Partnering to Improve Health Care Quality for Mothers and Babies

Promoting Primary Vaginal Deliveries (PROVIDE) Initiative

DATA COLLECTION

FAQ

1. **Where can I find the latest Chart Audit Form?**
   A. The most updated data audit sheets, data entry instructions, FAQ answers, the measurement grid, and more will always be posted at the online PROVIDE Tool Box under "Data Resources".

2. **If we've picked an area (induction, FHR concern, or dystocia) already, do we only submit on that for baseline?**
   A. No, you should not have chosen 1 area, yet. At baseline you submit your first 20 NTSV cesarean charts of each baseline month no matter what they are. You submit each case individually and tell us which category it falls under. Then we provide you a baseline data report and let you know where your largest opportunity for improvement lays. THEN you pick an area to focus on for Prospective data chart audits (1 of the 3) areas and only submit on your choice going forward (starting in January).

3. **Medical Indications for Cesarean Section (case audit exclusions, or Baseline "Other") include:**
   - Maternal or fetal hemorrhage
   - Hypertensive emergencies not responding to treatment
   - Abnormalities of placenta or umbilical cord
   - Fetal or maternal conditions that obstruct the pelvis
   - Active HSV lesions or HIV viral load >1000copies/ml
   - Other maternal medical indications (cardiac, neurological, orthopedic, pulmonary, malignancy, previous uterine surgery) that preclude vaginal delivery

4. **If it is a cesarean at maternal request, is it "Other"?**
   A. For Baseline, yes. For Prospective, there will not be an Other category for chart audit.

5. **What are the definitions of Induction vs. Augmentation? What about with SROM?**
   A. Induction of labor = pharmacological or mechanical methods to initiate labor following SROM without contractions. Augmentation =stimulation of contractions to increase their strength or frequency after SROM. Any contractions count. There is no further qualification on cervical dilation with those contractions. Please refer to page 120 of the CMQCC toolkit. There is additional information below the chart that explains the

rationale further (source ACOG AIM and reVITALIZE). If ANY contractions are present after SROM, that it is augmentation. If NO contractions are present, then it is induction. The second would be rare would be rare, but possible. Contractions present or absent is the decision point.

See below.

California Maternal Quality Care Collaborative

ACOG Key Labor Definitions

Measure	Source/	Specifications for Denominator and Numerator
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	Avoid the term 'prodromal labor'. Can be spontaneous in onset, spontaneous in onset and subsequently augmented, or induced
Spontaneous Onset of Labor	Labor without the use of pharmacologic and/or mechanical interventions to initiate labor Does not apply if AROM is performed before the onset of labor	May occur at any gestational age
Induction of Labor	The use of pharmacologic 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 The use of pharmacologic and/or mechanical methods to initiate labor following spontaneous ruptured membranes without contractions
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.	Does not apply if Induction of Labor is performed

6. **If we have an induction that is also a labor dystocia OR an induction that is also FHR concern, which category is it?**
   A. We have made each category *mutually exclusive.* That means you should first determine if it is a FHR concern. If it is, please submit as a FHR concern case. If it is not, next determine if it is an induction. If it is an induction case, but not an FHR case, please submit under "induction". If it is a labor dystocia during a spontaneous labor, please submit under "labor dystocia."

7. **In the Chart Audit Sheet under FHR concern, one of the "corrective measures" is "Elicited stimulation (scalp, vibroacoustic, or abdominal wall). I am concerned that individuals might think they need to do this to "correct a FHR pattern", which is inappropriate and not the intent of the stimulation. The intent is to elicit an acceleration to rule out fetal acidosis.**

A. This is correct. Eliciting a scalp stimulation is not a method to resuscitate a baby within the uterus. A scalp stimulation, however, is a way to exclude acidosis. The 2012 article by Spong, listed as a reference, states "Fetal heart rate acceleration in response to fetal scalp stimulation is supportive evidence suggesting the absence of metabolic acidosis." Still, there is concern that a delivering clinician may perform a cesarean delivery when a Category II tracing exists without excluding acidosis. Therefore, the article adds "In the case of an indication with a Category II pattern, confirmatory testing, if any, should be documented, such as a negative response to scalp stimulation or minimal variability." This was added this under "Corrective measures" to make certain the delivering clinician took the step to document the negative response before the cesarean delivery, thus validating the concern about developing fetal acidosis.

8. **When does prospective data submission start? Should we be submitting for October, November, December 2017?**
   A. No, only baseline data (July, August, September) and prospective data (beginning January 2018) reports will be created. Please do not start auditing charts for your focus area until January 2018. Prospective data is due by the 15th of the following month (e.g. Feb 15th).

Have a question? FPQC@health.usf.edu and we'll get it to the right person.