FPQC
Florida Perinatal Quality Collaborative

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

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Lessons Learned from Implementing an Induction Policy

Tampa General Hospital PROVIDE Team

Karen Bruder

Sherri Badia

Pat Barry

Frances Manali

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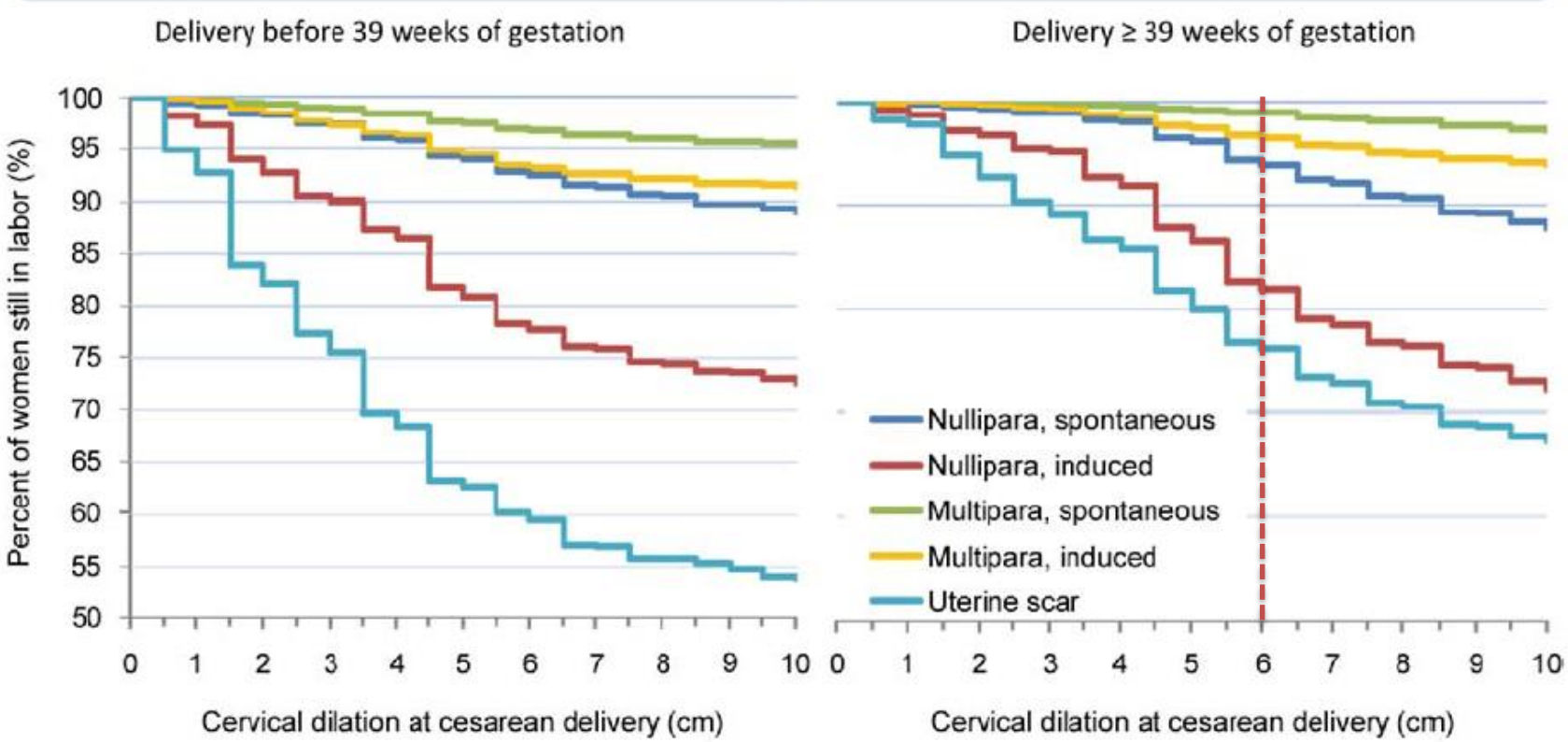
for Mothers and Babies

ACOG Standard Definitions

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

FIGURE 2

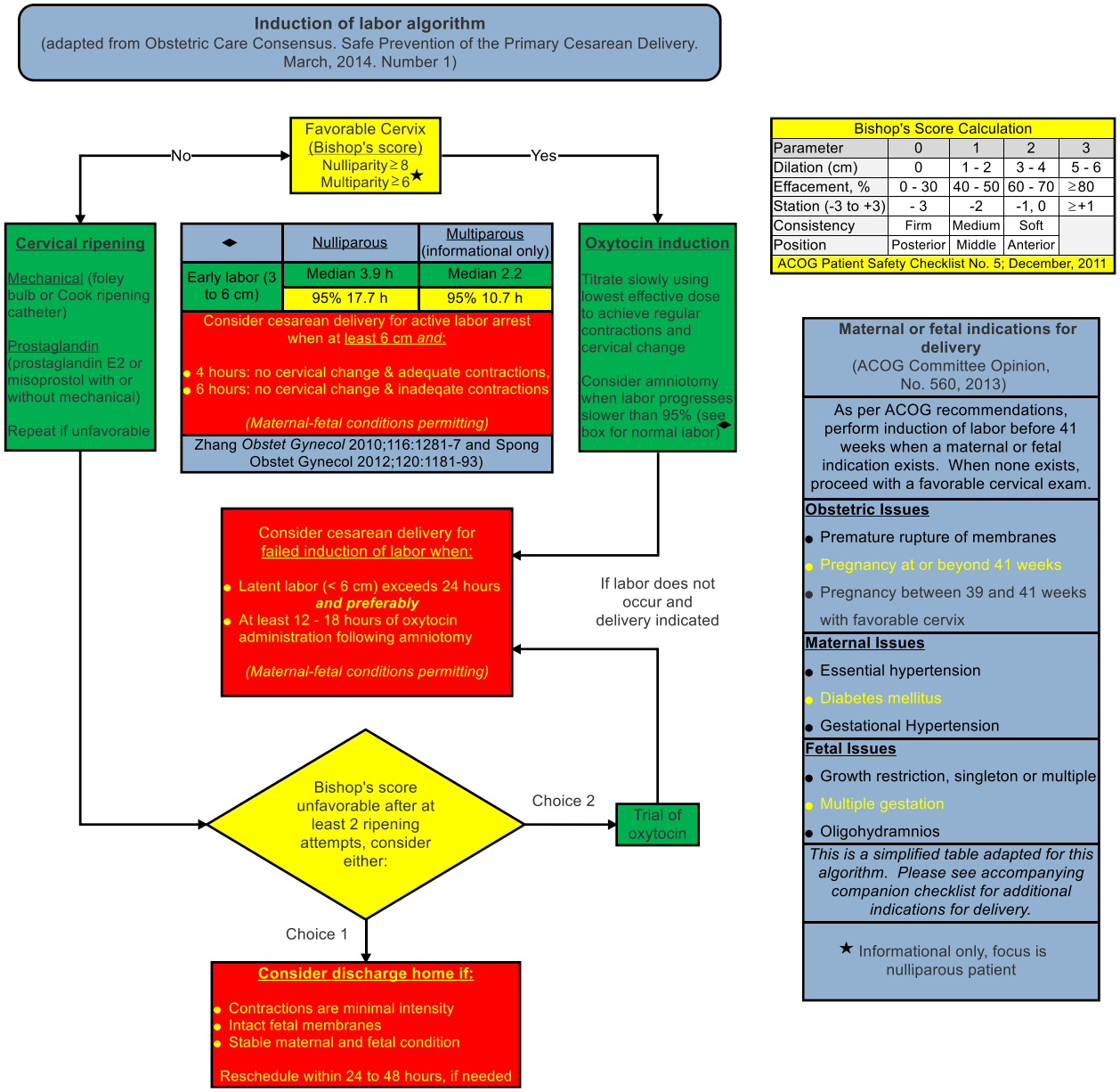
Cervical dilation at cesarean delivery



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.

Zhang. Contemporary cesarean delivery practice in the US. Am J Obstet Gynecol 2010.

Finding: More than 50% of induced nullips are <6cm at CS



Bishop's Score Calculation				
Parameter	0	1	2	3
Dilation (cm)	0	1 - 2	3 - 4	5 - 6
Effacement, %	0 - 30	40 - 50	60 - 70	≥80
Station (-3 to +3)	- 3	-2	-1, 0	≥+1
Consistency	Firm	Medium	Soft	
Position	Posterior	Middle	Anterior	

ACOG Patient Safety Checklist No. 5; December, 2011

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

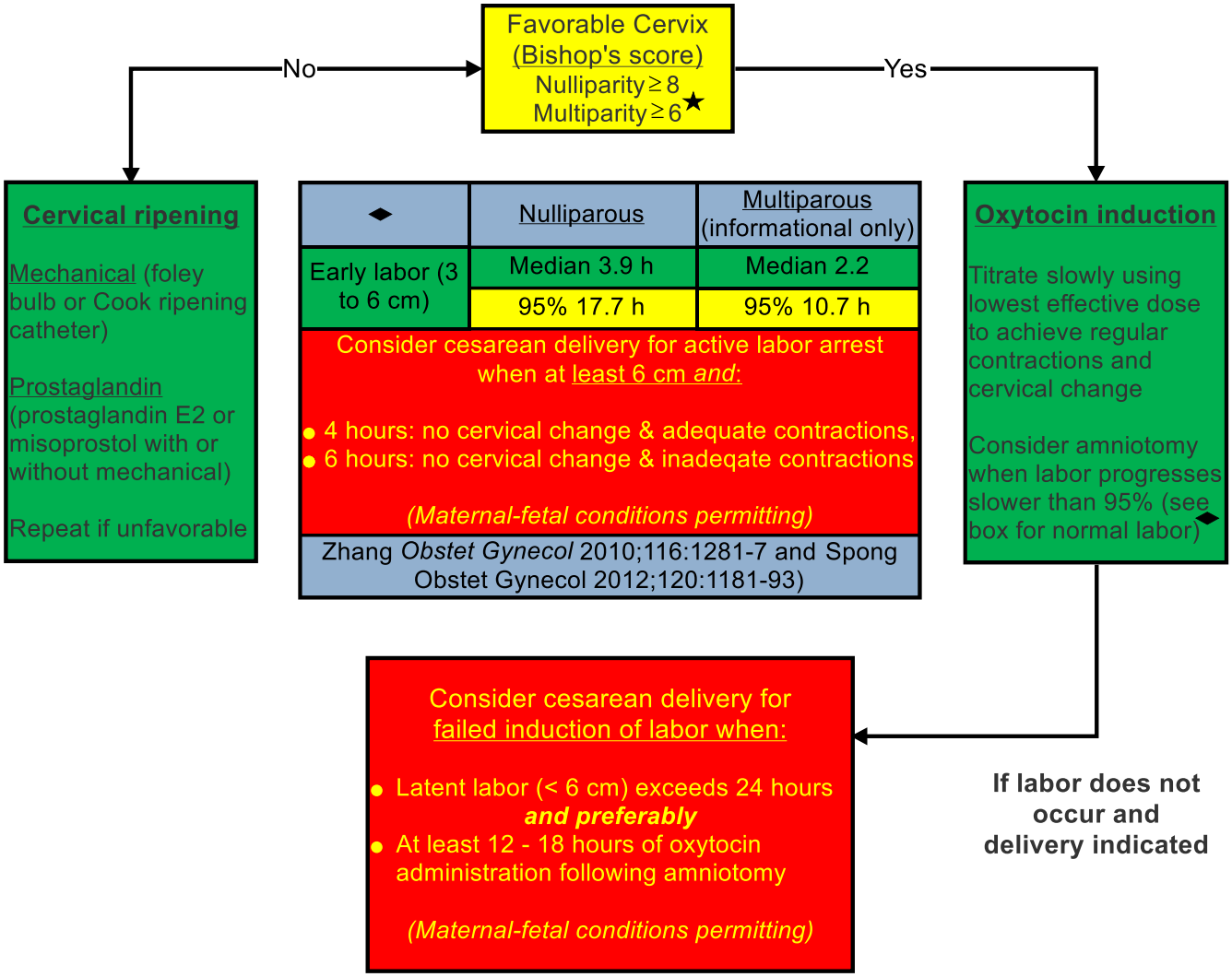
Fetal Issues
- Growth restriction, singleton or multiple
- Multiple gestation
- Oligohydramnios

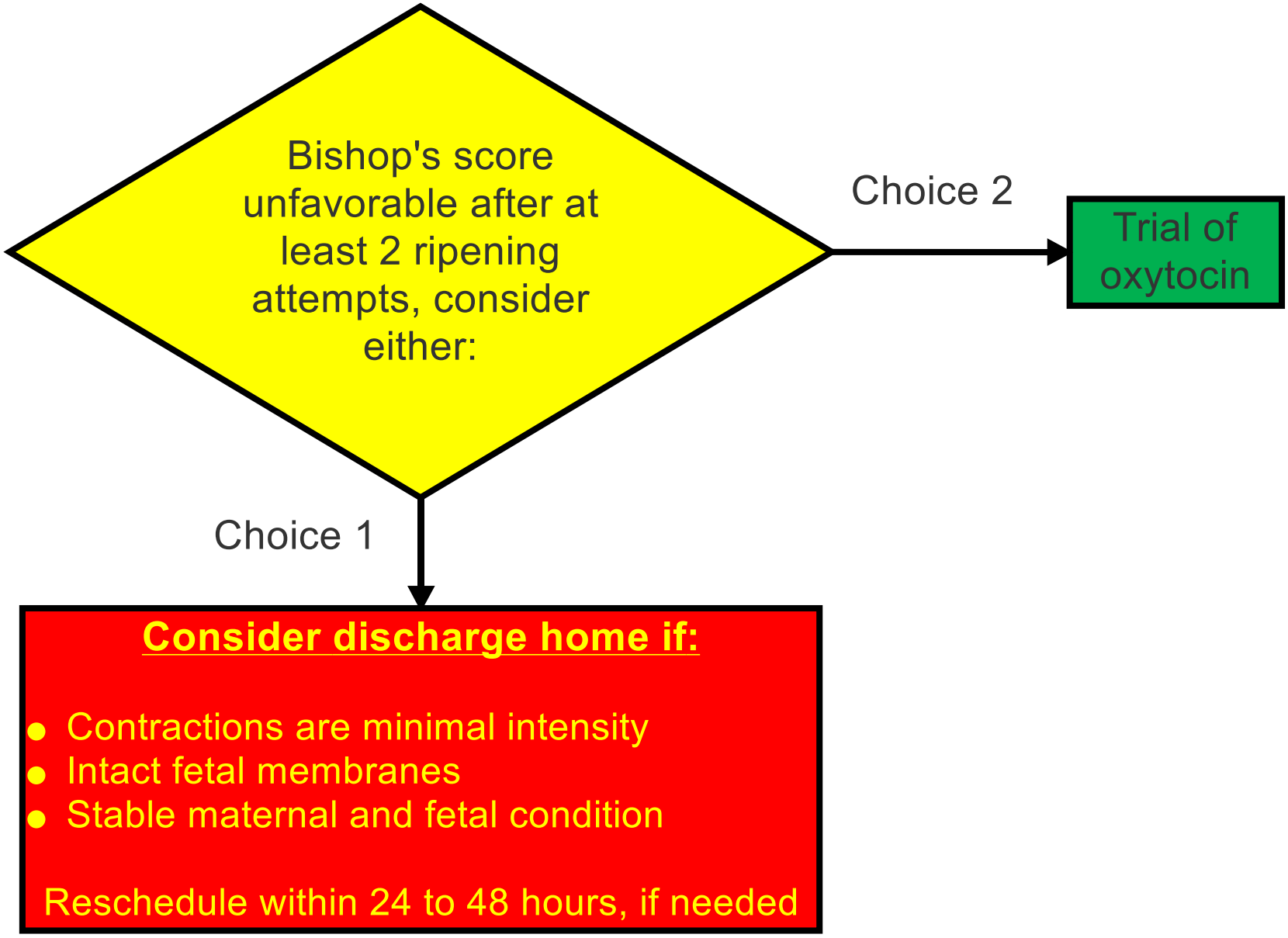
This is a simplified table adapted for this algorithm. Please see accompanying companion checklist for additional indications for delivery.

★ Informational only, focus is nulliparous patient

Bishop's Score Calculation				
Parameter	0	1	2	3
Dilation (cm)	0	1 - 2	3 - 4	5 - 6
Effacement, %	0 - 30	40 - 50	60 - 70	≥80
Station (-3 to +3)	- 3	-2	-1, 0	≥+1
Consistency	Firm	Medium	Soft	
Position	Posterior	Middle	Anterior	
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.




Bishop's score unfavorable after at least 2 ripening attempts, consider either:
Choice 2
Trial of oxytocin
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

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PROVIDE
(Promoting Primary Vaginal Deliveries)

Baseline Report

Initiative-wide

Data Source: NTSV Cesarean Audits

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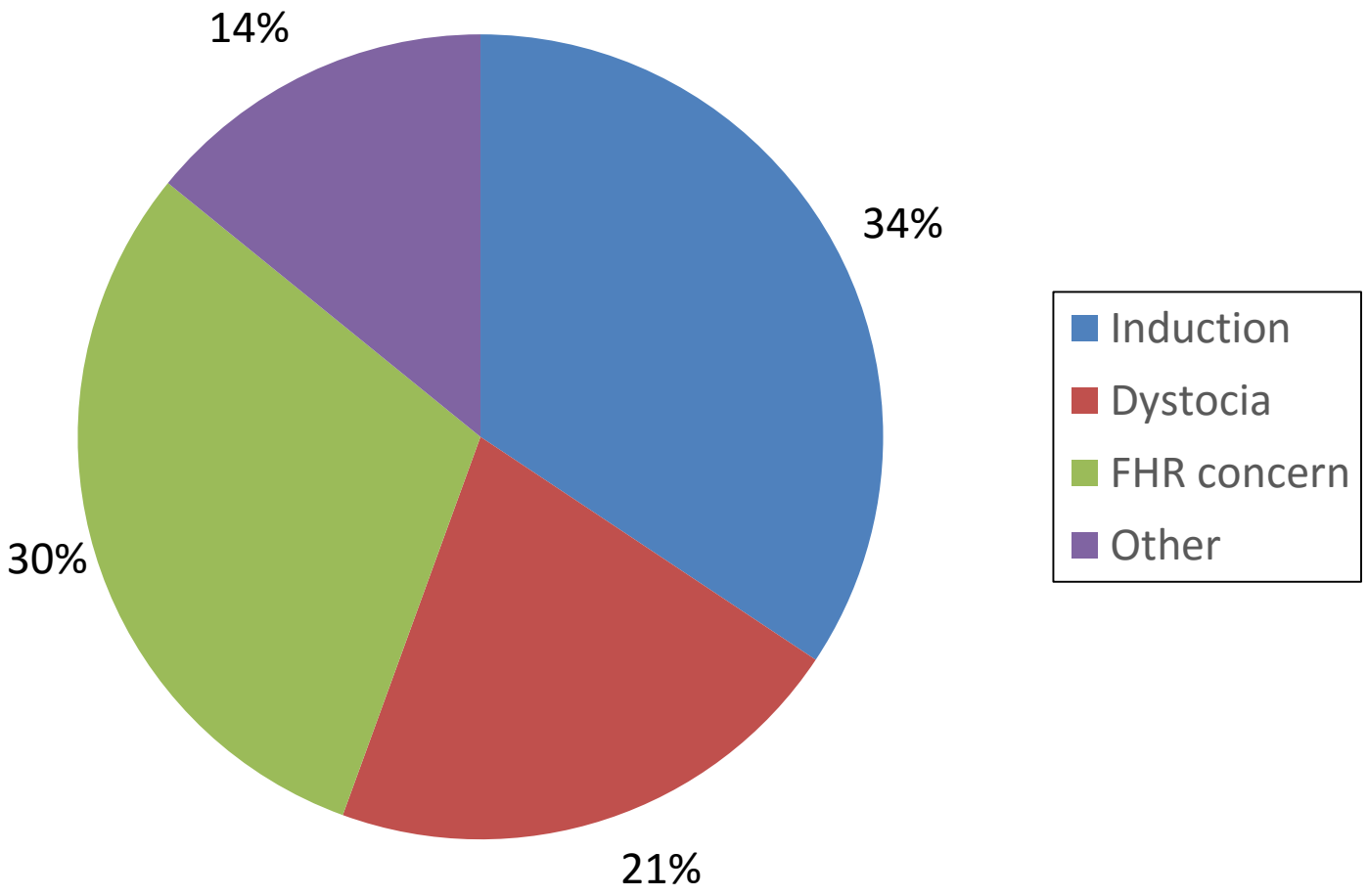
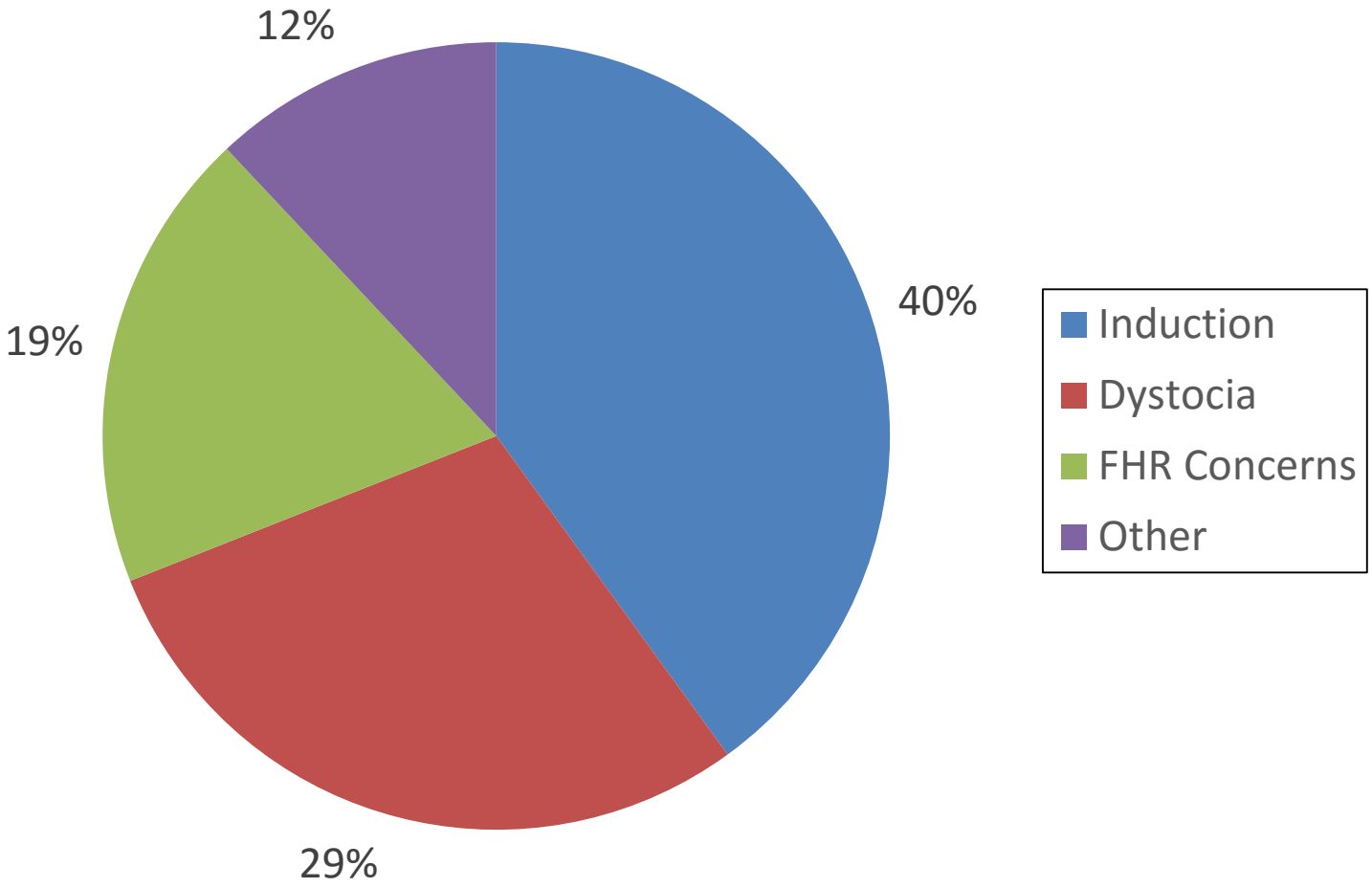
for Mothers and Babies

OVERALL ASSESSMENT
45 HOSPITALS

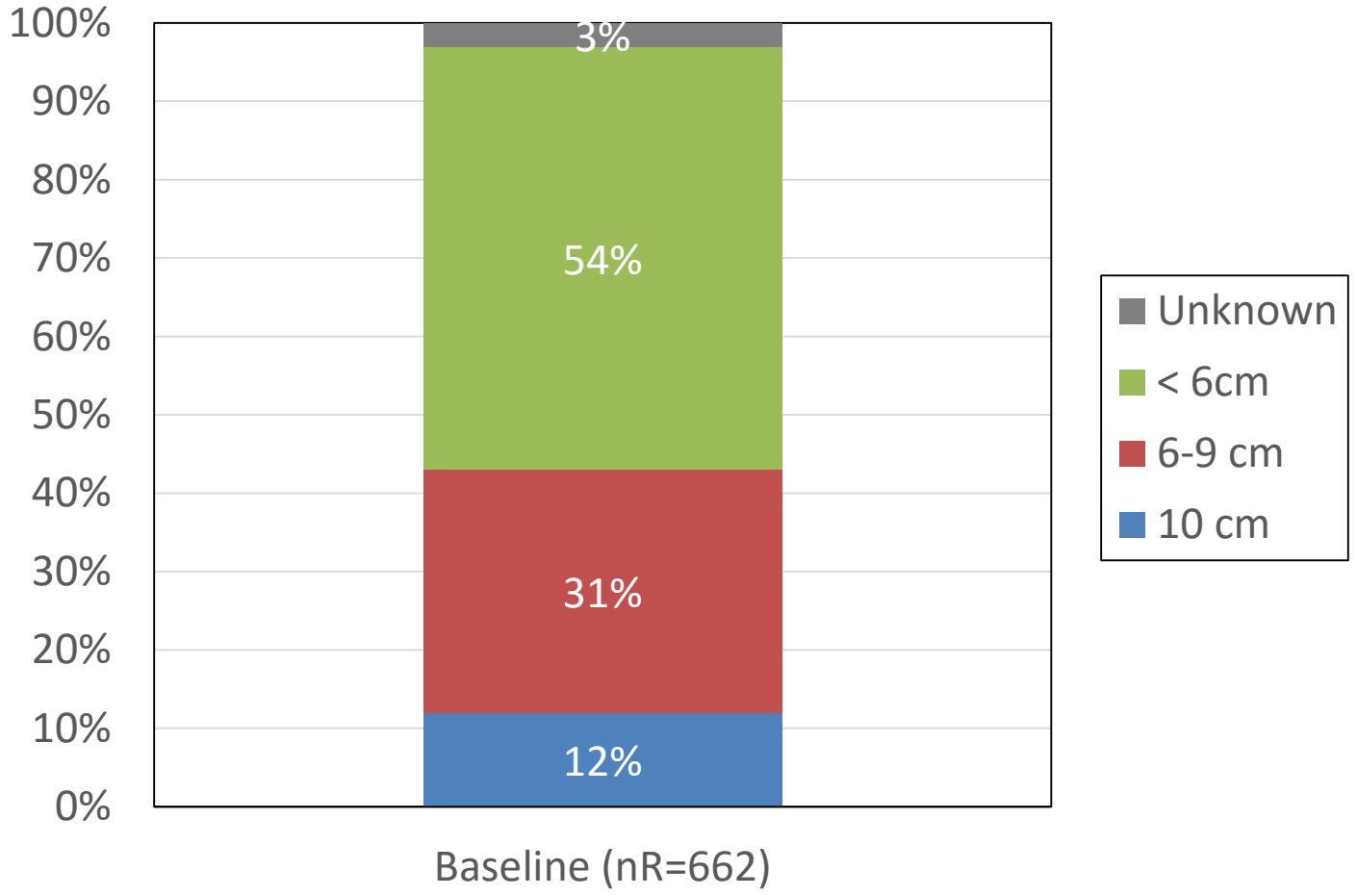
Overall 1: Percent of All NTSV Cesarean Deliveries Performed by Category During Baseline



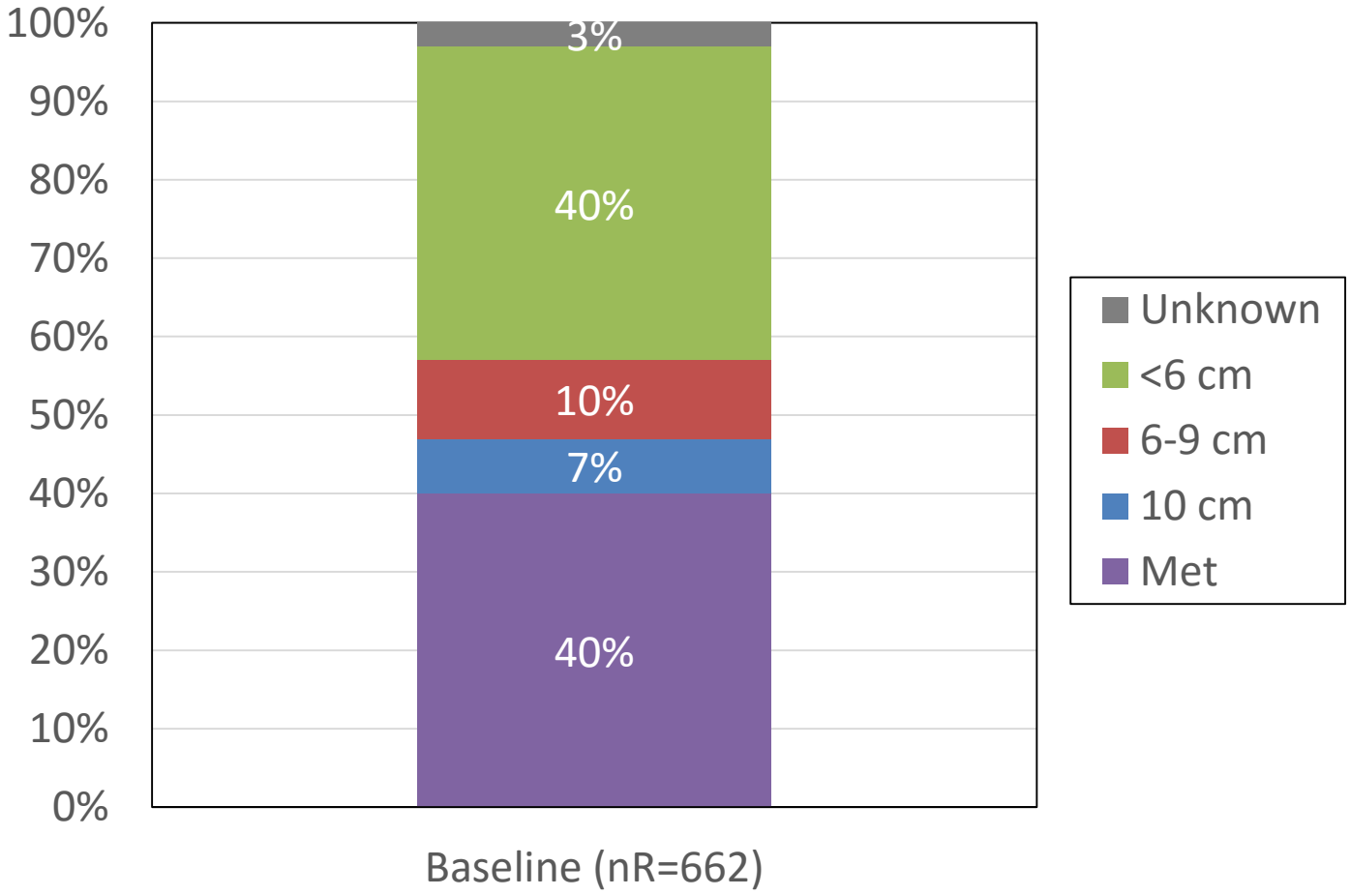
Overall 3: Percent of NTSV Cesarean Deliveries Performed Not Meeting Criteria by Category during Baseline



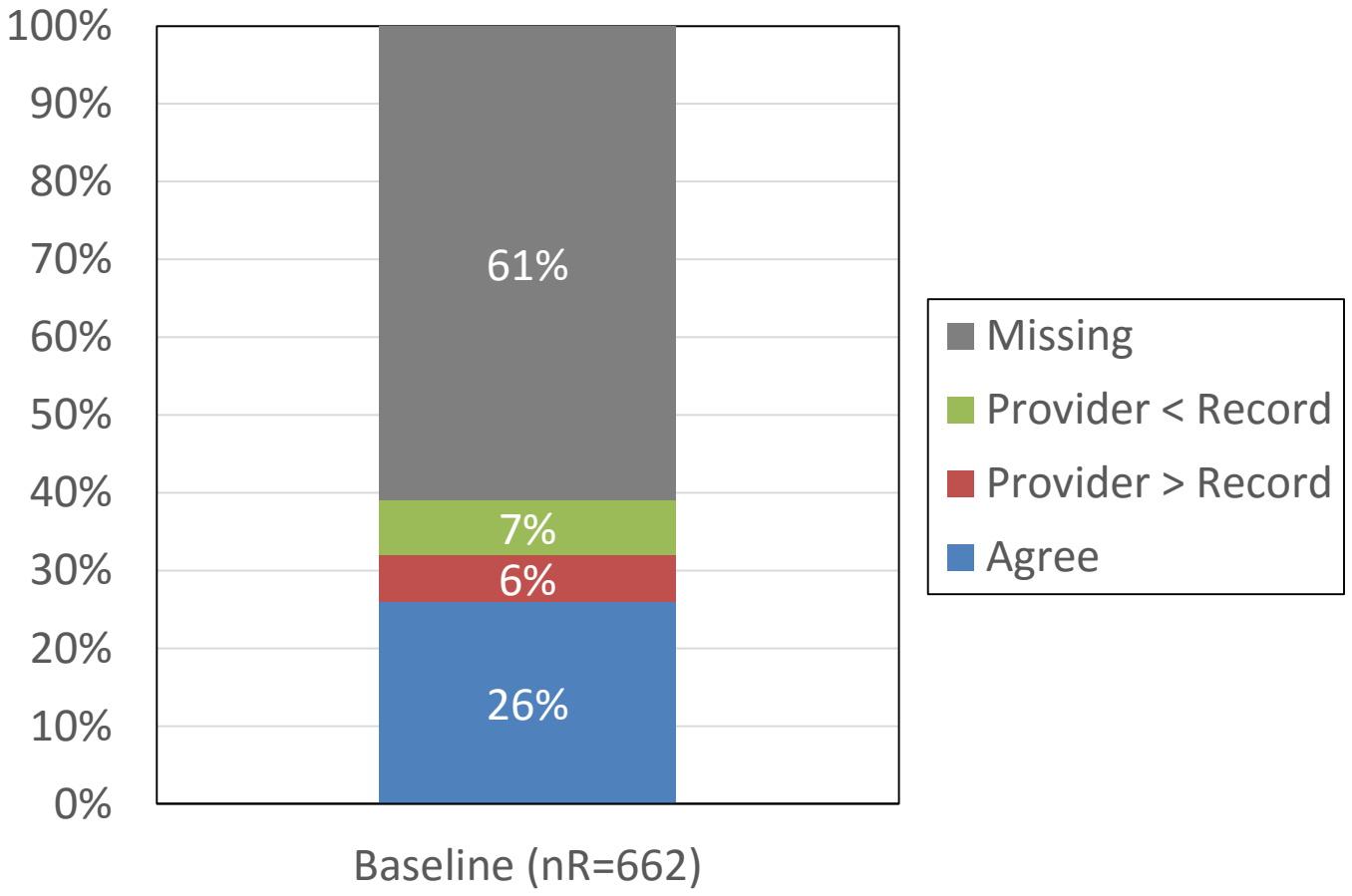
I-3a. Percent of NTSV Cesarean Deliveries with Induction by Cervix Dilation at Delivery



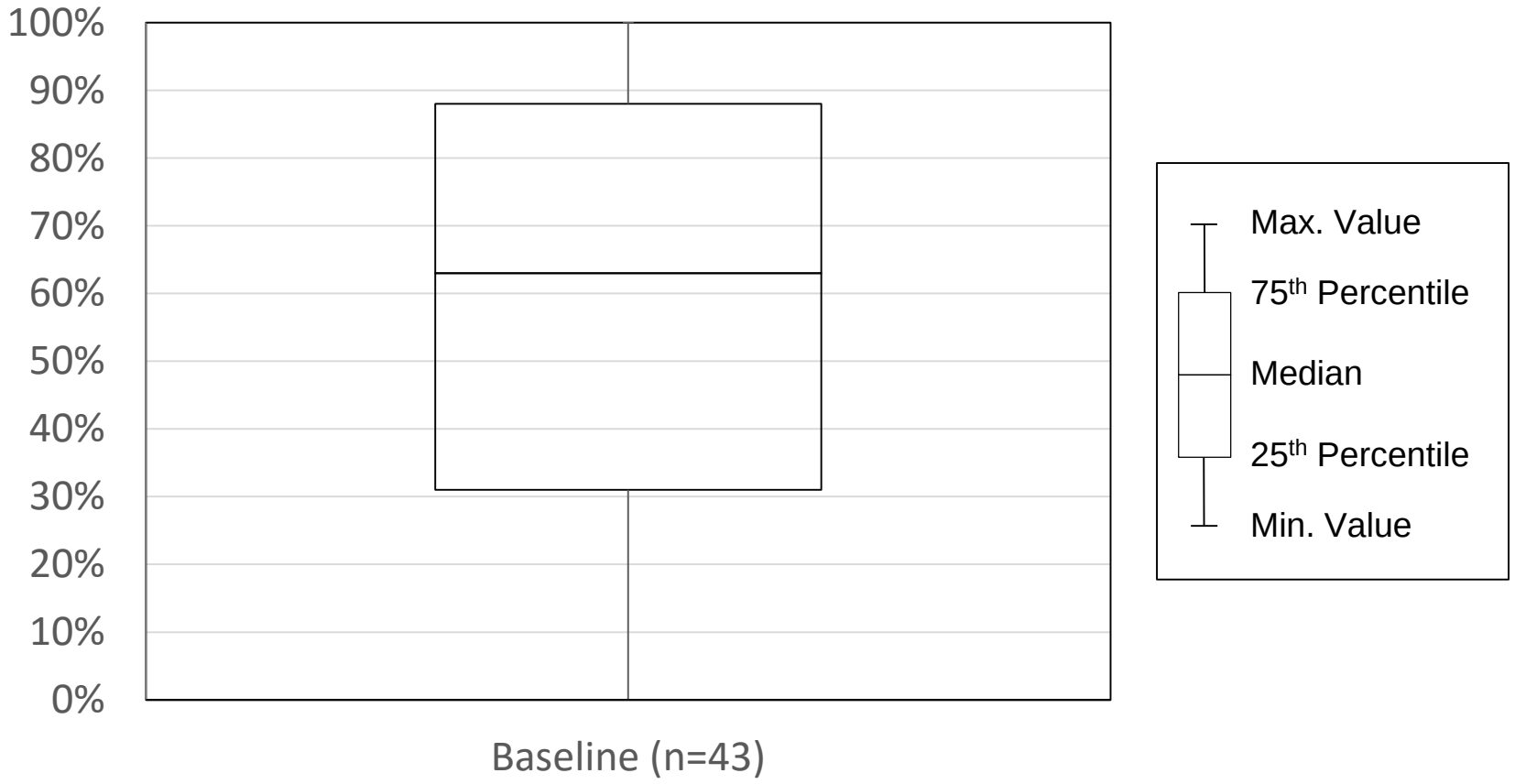
I-4: Percent of Cesarean Deliveries with Induction that Did Not Meet ACOG/SMFM Criteria by Cervical Dilatation



I-8: Percent of NTSV Cesarean Deliveries with Induction by Bishop Score Agreement at Time of Induction between Provider and Hospital Record



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 placentae
☐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
☐Heart disease
☐ Liver disease (e.g. cholestasis of pregnancy.)
☐Chronic HTN
☐Diabetes (Type I or II)
☐Renal disease
☐Oligohydramnios

- 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

Bishop's Score Calculation				
Parameter	0	1	2	3
Dilation (cm)	0	1 - 2	3 - 4	5 - 6
Effacement, %	0 - 30	40 - 50	60 - 70	≥80
Station (-3 to +3)	- 3	-2	-1, 0	≥+1
Consistency	Firm	Medium	Soft	
Position	Posterior	Middle	Anterior	
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

ACOG Patient Safety Checklist No 2. Inpatient Induction of Labor December 2011, reaffirmed 2014

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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

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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:

Indication for induction

Medical	**Elective**
☐ Abruptio placentae ☐ Chorioamnionitis ☐ Fetal demise ☐ Hypertension ☐ Premature rupture of membranes ☐ Postterm pregnancy ☐ Diabetes mellitus ☐ Renal disease ☐ Chronic pulmonary disease ☐ Chronic hypertension ☐ Fetal compromise: ☐ Preeclampsia/eclampsia ☐ Other:	**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:

Does this patient have any specific issues/needs 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.

Induction Date:	**Time to arrive at hospital:**
Scheduled by:	

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

L2004

Form #: L2004 Rev. 7/9/12

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

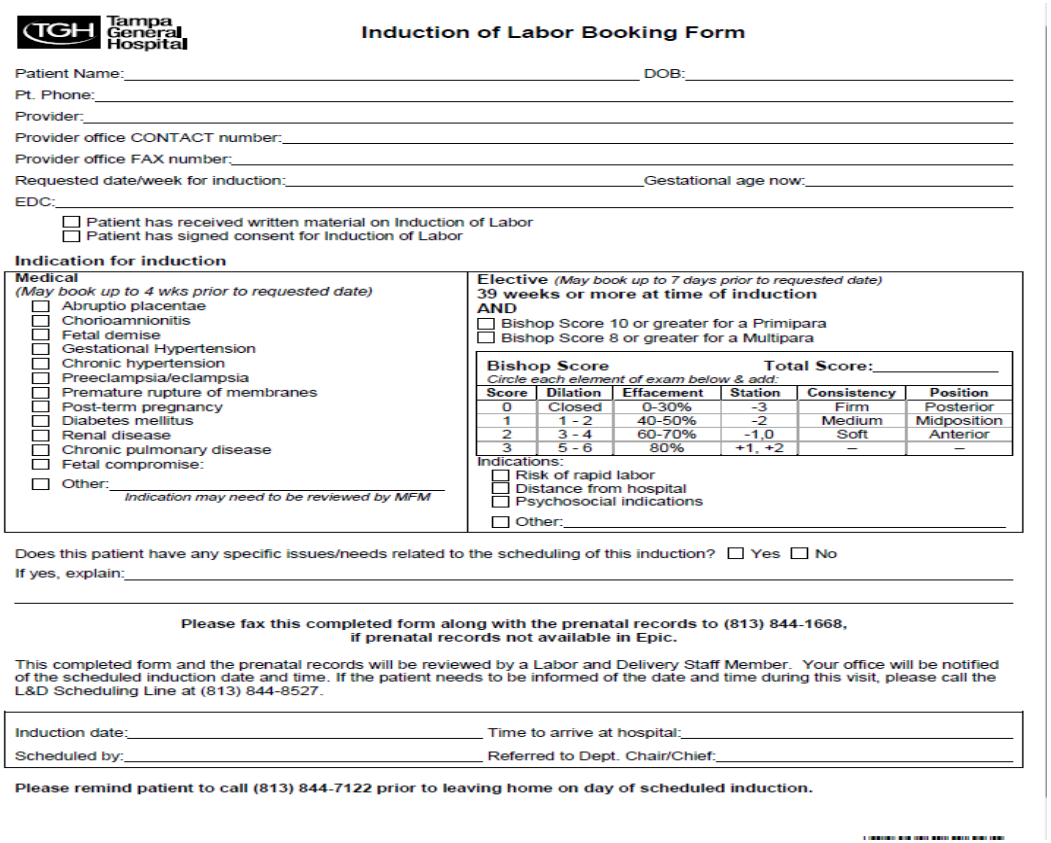
Evolving Process: Revised Booking Form

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

Elective
39 weeks or more at time of induction
OR
☐ 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



TGH Tampa General Hospital

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:_____

☐ Patient has received written material on Induction of Labor
☐ Patient has signed consent for Induction of Labor

Indication for induction

Medical
(May book up to 4 wks prior to requested date)
☐ Abruptio placentae
☐ Chorioamnionitis
☐ Fetal demise
☐ Gestational Hypertension
☐ Chronic hypertension
☐ Preeclampsia/eclampsia
☐ Premature rupture of membranes
☐ Post-term pregnancy
☐ Diabetes mellitus
☐ Renal disease
☐ Chronic pulmonary disease
☐ Fetal compromise:
☐ Other:_____
Indication may need to be reviewed by MFM

Elective *(May book up to 7 days prior to requested date)*
39 weeks or more at time of induction
AND
☐ Bishop Score 10 or greater for a Primipara
☐ Bishop Score 8 or greater for a Multipara

Bishop Score **Total Score:**_____
Circle each element of exam below & add:

Score	Dilation	Effacement	Station	Consistency	Position
0	Closed	0-30%	-3	Firm	Posterior
1	1 - 2	40-50%	-2	Medium	Midposition
2	3 - 4	60-70%	-1,0	Soft	Anterior
3	5 - 6	80%	+1, +2	–	–

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:_____

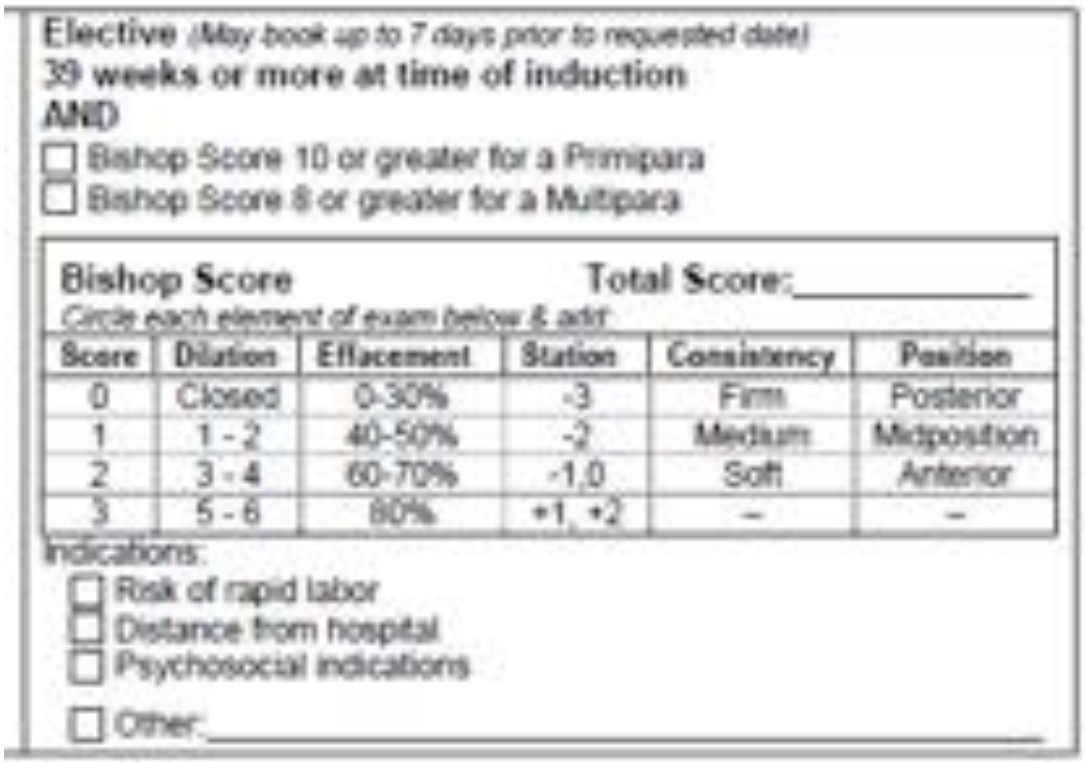
Please fax this completed form along with the prenatal records to (813) 844-1668, if prenatal records not available in Epic.

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) 844-8527.

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



Elective *(May book up to 7 days prior to requested date)*
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AND

- ☐ Bishop Score 10 or greater for a Primipara
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Bishop Score **Total Score:**_____
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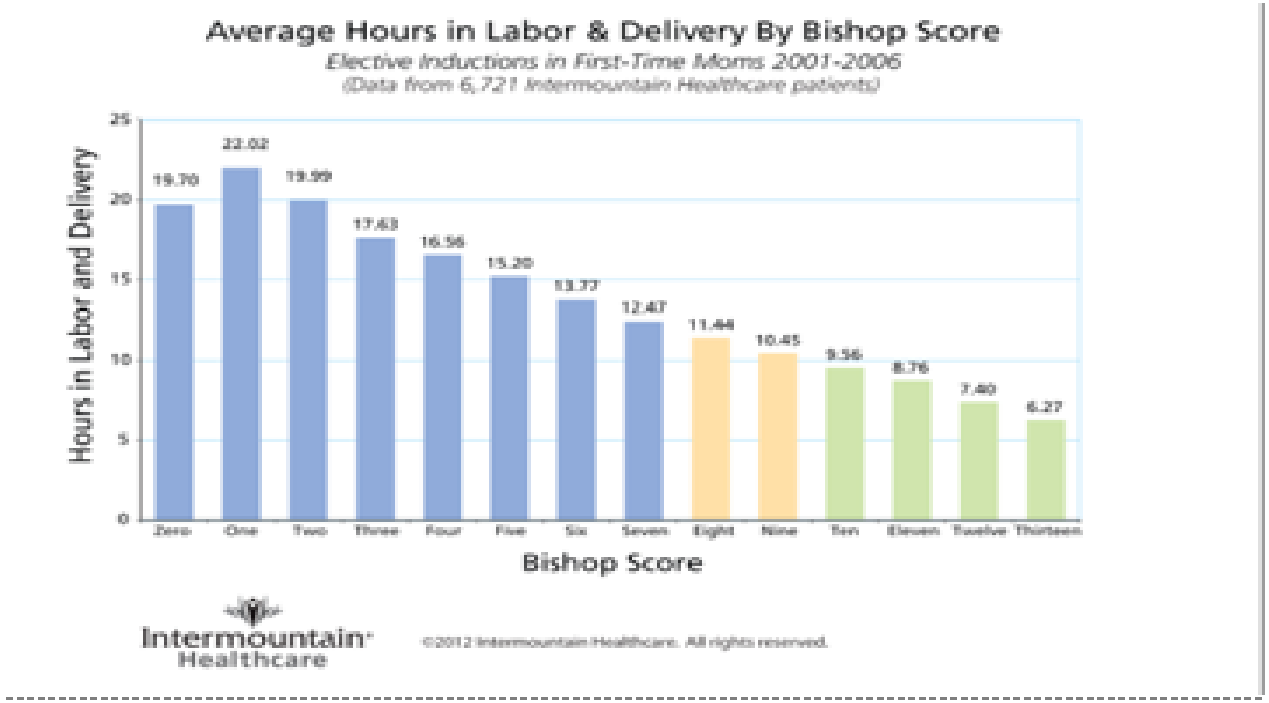
3	5 - 6	80%	+1, +2	–	–

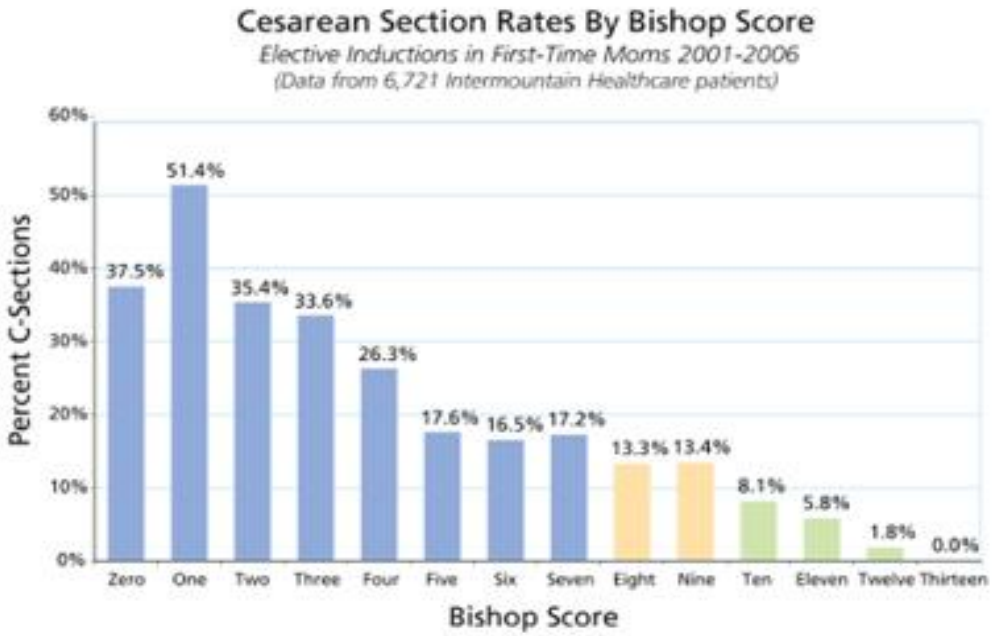
Indications:

- ☐ 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



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?

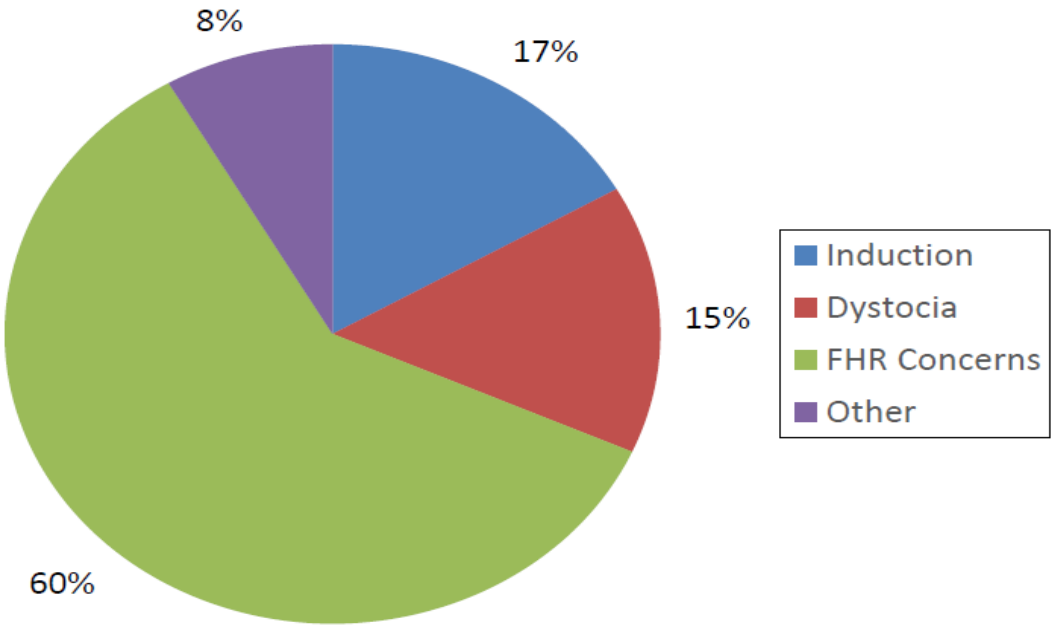
- Many Providers felt that it took the pressure off of them from the patient perspective since it was a TGH policy.
- Data abstractors call or email Nurse Clinicians if a provider is asking to induce a patient without meeting the criteria.
- MFM contacted if indicated to obtain final decision.

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



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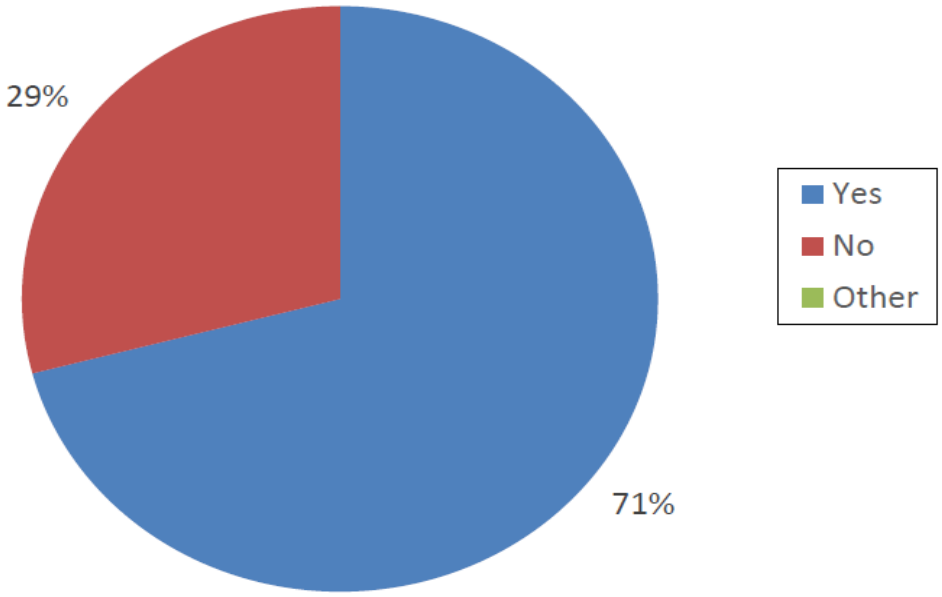
Overall 2: Percent of All Cesarean Deliveries Performed that Met Criteria During Baseline



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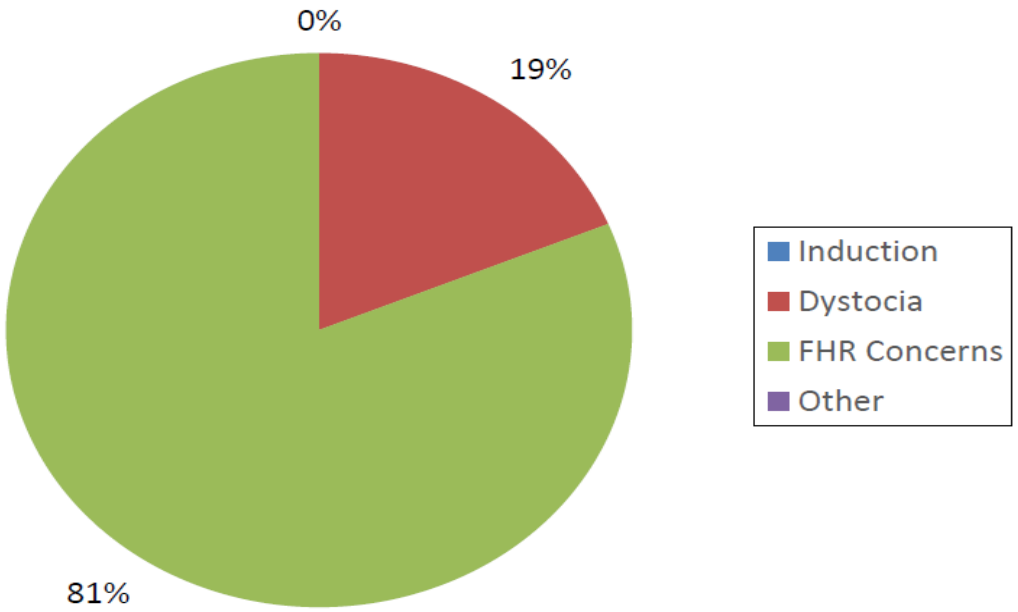
Overall 3: Percent of Cesarean Deliveries Performed Not Meeting Criteria by Category during Baseline



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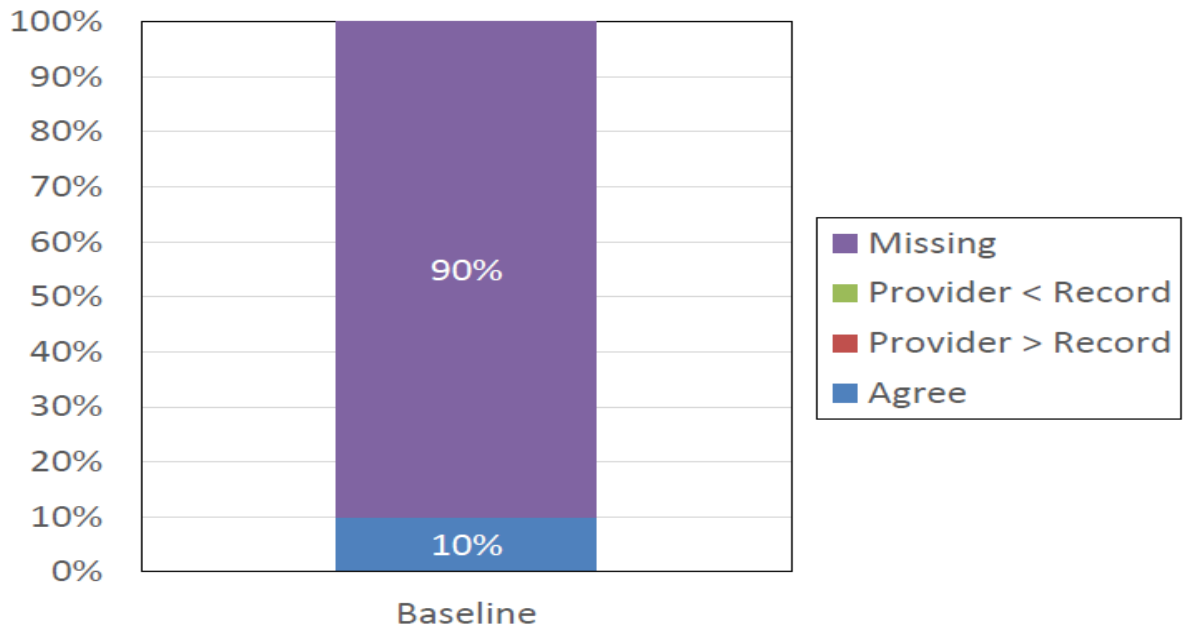
I-8: Percent of NTSV Cesarean Deliveries with Induction by Bishop Score Agreement at Time of Induction between Provider and Hospital Record



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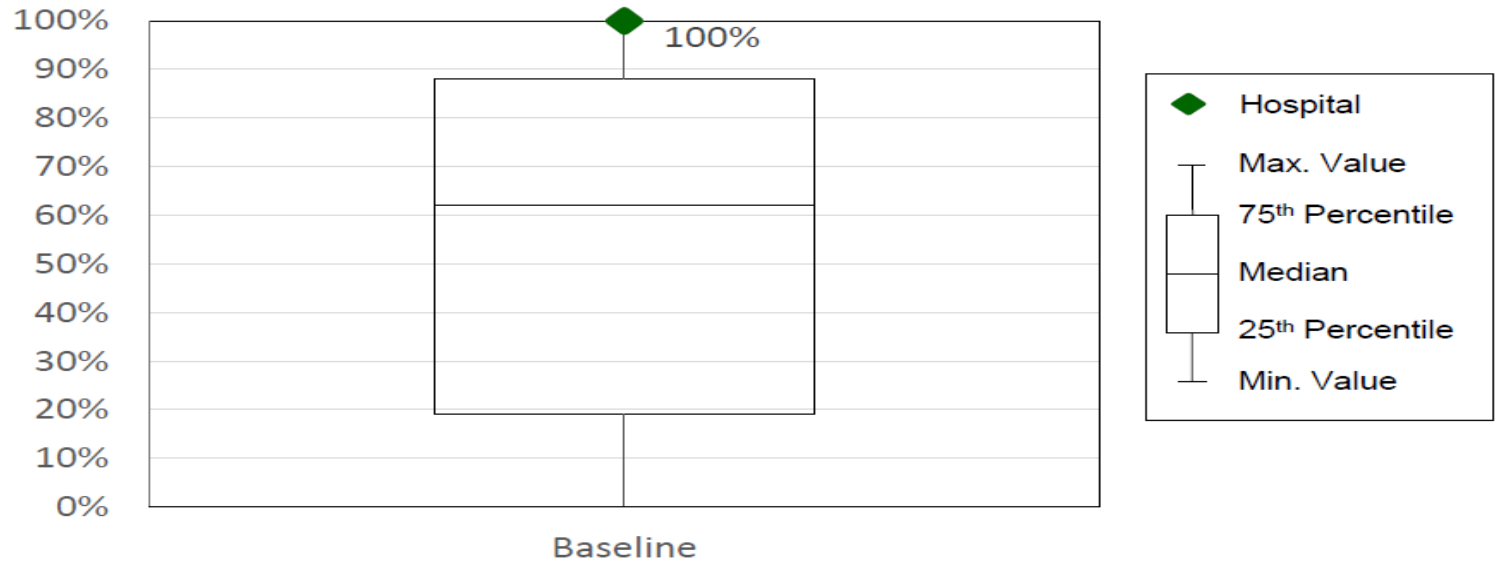

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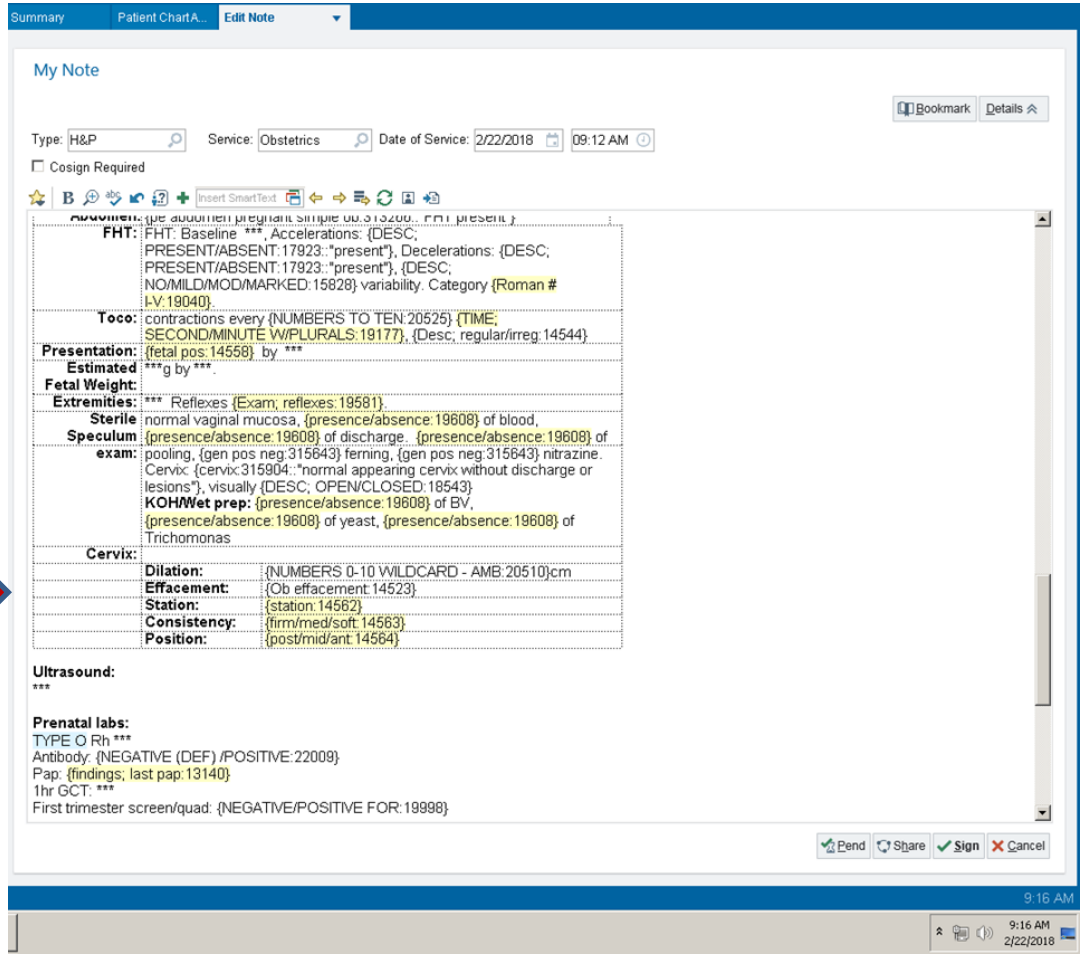
Partnering to Improve Health Care Quality for Mothers and Babies

Previous Standard L&D H&P (Epic)



Changes to Standard L&D Admission H&P (Epic)

click, rub or gallop"}

Abdomen: {pe abdomen pregnant simple ob:313266}

FHT: FHT: Baseline ***, Accelerations: {DESC; PRESENT/ABSENT:17923}, Decelerations: {DESC; PRESENT/ABSENT:17923}, {DESC; NO/MILD/MOD/MARKED:15828} variability. Category {Roman # I-V:19040}.

Toco: contractions every {NUMBERS TO TEN:20525} {TIME; SECOND/MINUTE W/PLURALS:19177}, {Desc; regular/irreg:14544}

Presentation: {fetal pos:14558} by ***

Estimated Fetal Weight: ***g by ***.

Extremities: {EXTREMITIES EXAM:60117150}. Reflexes {Exam; reflexes:19581}.

Sterile Speculum exam: normal vaginal mucosa, {presence/absence:19608} of blood, {presence/absence:19608} of discharge. {presence/absence:19608} of pooling, {gen pos neg:315643} ferning, {gen pos neg:315643} nitrazine. Cervix: {cervix:315904::"normal appearing cervix without discharge or lesions"}, visually {DESC; OPEN/CLOSED:18543}
KOH/Wet prep: {presence/absence:19608} of BV, {presence/absence:19608} of yeast, {presence/absence:19608} of Trichomonas

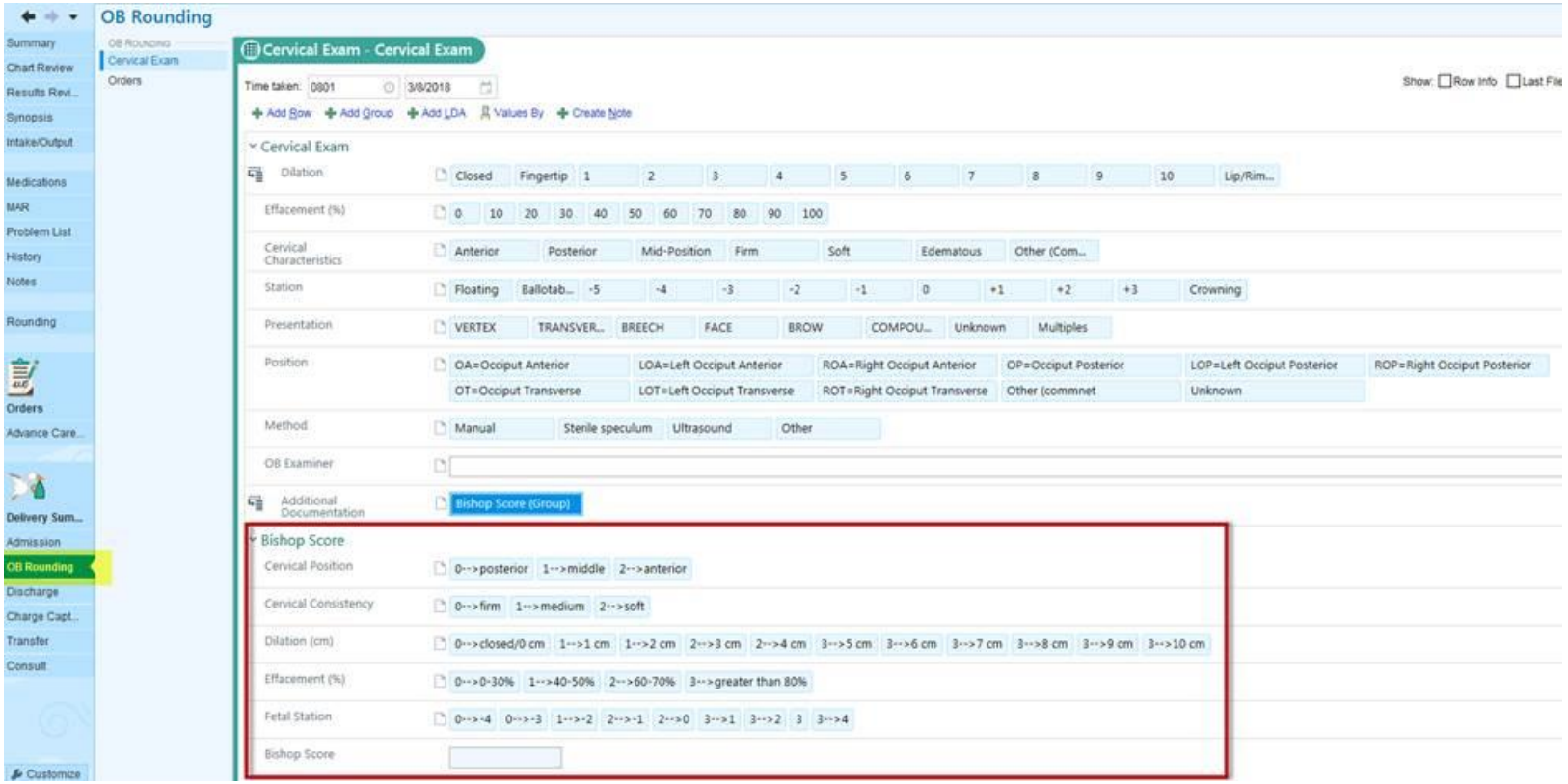
Cervix:

Dilation: {NUMBERS 0-10 WILDCARD - AMB:20510}cm
Effacement: {Ob effacement:14523}
Station: {station:14562}
Consistency: {firm/med/soft:14563}
Position: {post/mid/ant:14564}

Bishop Score: {NUMBERS 0-10 WILDCARD - AMB:20510}

Cervical Exam	Points				Subscore
	0	1	2	3	
Dilation	Closed	1 - 2 cm	3 - 4 cm	5 - 6 cm	
Effacement (%)	0 - 30	40 - 50	60 - 70	80	
Station	-3	-2	-1, 0	+1, +2	
Consistency	Firm	Medium	Soft		
Position	Posterior	Mid	Anterior		
Total Score					

Change to OB Rounding documentation
Bishop score calculator



FPQC
Florida Perinatal Quality Collaborative

Sacred Heart Hospital Pensacola Experience

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

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Comments?
Questions?

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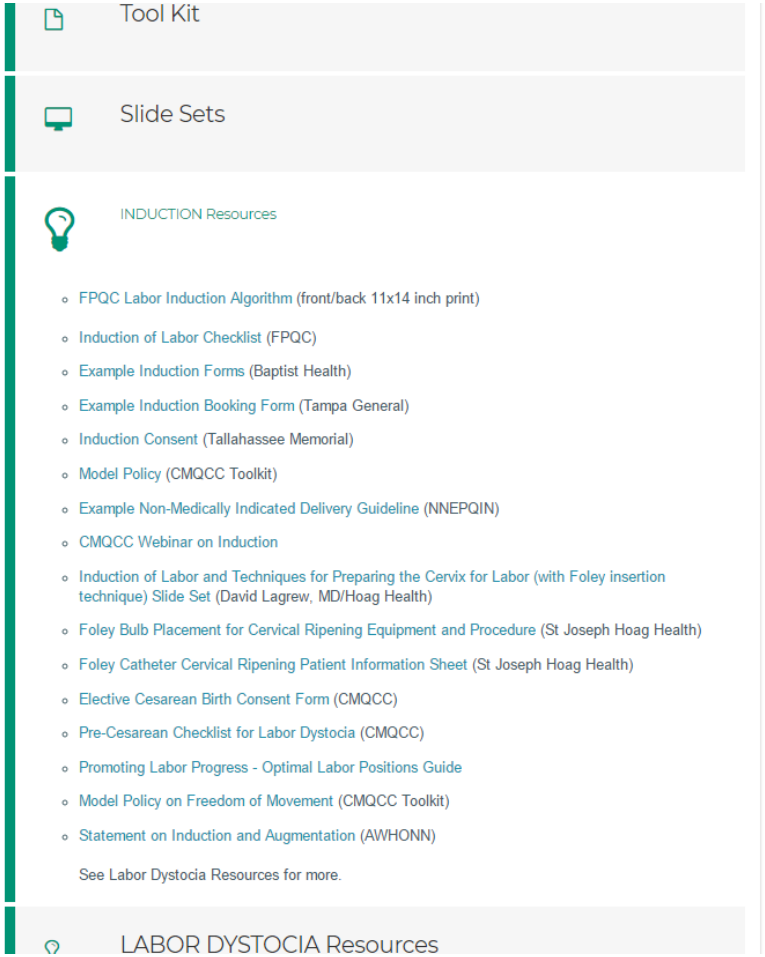
http://health.usf.edu/publichealth/chiles/fpqc/provide/toolbox



Tool Kit

Slide Sets

INDUCTION Resources

- FPQC Labor Induction Algorithm (front/back 11x14 inch print)
- Induction of Labor Checklist (FPQC)
- Example Induction Forms (Baptist Health)
- Example Induction Booking Form (Tampa General)
- Induction Consent (Tallahassee Memorial)
- Model Policy (CMQCC Toolkit)
- Example Non-Medically Indicated Delivery Guideline (NNEPQIN)
- CMQCC Webinar on Induction
- Induction of Labor and Techniques for Preparing the Cervix for Labor (with Foley insertion technique) Slide Set (David Lagrew, MD/Hoag Health)
- Foley Bulb Placement for Cervical Ripening Equipment and Procedure (St Joseph Hoag Health)
- Foley Catheter Cervical Ripening Patient Information Sheet (St Joseph Hoag Health)
- Elective Cesarean Birth Consent Form (CMQCC)
- Pre-Cesarean Checklist for Labor Dystocia (CMQCC)
- Promoting Labor Progress - Optimal Labor Positions Guide
- Model Policy on Freedom of Movement (CMQCC Toolkit)
- Statement on Induction and Augmentation (AWHONN)

See Labor Dystocia Resources for more.

LABOR DYSTOCIA Resources

Thank you!

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