



CMQCC
California Maternal
Quality Care Collaborative

Lowering NTSV CSR: Lessons from Our West Coast to Your West (and East) Coast

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Executive Medical Director

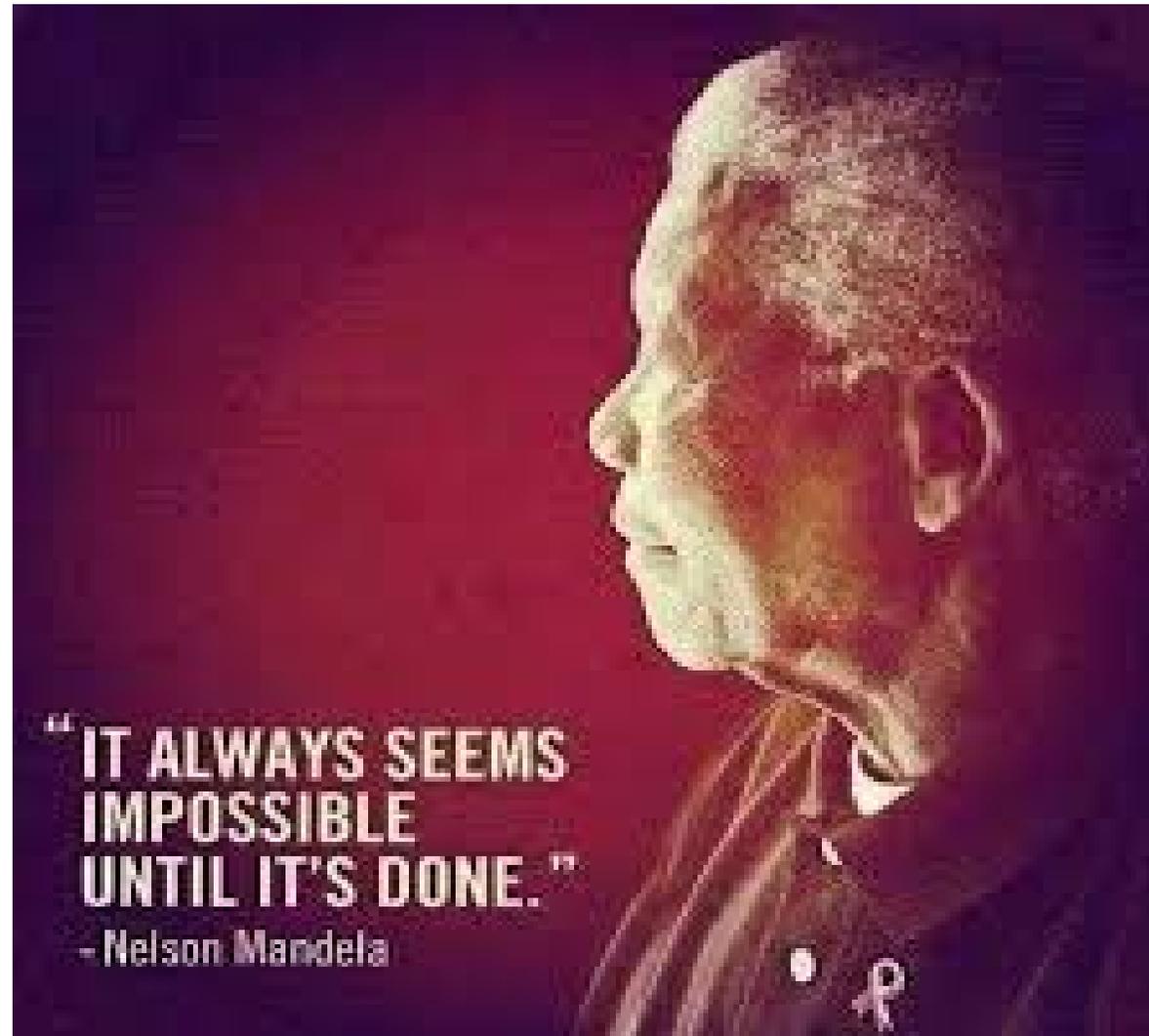
Women's and Children's Institute Providence St. Joseph Health-Southern California

A magnifying glass with a dark frame is positioned over a word cloud. The word 'disclosure' is the largest and most prominent word in the cloud, rendered in a bold, black, sans-serif font. Other words in the cloud are smaller and less legible, including 'disciplinatory', 'disclaimer', and 'discolor'. The background of the word cloud is a light, textured surface.

disclosure

Disclosure

The presenter has no financial disclosures to report

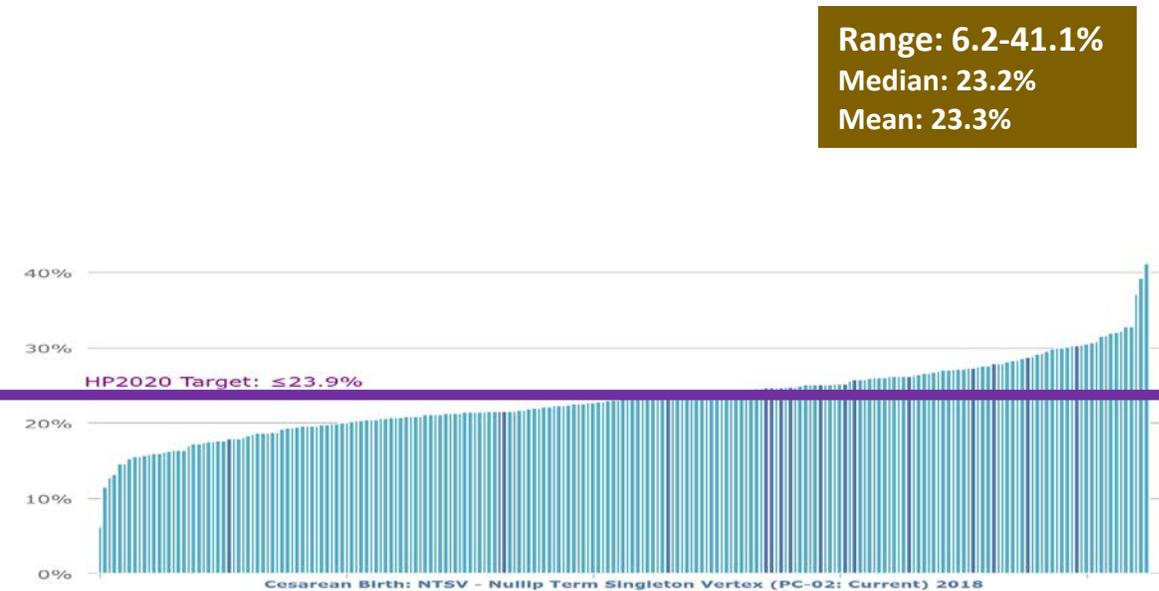
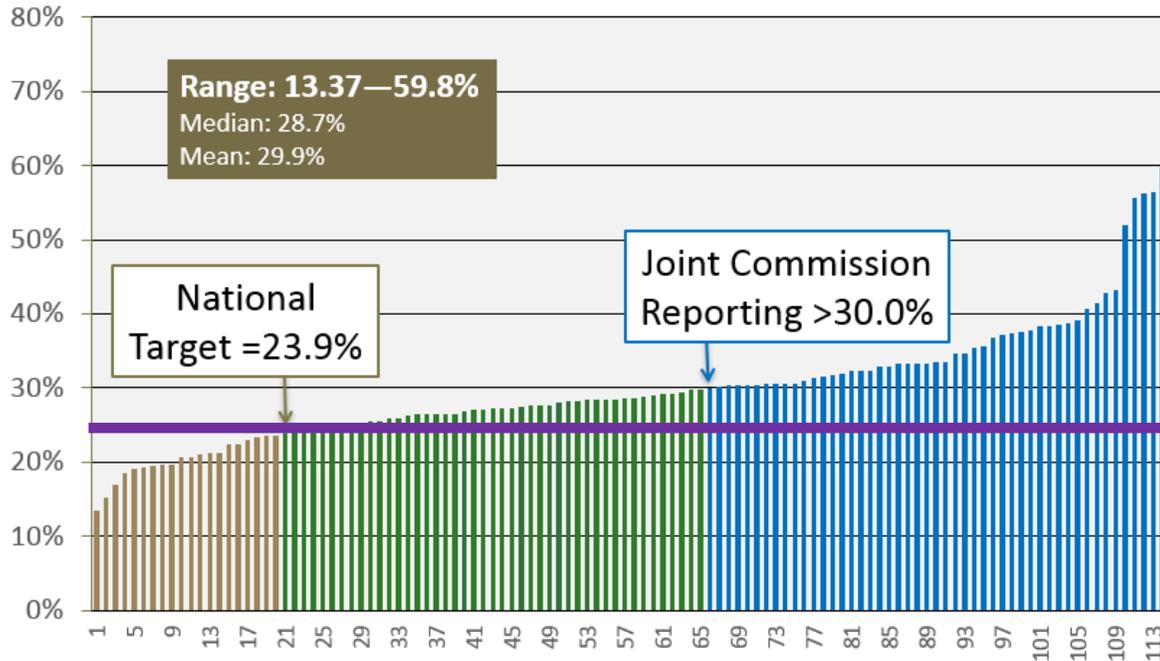


Transforming Maternity Care

A Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

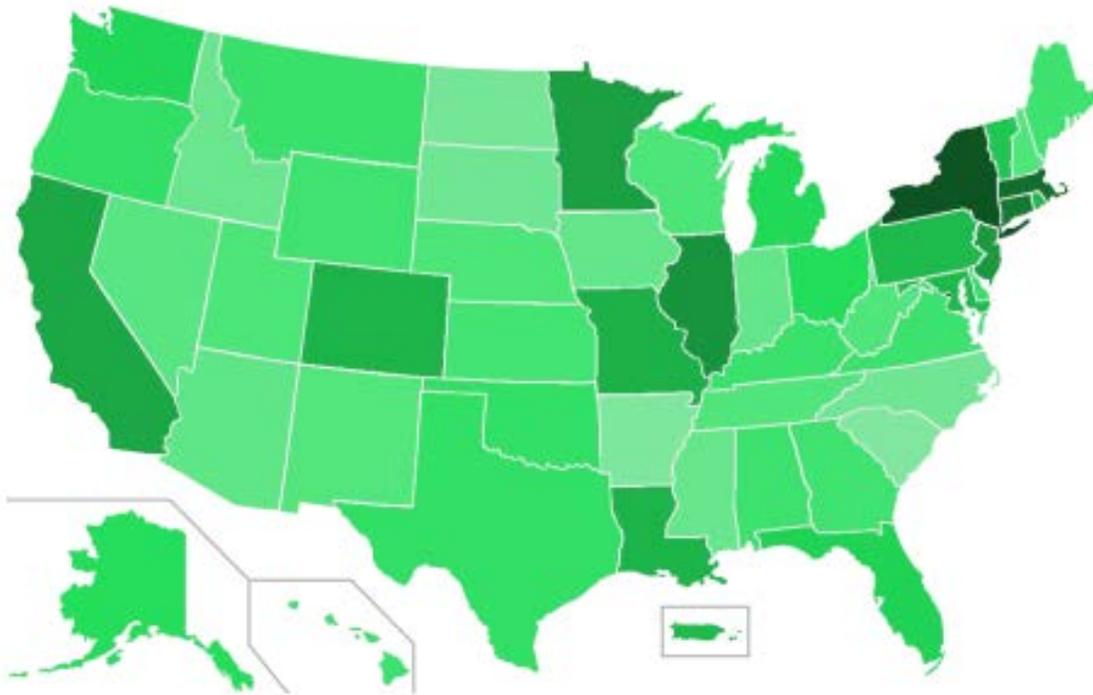


Two Coasts versus One Coast





Lawyers per Capita

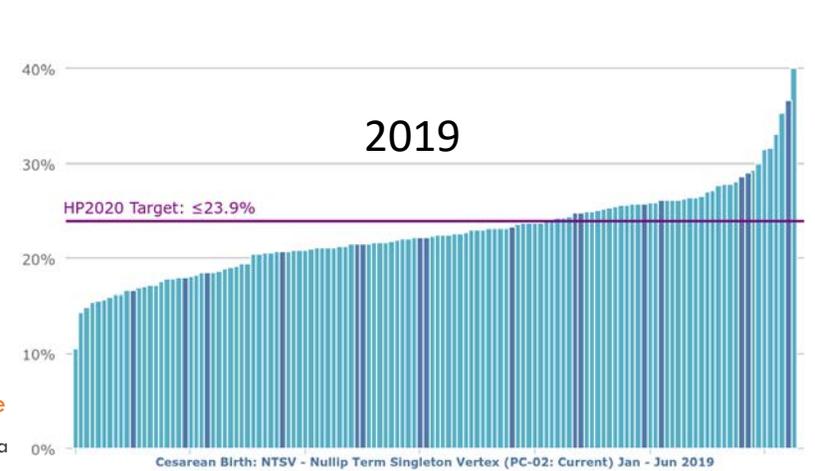
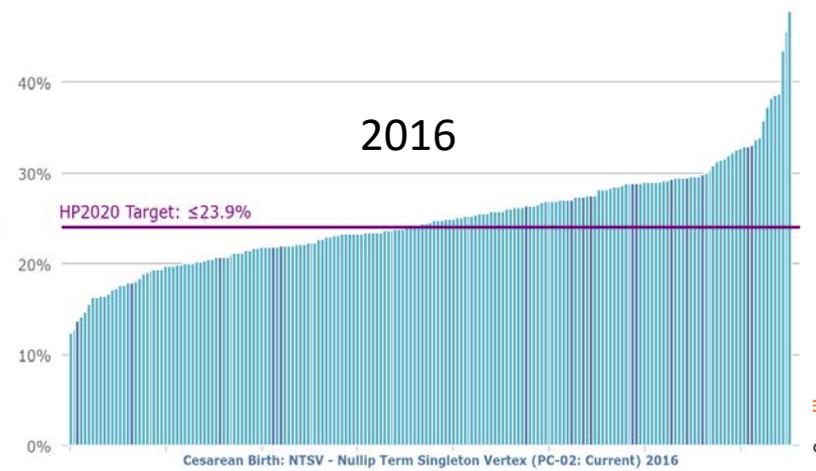
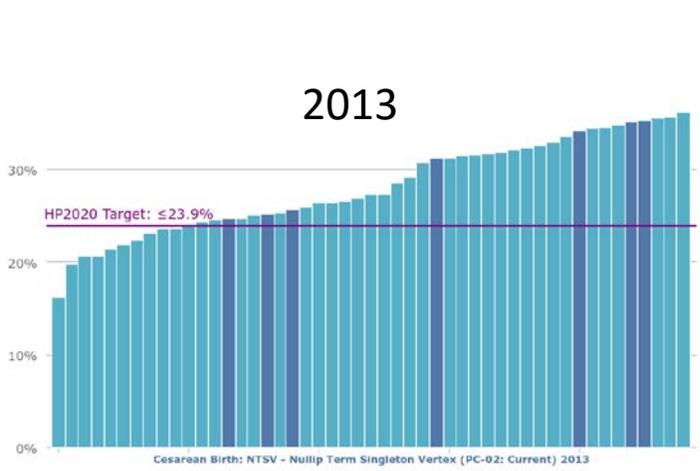
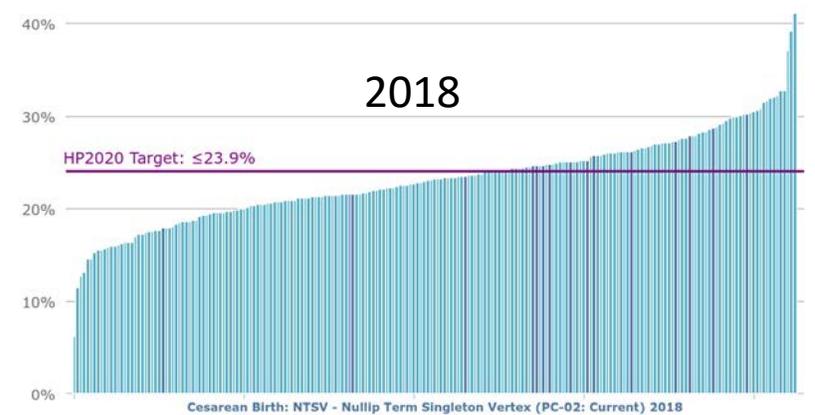
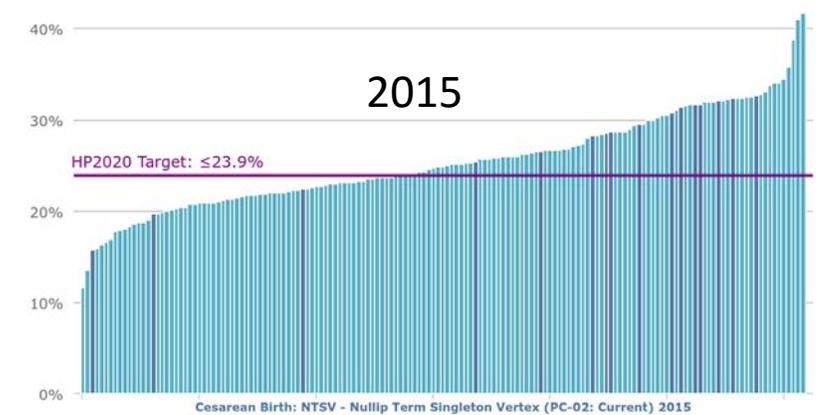
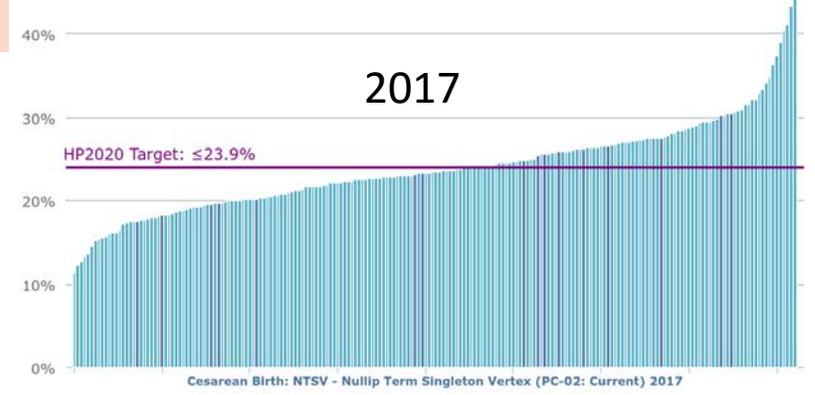
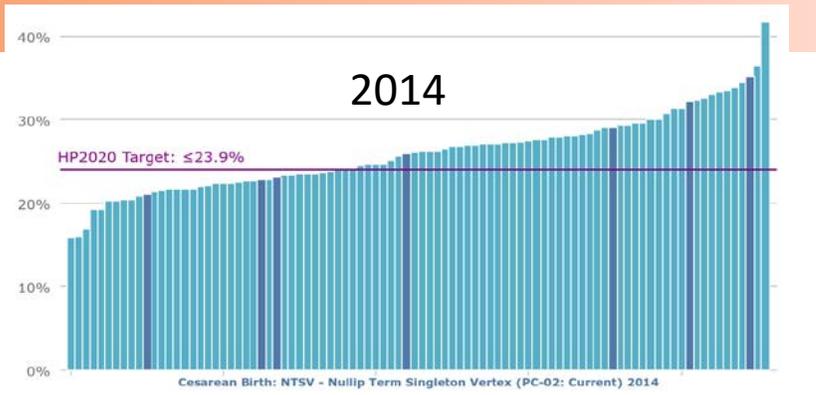


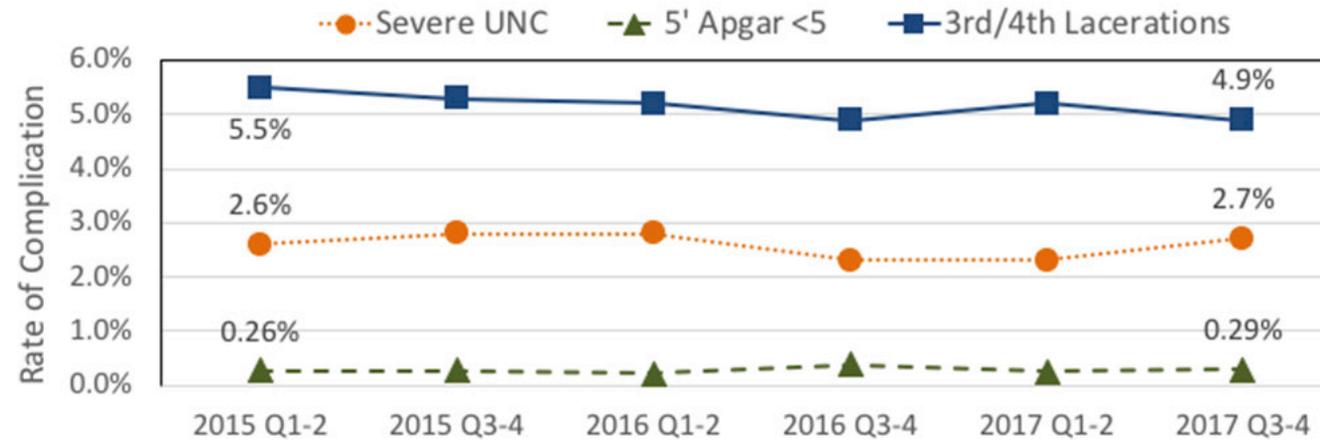
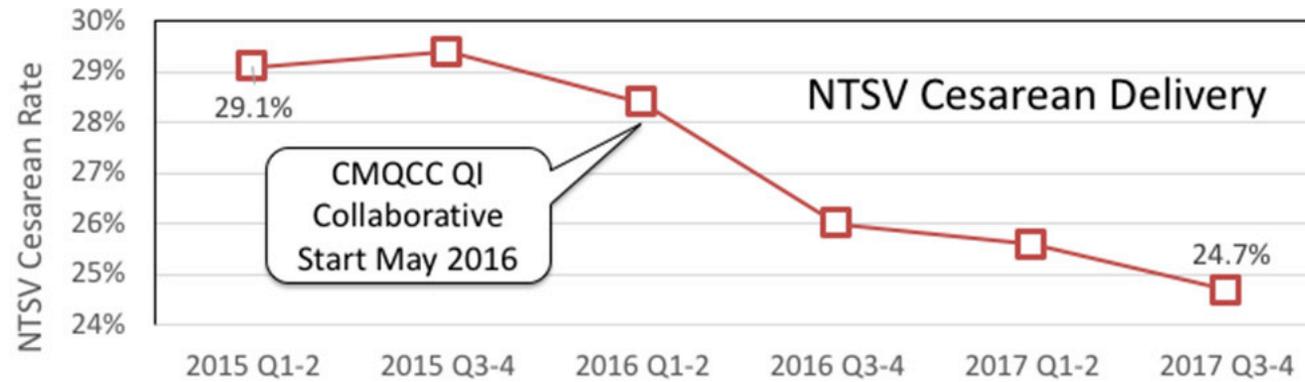
NO. OF LAWYERS PER CAPITA BY STATE (2013)				
Rank	State	Population	Lawyers	Lawyers Per 10,000 Residents
1.	D.C.	646,449	51,928	803.28
2.	New York	19,651,127	166,317	84.63
3.	Massachusetts	6,692,824	43,008	64.26
4.	Connecticut	3,596,080	21,150	58.81
5.	Illinois	12,882,135	62,496	48.51
6.	New Jersey	8,899,339	40,993	46.06
7.	Minnesota	5,420,380	24,091	44.45
8.	California	38,332,521	163,163	42.57
9.	Missouri	6,044,171	24,423	40.41
10.	Louisiana	4,625,470	18,528	40.06

But you need to check your zip code!



The California Journey



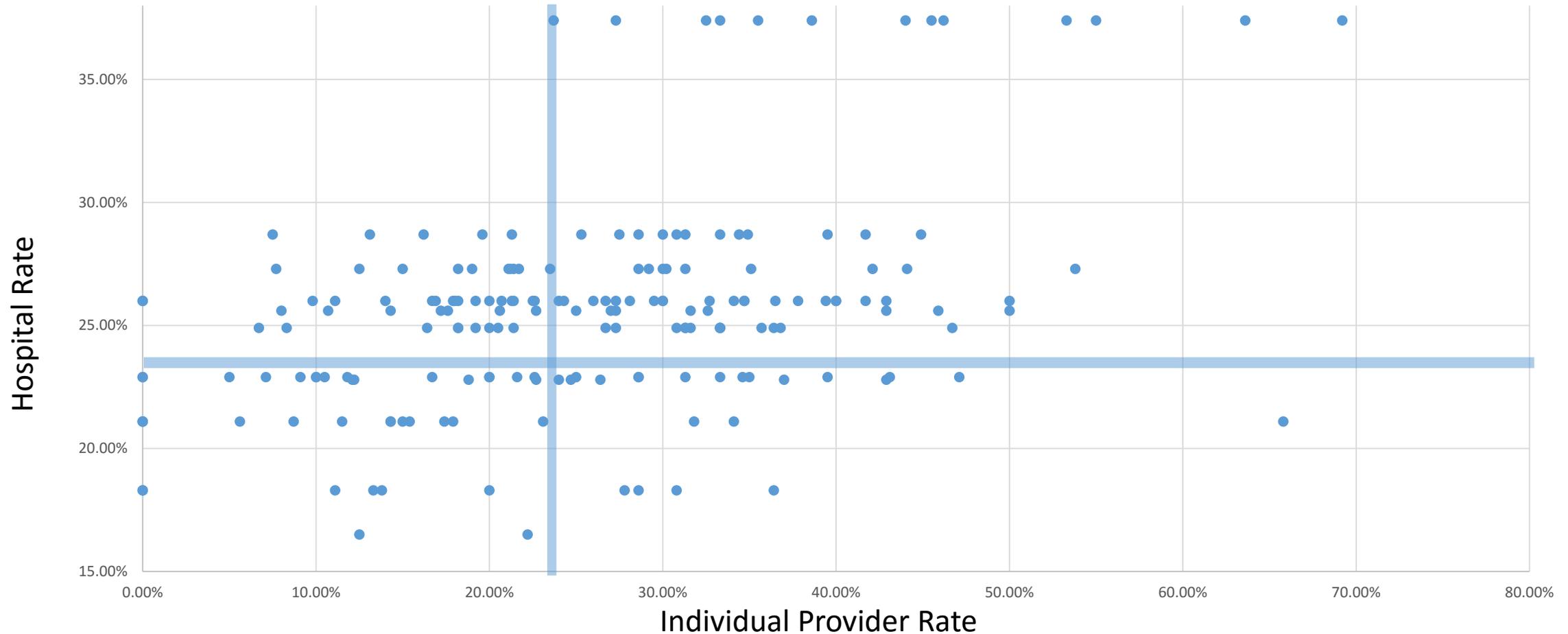


Main et al SMFM 2019, 46 hospitals met inclusion criteria with a mix of hospital types: university, community, and integrated health system; and high, medium and small delivery volume. They included an annual average of 115,000 births (of which 35% were NTSV).

Important: Hospitals have many Providers



Breaking Down Hospital Rates by Physician Rates





The Problem Picking Chances for CS Solely by Hospital





Lowering the cesarean section rate in a private hospital: comparison of individual physicians' rates, risk factors, and outcomes.

STUDY DESIGN:

We retrospectively reviewed detailed computerized delivery records (n = 16,230) collected from May 16, 1988, to July 30, 1995. We excluded physicians who had <100 deliveries at our institution during the study period. The physicians were divided into two groups depending on whether their individual cesarean section rates were greater than (control group) or less than 15% (target group). Various cesarean section rates, risk factors for abdominal delivery, labor management techniques, and neonatal outcome parameters were calculated for each group. The cesarean section rates of the two groups were analyzed by year to assess changes.

RESULTS:

As expected by study design, the overall cesarean section rate was markedly different between the two groups (13.8% vs 23.8%). In addition, the primary, repeat, primigravid, and multiparous cesarean section rates were all lower for the target group. The rates of

To the point: “Individual physician's lower cesarean sections are primarily obtained by labor management and attempting vaginal birth after cesarean delivery. These practice patterns did not appear to lead to any increase in perinatal morbidity or mortality.”

CONCLUSIONS:

Individual physician's lower cesarean sections are primarily obtained by labor management and attempting vaginal birth after cesarean delivery. These practice patterns did not appear to lead to any increase in perinatal morbidity or mortality.

Lagrew and Adashek. Am J Obstet Gynecol. 1998 Jun;178(6):1207-14.

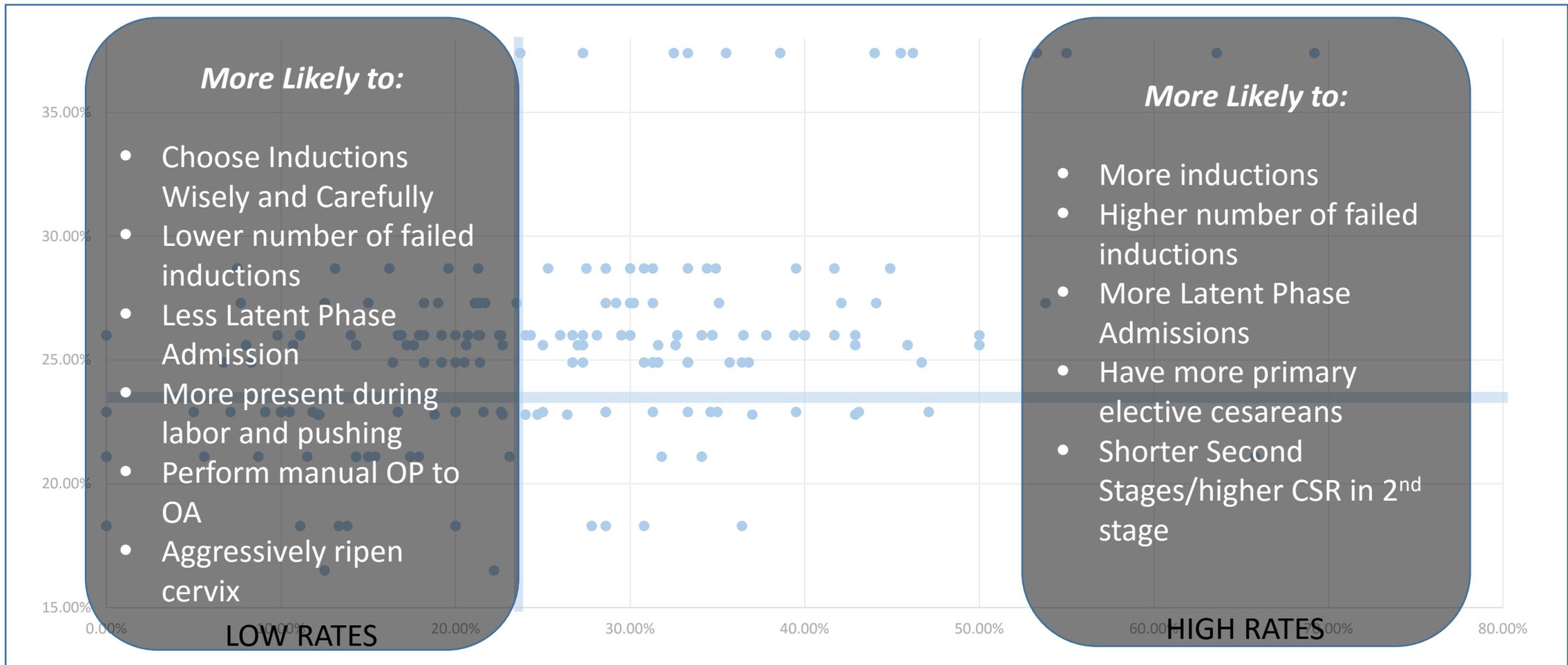


Analyzing Hospital Rates by Physician Rates

- Hospitals with lower rates have moved the bell shaped curve for providers
- Range of *provider's CSR wide* at all of the hospitals
- Note that *low rate providers could achieve the lower rates with the same staff and facilities* suggesting that the practice patterns of the high rate providers were the most likely cause of more cesarean deliveries.
- In general one could identify certain practices which led to lower rates.



How Do They Get Lower Rates?





National Cesarean Reduction Bundle



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 NICHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as herpes and 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



RESPONSE

To Every Labor Challenge

- Have available an in-house maternity care provider or alternative coverage which guarantees timely and effective responses to labor problems.
- Uphold standardized induction scheduling to ensure proper selection and preparation of women undergoing induction.
- Utilize standardized evidence-based labor algorithms, policies, and techniques, which allow for prompt recognition and treatment of dystocia.
- Adopt policies that outline standard responses to abnormal fetal heart rate patterns and uterine activity.
- Make available special expertise and techniques to lessen the need for abdominal delivery, such as breech version, instrumented delivery, and twin delivery protocols.

REPORTING/SYSTEMS LEARNING

Every birth facility

- Track and report labor and cesarean measures in sufficient detail to: 1) compare to similar institutions, 2) conduct case review and system analysis to drive care improvement, and 3) assess individual provider performance.
- Track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety.

Used as model for
the CMQCC toolkit

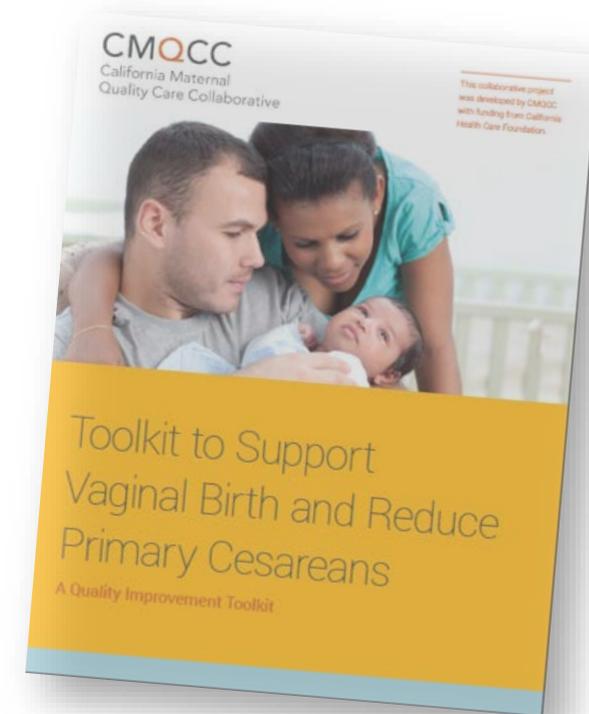
PATIENT SAFETY BUNDLE

Safe Reduction of Primary Cesarean Births



The CMQCC Toolkit

- Comprehensive, evidence-based “How-to Guide” to reduce primary cesarean delivery in the NTSV population
- Will be the resource foundation for the CA QI collaborative project
- The principles are generalizable to all women giving birth
- Released on the CMQCC website April 28, 2016
- Has a companion *Implementation Guide*





Which are “a walk in the park”, “rolling hills” or “climbing mountains”?

Transforming Maternity Care

Toolkit to Support Vaginal Birth and Reduce Primary Cesareans



Walk in the Park

- Adopt provider education
- Standardized pain management
- Track outcomes and balancing measures (for many on electronic systems)



Peanut Ball

Recognition

- Decrease length of labor
- Decreasing CS rate in patients with epidurals



Tussey, C. M., Botsios, E., Gerkin, R. D., Kelly, L. A., Gamez, J., & Mensik, J. (2015). Reducing length of labor and cesarean surgery rate using a peanut ball for women laboring with an epidural. *The Journal of Perinatal Education*, 24(1), 16-24. <http://dx.doi.org/10.1891/1058-1243.24.L16>



REPORTING/SYSTEMS

Using Data to Drive Improvement



Key Strategies for Using Data to Reduce Cesareans

Reporting

- Make data compelling to Providers
- Assist organizations to understand data associated with their hospital
- Assist providers to understand their CS rates
- Engage women, employers, and the general public in the improvement process

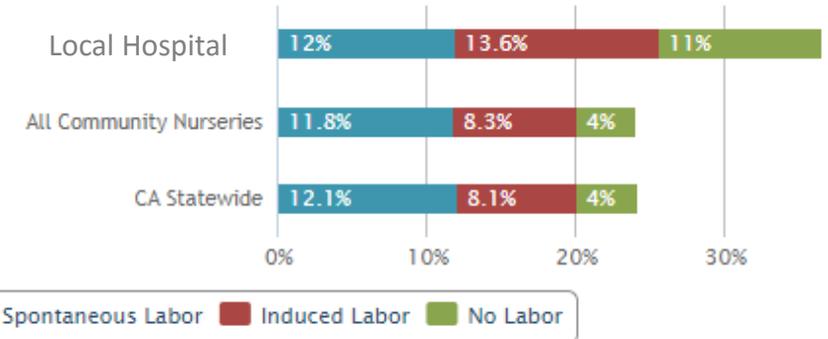
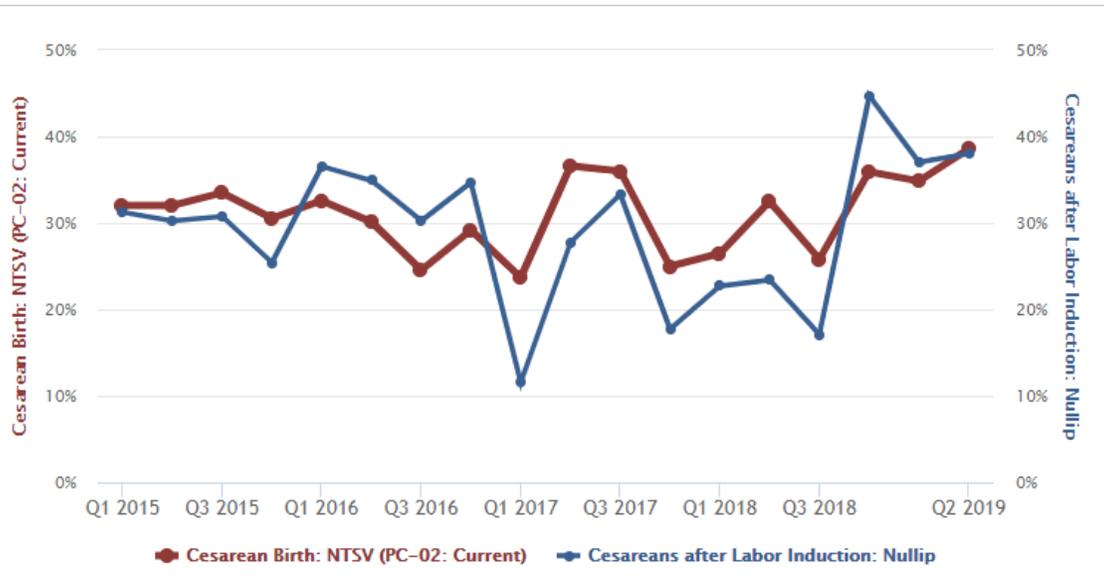


Reporting

Use strategies to engage **women, employers** and the **general public** in the improvement project

- Public release of selected hospital-level measures that have been well-vetted
- Provide a lay explanation of the measures
- Widely distribute these measures through multiple media channels to capture the greatest attention

Using Data to Direct Change



Transforming Maternity Care

A Toolkit to Support Vaginal Birth and Reduce Primary Cesareans



CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

1. Diagnosis of Dystocia/Arrest Disorder (all 3 should be present)

- Cervix 6 cm or greater
- Membranes ruptured, then
- No cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hours of oxytocin administration with inadequate uterine activity

2. Diagnosis of Second Stage Arrest (only one needed)**No descent or rotation for:**

- At least 4 hours of pushing in nulliparous woman with epidural
- At least 3 hours of pushing in nulliparous woman without epidural
- At least 3 hours of pushing in multiparous woman with epidural
- At least 2 hour of pushing in multiparous woman without epidural

3. Diagnosis of Failed Induction (both needed)

- Bishop score ≥ 6 for multiparous women and ≥ 8 for nulliparous women, before the start of induction (for non-medically indicated/elective induction of labor only)
- Oxytocin administered for at least 12-18 hours after membrane rupture, without achieving cervical change and regular contractions. *Note: At least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit



Rolling Hills

- Provider and unit culture which values and promotes vaginal birth
- Optimizing patient and family engagement in education, informed consent and shared decision making
- Standardized response to FHR abnormalities
- Timely identifications of specific problems such as herpes, breech, etc.
- Available in-house maternity care
- Special expertise for special conditions, e.g. breech version
- Track and report labor and cesarean in specific detail, assess individual performance





EATS STRATEGY FOR LUNCH

PETER DRUCKER

Most Important?
A Culture that values vaginal delivery



Readiness

Sharing in decision making





Birth Preferences Worksheet

Readiness

- Collaborate with healthcare provider to determine birth preferences
- Tailor choices to what is available at each facility

CMQCC
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My Preferences for Labor and Birth: A Plan to Guide Decision Making and Inform My Care Team

Your Name and Date of Birth: [Redacted]

Your Due date: [Redacted]

Physician/Midwife: [Redacted]

Pediatrician/Family Doctor: [Redacted]

Your Labor Support Team (please include partner, doula, friends, relatives, or children who will be present):
[Redacted]

While low-risk women will need very little intervention, women with certain medical conditions may need procedures, such as continuous monitoring or induction of labor, to improve safety and ensure a healthy delivery. Your provider can tell you about the benefits, risks and alternatives of the decisions you may face during labor and birth. This is an opportunity to share your values and preferences and make informed decisions together, based on your specific needs. This form should go with you to the hospital to be shared with your care team and reviewed as labor progresses.

Environment:
Which options will make you most comfortable?

- I would like to limit the number of guests in my room while I am in labor by having a sign posted on the door to my labor and delivery room
- I would like to have the lights dimmed during labor
- I plan to bring in music from home (my own MP3 player, CD player, etc.)
- I plan to bring in essential oils/aromatherapy (no flames, please).
- I plan to bring in a "focal point" from home

Preferences for Food and Fluids

- I prefer to keep myself hydrated by drinking fluids. I would like to avoid intravenous fluids unless it is medically necessary
- I do not mind receiving intravenous hydration during labor
- If it is safe for me to do so, I would like to eat lightly during labor

Labor Preferences

- If safe to do so, I prefer to labor at home during the early phase of labor, and be admitted to the hospital when I am in active labor
- I would like to have freedom of movement while I am in labor (walking, standing, sitting, kneeling, using the birth ball, etc.), if safe and possible
- I prefer to move around or change positions to improve my labor progress before trying Pitocin to increase my labor progress
- If labor is progressing normally, I prefer to be patient and let it

Some of your decisions before and during childbirth may affect your risk of cesarean. These decisions are best made in collaboration with your provider during prenatal care visits, well in advance of the time of birth. Here are some common decision points:

- whether to wait for labor to begin on its own (induction of labor may increase your risk of cesarean)
- whether to be admitted to the hospital in early labor or to wait until active labor (being admitted in active labor improves your chances of having a vaginal birth)
- how to monitor your baby's fetal heart rate (low-risk women who are continuously monitored may be more likely to have a cesarean)
- whether to have continuous labor support by a trained caregiver like a doula (continuous labor support improves your chances of having a vaginal birth)
- how to help manage labor pain and labor progress



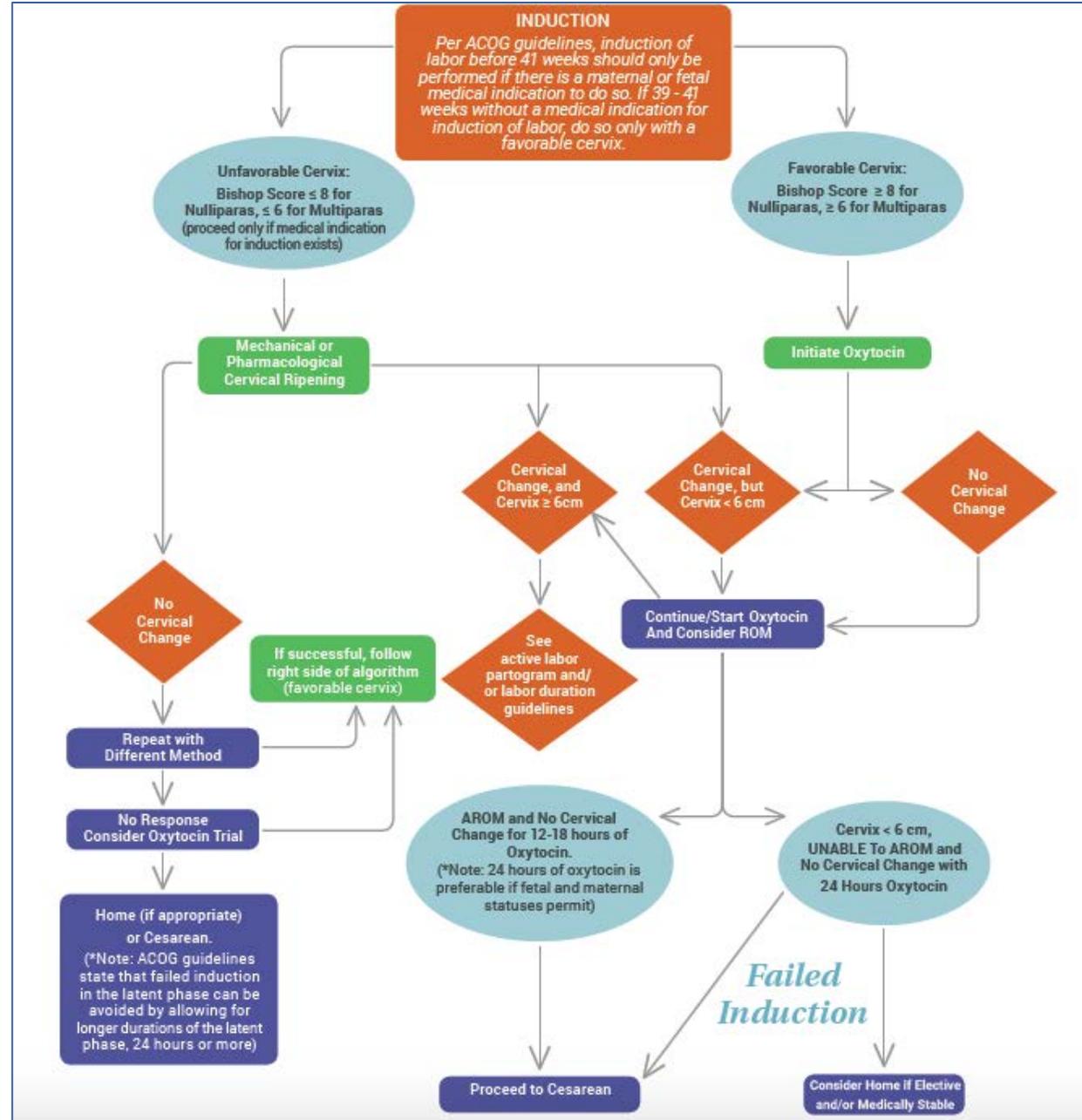
Mountains to Climb

- Implement standard admission criteria, triage management for spontaneous labor
- Uphold standardized induction scheduling, proper selection and preparation
- Utilize evidence based labor algorithms
- Adopt policies standard responses to FHR patterns



Induction of Labor Algorithm

Response



GRAND ROUNDS: ARRIVE TRIAL

Can we adopt and get the
same results?

tive

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ESTABLISHED IN 1812

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Labor Induction versus Expectant Management in Low-Risk Nulliparous Women

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ABSTRACT

BACKGROUND

The perinatal and maternal consequences of induction of labor at 39 weeks among low-risk nulliparous women are uncertain.

METHODS

In this multicenter trial, we randomly assigned low-risk nulliparous women who were at 38 weeks 0 days to 38 weeks 6 days of gestation to labor induction at 39 weeks 0 days to 39 weeks 4 days or to expectant management. The primary outcome was a composite of perinatal death or severe neonatal complications; the principal secondary outcome was cesarean delivery.

RESULTS

A total of 3062 women were assigned to labor induction, and 3044 were assigned to expectant management. The primary outcome occurred in 4.3% of neonates in the induction group and in 5.4% in the expectant-management group (relative risk, 0.80; 95% confidence interval [CI], 0.64 to 1.00). The frequency of cesarean delivery was significantly lower in the induction group than in the expectant-management group (18.6% vs. 22.2%; relative risk, 0.84; 95% CI, 0.76 to 0.93).

CONCLUSIONS

Induction of labor at 39 weeks in low-risk nulliparous women did not result in a significantly lower frequency of a composite adverse perinatal outcome, but it did result in a significantly lower frequency of cesarean delivery. (Funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development; ARRIVE ClinicalTrials.gov number, NCT01990612.)

The authors' affiliations are listed in the Appendix. Address reprint requests to Dr. Grobman at the Department of Obstetrics and Gynecology, Northwestern University, 250 E. Superior St., Suite 05-2175, Chicago, IL 60611, or at w.grobman@northwestern.edu.

*A list of other members of the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network is provided in the Supplementary Appendix, available at NEJM.org.

N Engl J Med 2018;379:513-23.
DOI:10.1056/NEJMoa1800566
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ARRIVE TRIAL SUMMARY

- The ARRIVE Trial was released on February 1st at the Society for Maternal Fetal Medicine Annual Meeting and published in NEJM August 2018 . The ARRIVE trial was a randomized controlled trial comparing labor induction at 39 weeks to expectant management to 42 2/7 weeks among low risk nulliparous women.
- Delivery in the IOL group was significantly earlier than in the EM group (**39.3 weeks** [IQR 39.1 to 39.6] vs **40.0 weeks** [IQR 39.3 to 40.7]; $P < .001$).
- Preeclampsia and gestational hypertension occurred in **9%** of the IOL group versus **14%** of the EM group.
- Among newborns, **3%** in the IOL group needed respiratory support versus **4%** in the EM group.
- The primary (adverse) **perinatal outcome occurred in 4.4% of the IOL group versus 5.4%** of the EM group (RR 0.81, 95% CI 0.64 to 1.01; $P = .06$).
- **Frequency of CD also was significantly lower in the IOL group (18.6% vs 22.2%; RR 0.84, 95% CI 0.76 to 0.93).**
- **The IOL group on average had 6 more hours in labor and delivery.**

Grobman WA, et al. A randomized trial of elective induction of labor at 39 weeks compared with expectant management of low-risk nulliparous women. Am J Obstet Gynecol 2018; 218:S601.

Grobman WA et al. Labor Induction versus Expectant Management in Low-Risk Nulliparous Women N Engl J Med 2018;379:513-23.



How did they get such a low CSR in both groups?

- Very selective group of patients (51 K down to 6K patients)
- Very selective group of providers (evidenced by both management having low CSR)
- Truly low risk patients (average age 24)
- Aggressive cervical preparation (even outpatient cervical ripening)
- Adherence to failed induction criteria



Pre-cesarean Checklist for Labor Dystocia or Failed Induction

Patient Name: _____ MR#: _____
 Gestational Age: _____ Date of C-section: _____
 Time: _____ ; Initial: _____
 Obstetrician: _____ ; Initial: _____
 Bedside Nurse: _____ ; Initial: _____

Indication for Primary Cesarean Delivery:

- Active Phase Arrest > 6 cm Dilation (must fulfill one of the two criteria)
 - Membranes ruptured (if possible), then:
 - Adequate uterine contractions (e.g. moderate or strong to palpation, or > 200 MVU, for > 4 hours) without improvement in dilation, effacement, station or position
 - OR
 - Inadequate uterine contractions (e.g. < 200 MVU) for > 6 hours of oxytocin administration without improvement in dilation, effacement, station or position
- Second Stage Arrest (must fulfill any one of four criteria)
 - Nullipara with epidural pushing for at least 4 hours
 - OR
 - Nullipara without epidural pushing for at least 3 hours
 - OR
 - Multipara with epidural pushing for at least 3 hours
 - OR
 - Multipara with epidural pushing for at least 2 hours

Failed Induction (must have both criteria if cervix unfavorable, Bishop Score < 8 for nullips and < 6 for multips)

Cervical Ripening used (when starting with unfavorable Bishop scores as noted above). Ripening agent used: _____ Reason ripening not used if cervix unfavorable: _____

AND

- Unable to generate regular contractions (every 3 minutes) and cervical change after oxytocin administered for at least 12-18 hours after membrane rupture. *Note: at least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

Latent Phase Arrest < 6 cm dilation (must fulfill one of the two criteria)

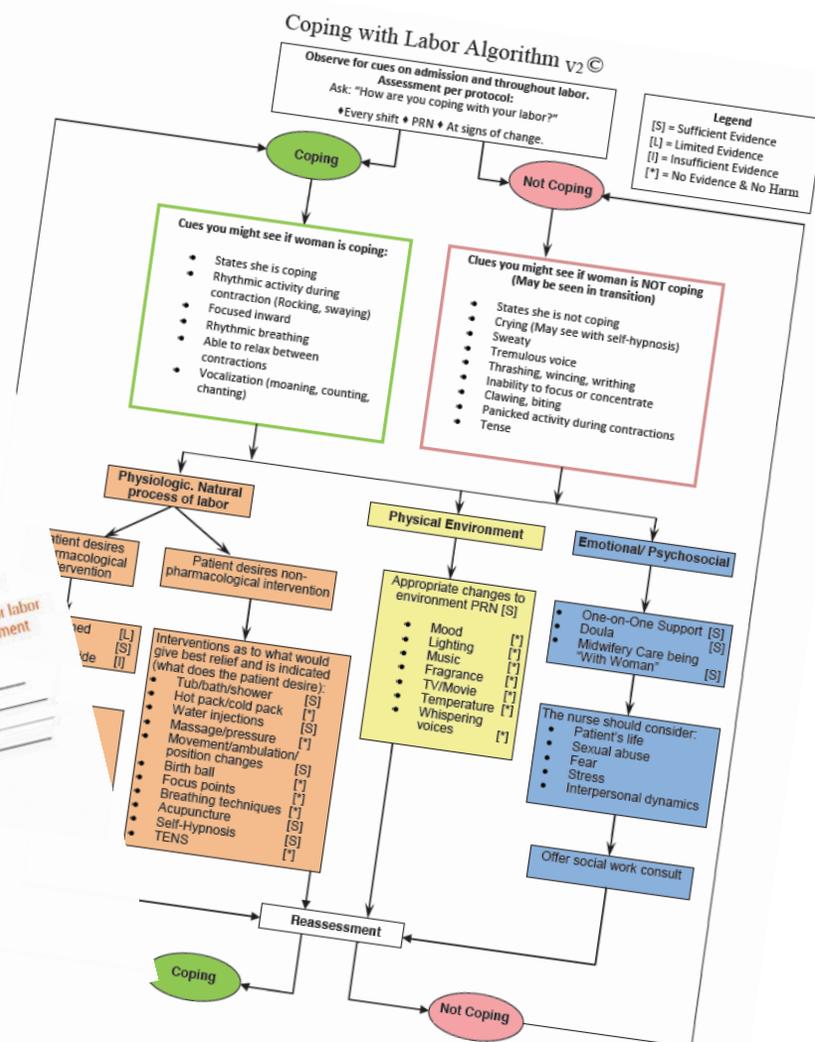
- Moderate or strong contractions palpated for > 12 hours without cervical change
- OR
- IUPC > 200 MVU for > 12 hours without cervical change

*As long as cervical progress is being made, a slow but progressive latent phase e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women is not an indication for cesarean delivery as long as fetal and maternal statuses remain reassuring. Please exercise caution when diagnosing latent phase arrest and allow for sufficient time to enter the active phase.

Although not fulfilling contemporary criteria for labor dystocia as described above, my clinical judgment deems this cesarean delivery indicated

Failed Induction: Duration in hours: _____
 Latent-Phase Arrest: Duration in hours: _____
 Active-Phase Arrest: Duration in hours: _____
 Second-Stage Arrest: Duration in hours: _____

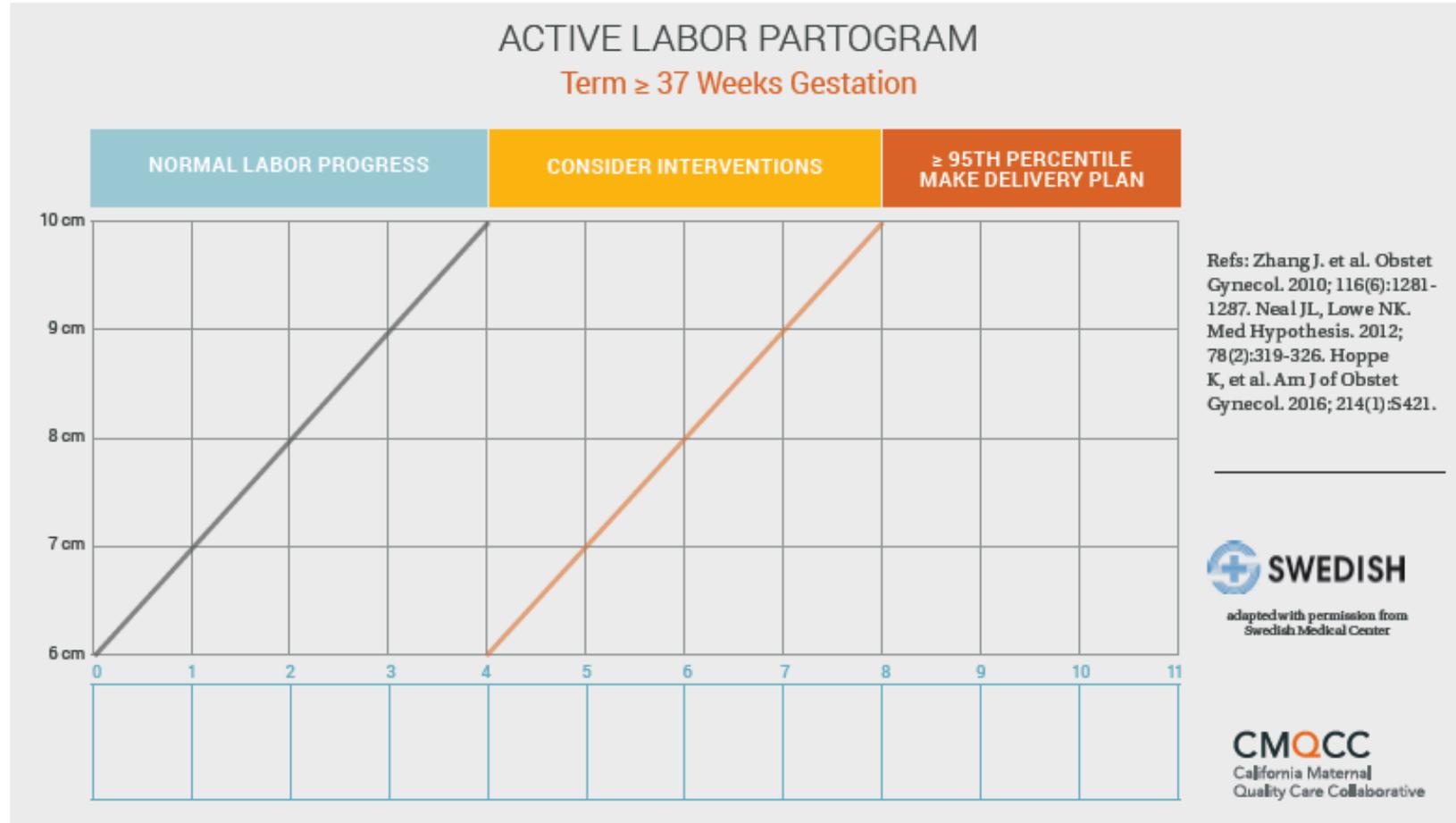
Comments: _____





Active Labor Partogram

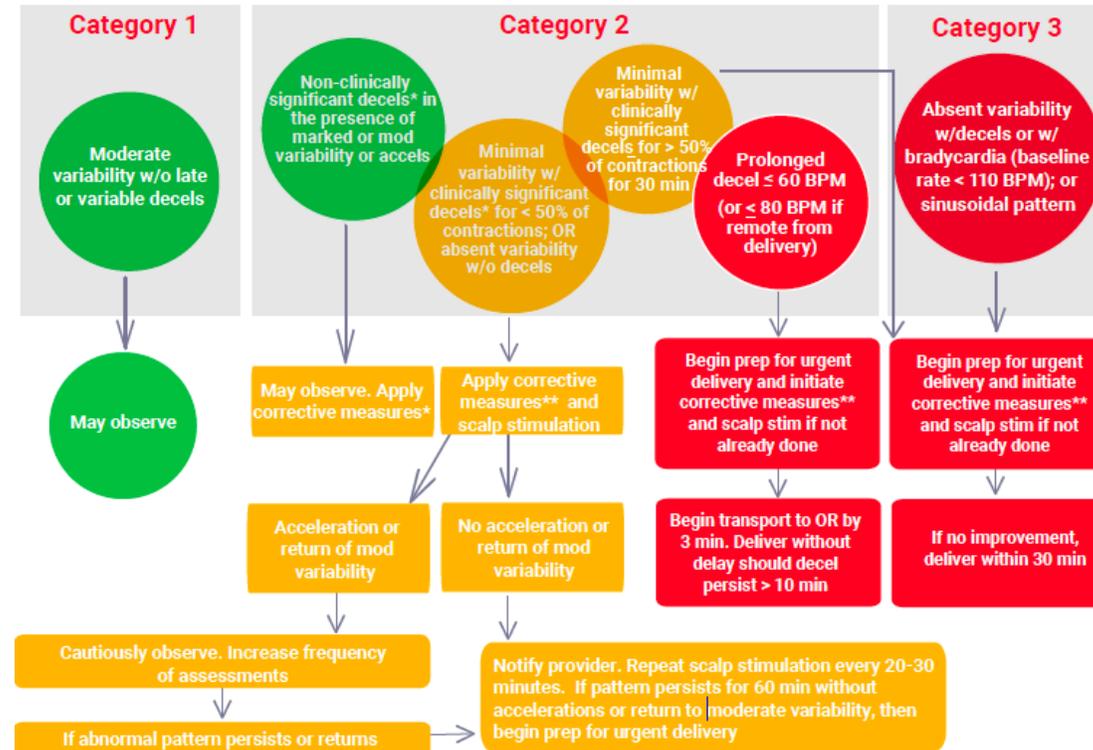
Response





Appendix Q Example Algorithm for the Management of Intrapartum Fetal Heart Rate Tracings

Example Algorithm: Management of Intrapartum FHR Tracings



*Clinically significant decelerations include:

- Variable decels lasting > 60 sec with a nadir > 60 BPM below baseline
- Variable decels > 60 sec with a nadir < 60 BPM regardless of baseline
- Late decels of any depth
- Any prolonged decel as defined by NICHD

(Clark et al *Am J Obstet Gynecol*. 2013;209(2):89-97)

**Corrective measures include:

- Oxygen administration
- Maternal position change
- Fluid bolus
- Reduction or discontinuation of pitocin
- Administration of terbutaline for tetanic contraction or tachysystole
- Administration of pressors, if hypotension present
- Amnioinfusion for deep, repetitive variable decelerations

(Miller LA, Miller DA. *J Perinat Neonatal Nurs*. 2013;27(2):126-133.)



Examples

Response

- Spontaneous labor algorithms/dystocia checklists
- Induction algorithms/checklists/policies for timing, scheduling, proper selection
- Algorithms for standard intervention for FHR changes
- Model policies for oxytocin
- Tools for effective communication

Last
Thoughts

Summaries





Take-home Lessons from Our Experience

- Power of sharing provider-level data
- Key role of Nurses and Physician Leaders
- Need a reason to change
- National guidelines very helpful
- Needs “constant gardening”





Uphill or Wind Behind Your Back?

- Easy:
 - Birthing balls and other natural labor tools
 - Tools to support early management and supportive care
 - Tools and planning to increase mobility
- Hard
 - Intermittent auscultation adoption
 - Doula (economic model)
 - Admission after 4 cm (but also key strategy)





Opinion Leaders vs. Audit/Feedback

- 76 physicians in 16 community hospitals
- Looked at trial of labor
- After 24 months no difference between control and groups in audit and feedback group
- Opinion leader groups were 85% higher than controls and 46% higher than audit groups
- No adverse outcome differences

Lomas et al, JAMA 1991;265:2202

Transforming Maternity Care

A Toolkit to Support Vaginal Birth and Reduce Primary Cesareans



The formal role of leadership teams

- Leadership, tools, and organizational processes play an important role in developing and embedding a reliable-seeking culture across an organization.
- Progress toward a reliability-seeking, system-oriented approach to care remains ongoing, and movement in that direction requires deliberate and sustained effort by committed leaders in health care.

Weaver, Health Care Manage Rev. 2015 Jul-Sep;40(3):183-92

Transforming Maternity Care

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QI Academy

Strengthen your team's quality improvement skills with CMQCC's QI ACADEMY!

The QI Academy is designed to help hospitals build a multidisciplinary maternal QI team that fosters sustainable change and enhances professional experience.

QI Academy is a dynamic learning environment for participating hospitals to receive mentorship in enhancing their perinatal QI team's skills. The year-long educational initiative focuses on application of evidence-based QI techniques to a hospital-specific project, giving participants the opportunity to apply learning and demonstrate leadership. Hospitals select a maternal QI project that is focused on one of CMQCC's toolkits or the implementation of a national AIM bundle. The project must have identified data metrics that can be trended over the course of the year.

The first cohort of hospitals began in August 2018, and a second began in February 2019. New cohorts are planned to begin approximately every 6 months, and each cohort runs for a year. CMQCC will support the teams on monthly educational learning calls. All CMQCC member hospitals are invited to apply for QI Academy.

Participating teams must:

- Include nursing and physician leadership; quality leadership is strongly encouraged
- Pay a participation fee of \$475 per hospital team.

Interested in more information? Email info@cmqcc.org.



Thank You!



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Transforming Maternity Care

A Toolkit to Support Vaginal Birth and Reduce Primary Cesareans



Other Thoughts

Some other selections
from the toolkit



READINESS

Developing a maternity culture that values, and supports intended vaginal birth



Strategies

Readiness

- Improve access and quality to modern childbirth education
- Improved shared decision making at critical points
- Bridge provider knowledge and skills gap
- Transition to value based payments



Examples

Readiness

- Sources of best childbirth education tools
- Tools/policies/concepts of “mother friendly” hospital
- Approaches to shared decision making and training aspects
- Payment models for value based results



RECOGNITION AND PREVENTION

Key Strategies for Supporting Intended Vaginal Birth



Strategies

Recognition

- Implement institutional policies which support vaginal birth
- Early labor management and supportive care
- Labor support personnel (e.g. doulas)
- Infrastructure/equipment
- Best practices for regional anesthesia
- Protocols for intermittent auscultation
- Protocols for modifiable conditions like HSV and breech position



Examples

Recognition

- Model policies for intermittent monitoring, freedom of movement, early labor support, etc.
- Coping with labor algorithm
- Guidelines for working with doulas
- Patient education and decision guides

In fact, there are over 27 Tools in this section alone



Promoting mobility in labor/birth

Recognition

- For both patients with and without regional anesthesia/analgesia
- Know your labor beds and what they can do
- Use of birthing balls and peanut balls
- Posters in labor rooms of labor positions
- Use of telemetry EFM



RESPONSE

Management of Labor Abnormalities



Strategies

Response

- Create highly reliable teams and improve interdisciplinary communication
- Adopt standard measures for labor and FHR abnormalities
- Utilize operative vaginal deliveries in appropriate cases
- Identify malposition and perform manual rotation
- Develop alternative coverage patterns such as hospitalist/midwives