIPANTS Observational study of cesarean delivery rates from 2014 to 2019 among 7 574 889 NTSV births in the US and at 238 nonmilitary hospitals providing maternity services in California. From 2016 to 2019, California Maternal Quality Care Collaborative partnered with Smart Care California to implement multiple approaches to decrease the rates of cesarean delivery. Hospitals with rates of cesarean delivery greater than 23.9% for NTSV births were invited to join 1 of 3 cohorts for an 18-month quality improvement collaborative between July 2016 and June 2019.

JAMA.2021;325(16):1631–1639.
doi:10.1001/jama.2021.3816

Labor Support



PHYSICIAN BADGE TAG

Physician Badge Tag

Prevent Her 1st Cesarean Section

Latent Phase Arrest (Failed Induction of Labor)

- If <6cm dilated → 12 hrs of oxytocin after ROM?

Active Phase Arrest (Arrest of Dilation)

- If 6-10cm dilated + ROM → 4h with adequate uterine activity or at least 6h with inadequate uterine activity with oxytocin

Arrest of Descent (2nd stage)

- If completely dilated → pushing ≥3hr without epidural in Second Stage (or 4hrs with epidural)

Elective Induction of Labor

- Prior to 41 weeks
- Bishop score ≥ 8 (nulliparous); ≥6 (multiparous)
- Physician Documentation (tell the story)
- Labor management
- Decision/rationale for C-section

Laborist Contact Number

#(818)885-8500 ext. 5350

Education and Adoption of ACOG/SMFM Guidelines



Share Unblinded Data

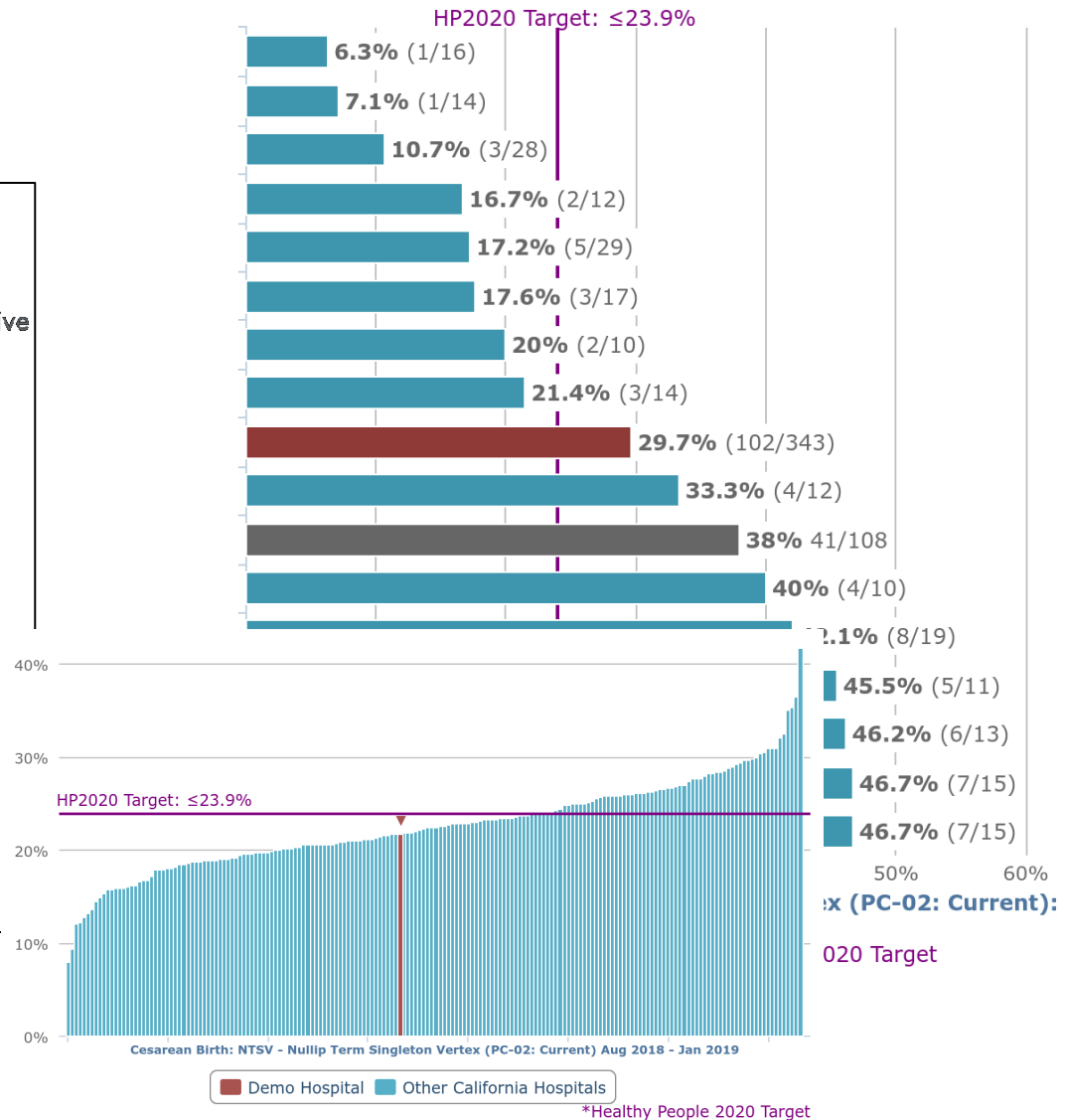


Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates

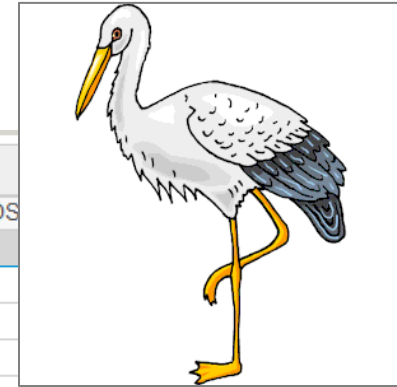
At Start of Project

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-primary-cesareans/collaborative>



Identify NTSV Patients

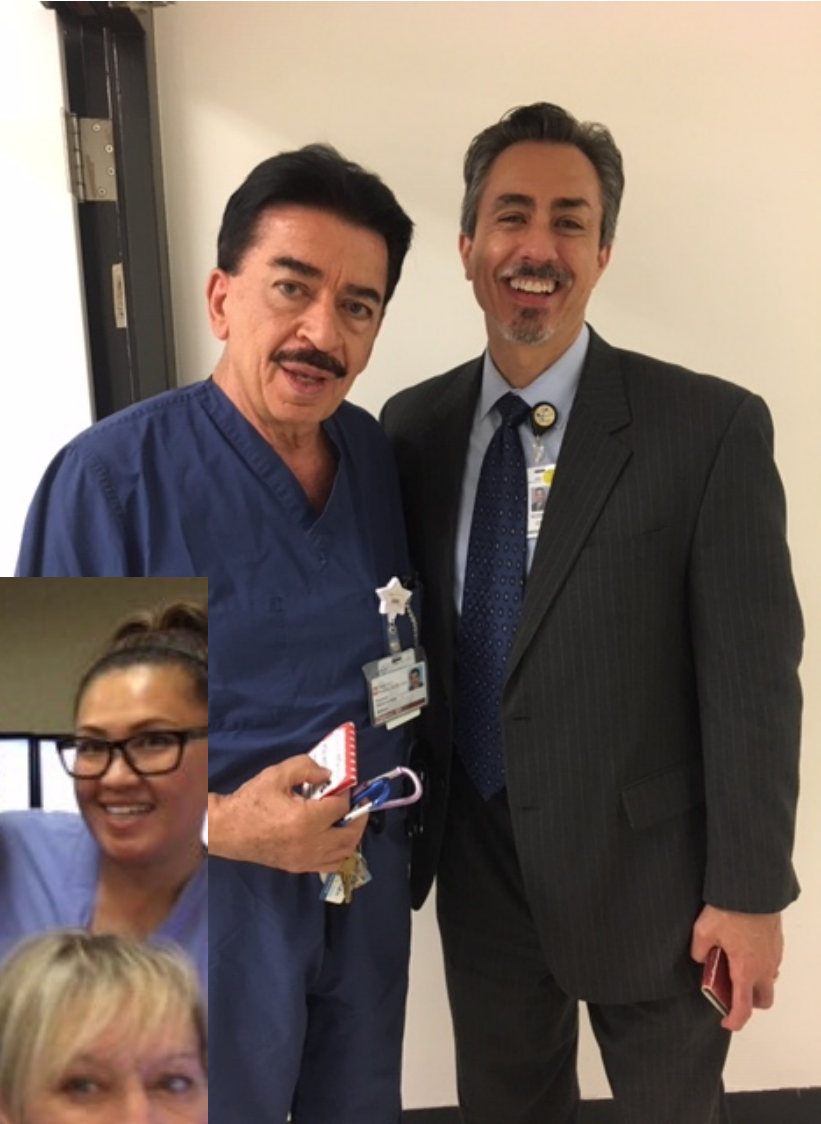
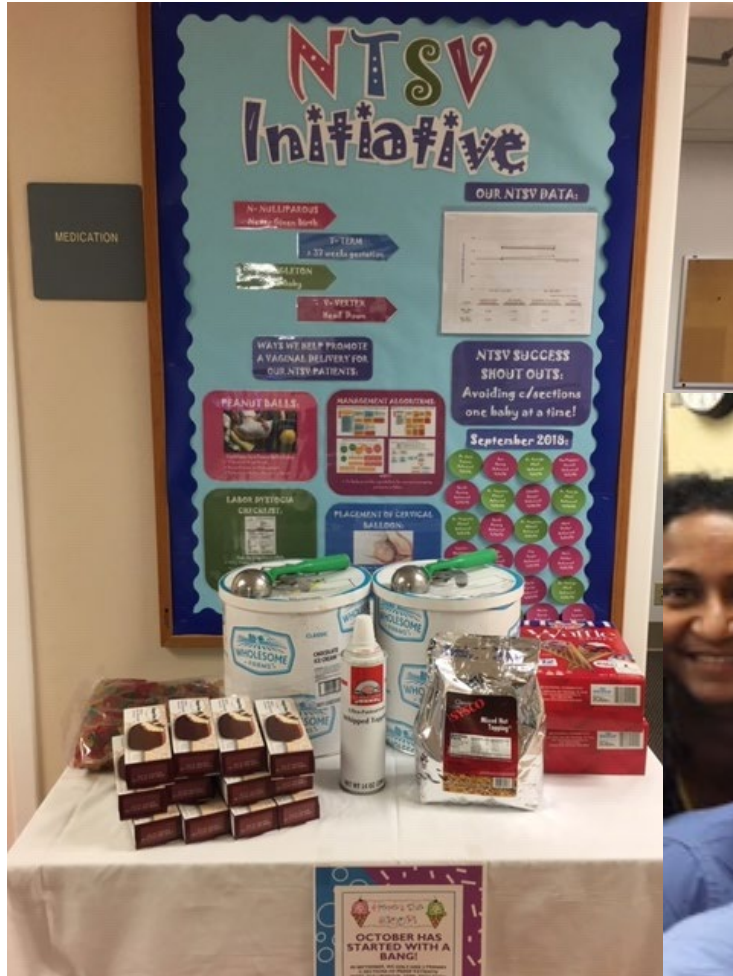


Median LOS: 23:01 Total: 15 WR: 0 Filter: OB Inpatient, OBS, OB Chei

Bed	S	Name	Status	EGA	RN	Extension	Provider	Anesthesia	To Do	Notifications	NR	LOS
2101,A	Avail											
2101,B	Avail											
2102,A	Avail											
2103,A	Avail											
2104,A	Avail											
2105,A	Assi	RC	PP Vag	✓	Rachel	DP	SMG		B			0:6:39
2106,A	Assi	ME	Labor	35 0/7	Denise/KL	Name Alert	OBHG				<input checked="" type="checkbox"/>	0:5:58
2107,A						DP	OBHG		B		<input checked="" type="checkbox"/>	0:8:30
2108,A							OBHG	Indwelling/infusin	R			1:19:59
2109,A							SMG					
2110,A							OBHG	Disconti				



Team Build



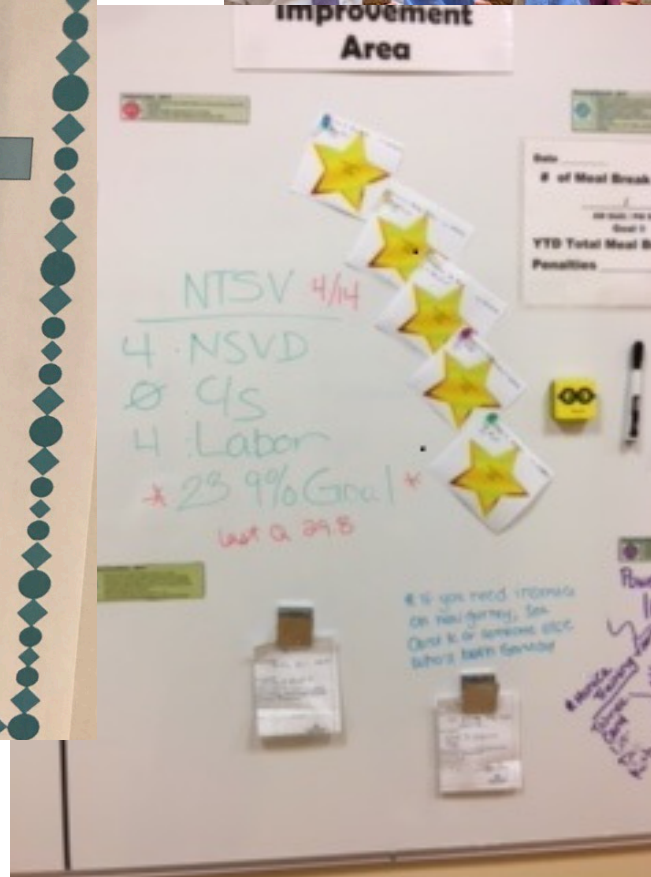
Recognize "Saves"



NTSV SHOUT OUTS
February 2019
Avoiding c/sections one patient at a time.

NURSES:	DOCTORS:
Susannah Grimes: 3	Dr. Shafee: 6
DeLacey Andersen: 2	Dr. Borrowdale: 4
Angela Hirvela: 2	Dr. Forghani: 3
Wanda Lincoln: 2	Dr. Khan: 3
Lydia Mauney: 2	Dr. Akerman: 1
Candice Crosby: 1	Dr. Bhatnagar: 1
Elyse Fagan: 1	Dr. Dang: 1
Ketsia Fleurima: 1	Dr. Garg: 1
Brandi Gergis: 1	
Ashley Gonzalez: 1	
Jennifer Harris: 1	
Geneve Hoang: 1	
Amanda Smith: 1	
Rachel Waddell: 1	

YESSSS!!!!!!



Celebrate Success!!!



Transparency



Mother and Baby ?

	Current	State Average
C-Section Rate (NTSV)	AVERAGE 25.1% (lower is better)	25.4% (lower is better)
Breastfeeding Rate	SUPERIOR 92.6%	68.5%
Episiotomy Rate	AVERAGE 8.2% (lower is better)	9.5%
VBAC Routinely Available	NOT RATED Yes	
VBAC Rate	BELOW AVERAGE 7.1%	

El Camino Hospital Claimed
 320 reviews
 Hospitals, Emergency Rooms, Obstetricians & Gynecologists

2500 Grant Rd
 Mountain View, CA 94040
 (650) 940-7000
 elcaminhospital.org

Maternity Care Data
 Based on data from Cal Hospital Compare

- C-Section Rate Average Rate
- Breastfeeding Rate Well Above Average Rate
- Episiotomy Rate Average Rate
- VBAC Routinely Available Yes
- VBAC Rate Below Average Rate

- Every Year the CA Secretary of HHS Recognizes Hospitals With NTSV CS Rates <23.9%
- CalHospitalCompare.org
- Yelp
- Joint Commission

Questions



CMOCC