PROVIDE

CALIFORNIA TOOLKIT & AIM RECOMMENDATIONS

to Support Vaginal Birth

OB Quality Improvement and Safety Efforts Help to *Decrease* Liability

Utilize evidence-based best practice protocols that follow national consensus (e.g. oxytocin)

Utilize expert-vetted standardized approaches for labor and fetal heart rate abnormalities

Communication techniques which engage the patient in "shared decision making" creates a strong deterrence to lawsuits

Reducing primary cesareans, protects against post-cesarean complications and poor outcomes during future care

Why has Cesarean Birth Reduction been so hard?

Direct challenge to Physician autonomy

Very **complex**, many factors; need to be able to focus on areas with real preventability

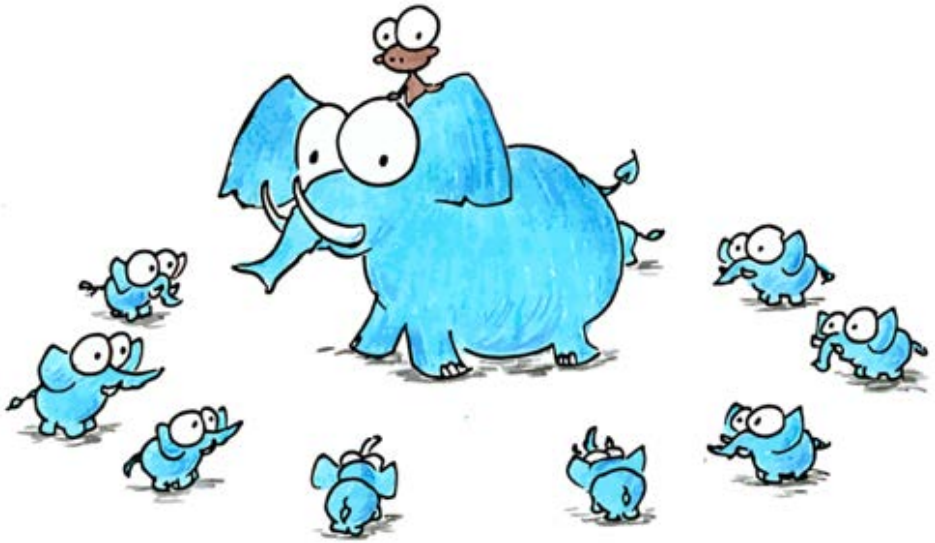
Need for **professional** society leadership

Timing: prior attempts were often "Voices in the wilderness"; "3rd rail of OB QI"; "Enter at your own risk…"

Risk: "Never got sued for doing a Cesarean"

Elephants in the room

- Medical Legal: Have we changed?
- Payment Reform: When will it transition?
- Provider: Willingness to change?
- Hospital: Willing to participate in culture change?

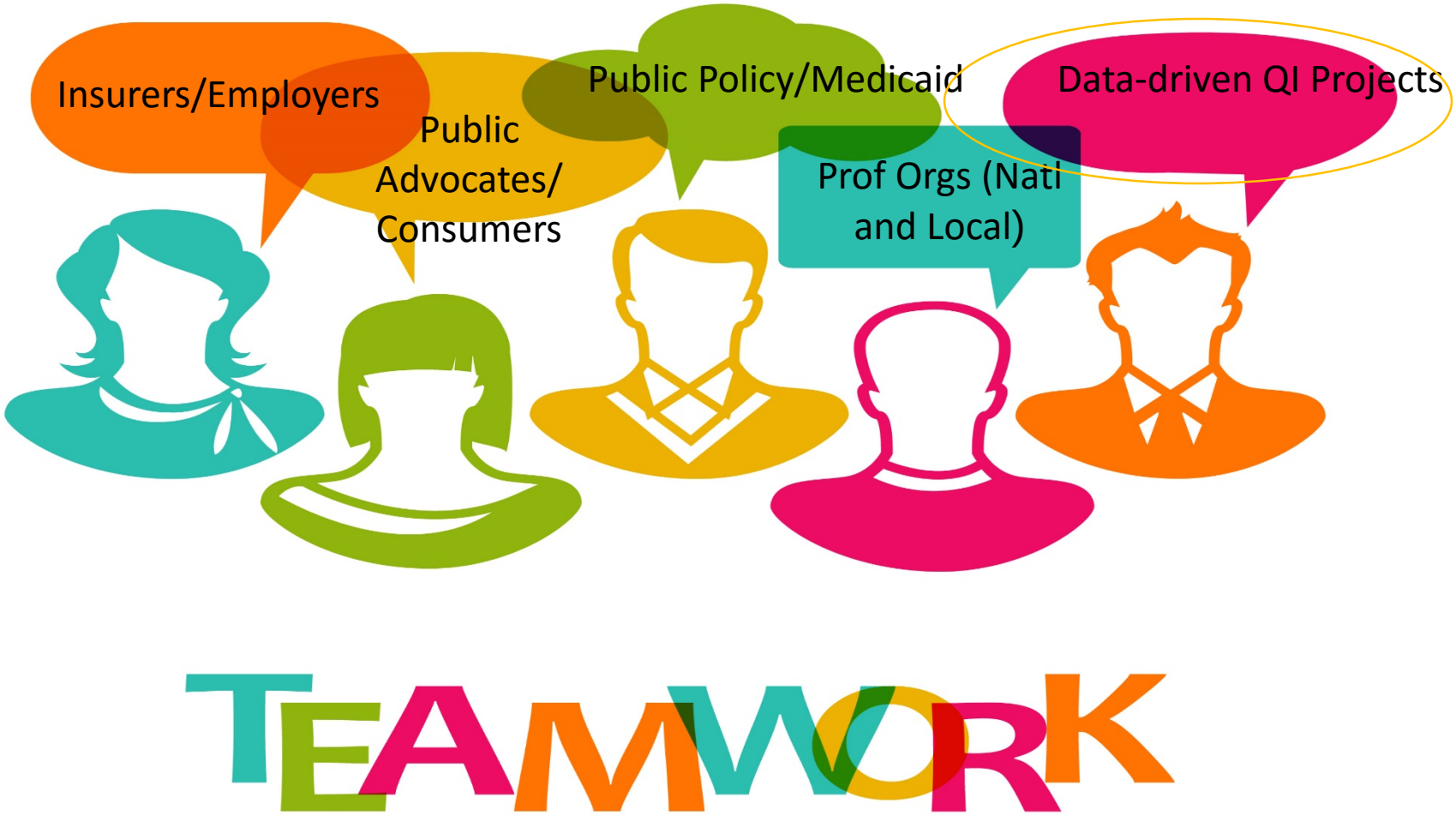


What drives Cesarean sections?
(the *opposite* supports vaginal birth)

- Time pressures
- Financial incentives
- No consequence for a high c/s rate
  - Professional standing, reputation, financial
  - Regulatory, payor
- Lack of clinical training
  - Response to FHT, labor dystocia, malpresentation

Condensed from Council on Patient Safety in Women's Health Care slides

It takes a Village to Reduce Unnecessary Cesareans

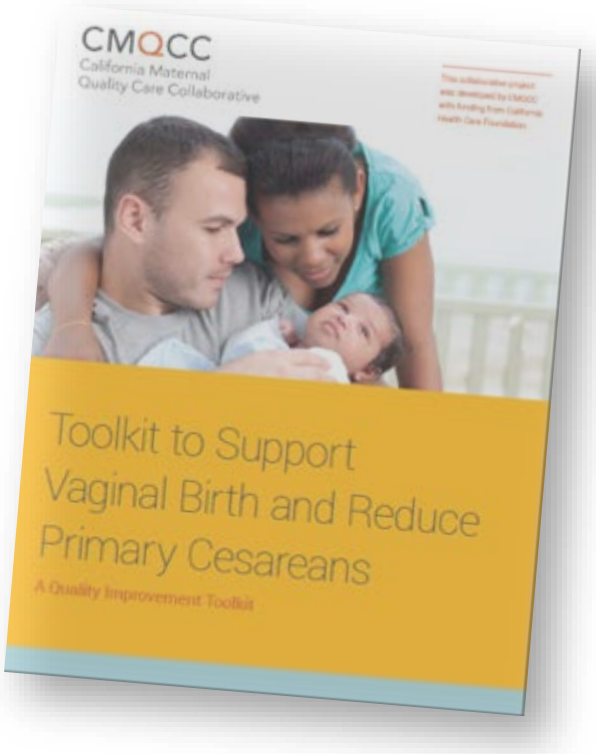


Planning and Support for this Project

- Florida Department of Health
- American College of Obstetricians and Gynecologists (ACOG) District XII
- Florida Chapter of the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)
- Florida affiliate of the American College of Nurse Midwives (ACNM)
- Alliance for Innovation in Maternal Health (AIM)
- California Maternal Quality Care Collaborative (CMQCC)
- Representatives from provider practice groups, hospitalists, health plans, hospital nurses and administration, public health professionals, childbirth educators, and doulas.

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*



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

Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

Number 1, March 2014 *(Reaffirmed 2016)*

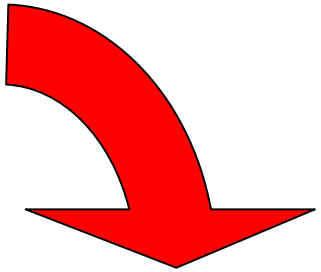
Safe Prevention of the Primary Cesarean Delivery

Abstract: In 2011, one in three women who gave birth in the United States did so by cesarean delivery. Cesarean birth can be life-saving for the fetus, the mother, or both in certain cases. However, the rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused. Variation in the rates of nulliparous, term, singleton, vertex cesarean births also indicates that clinical practice patterns affect the number of cesarean births performed. The most common indications for primary cesarean delivery include, in order of frequency, labor dystocia, abnormal or indeterminate (formerly, nonreassuring) fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia. Safe reduction of the rate of primary cesarean deliveries will require different approaches for each of these, as well as other, indications. For example, it may be necessary to revisit the definition of labor dystocia because recent data show that contemporary labor progresses at a rate substantially slower than what was historically taught. Additionally, improved and standardized fetal heart rate interpretation and management may have an effect. Increasing women's access to nonmedical interventions during labor, such as continuous labor and delivery support, also has been shown to reduce cesarean birth rates. External cephalic version for breech presentation and a trial of labor for women with twin gestations when the first twin is in cephalic presentation are other of several examples of interventions that can contribute to the safe lowering of the primary cesarean delivery rate.

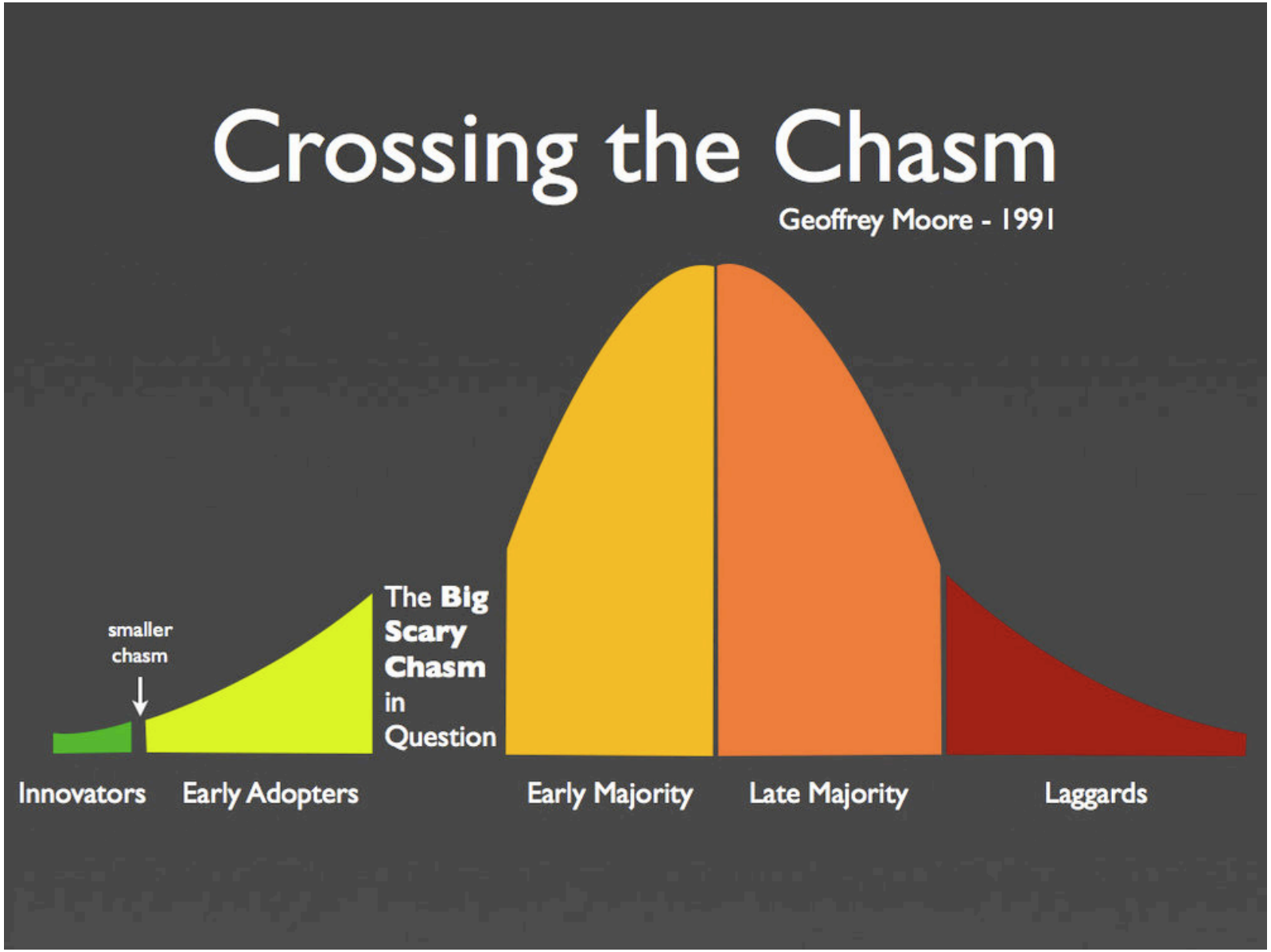
First and foremost, it should be understood that a labor support and cesarean reduction program seeks to reduce unnecessary cesarean births. The program's charter must clearly recognize that timely and well-chosen cesareans are sometimes necessary to prevent avoidable fetal-and maternal harm.

Paradigm Shift

Most Cesarean Births are inevitable though some are preventable



Changes in practice style can prevent many Labor Cesarean Births


Crossing the Chasm
Geoffrey Moore - 1991
smaller chasm
The Big Scary Chasm in Question
Innovators
Early Adopters
Early Majority
Late Majority
Laggards

Using a toolkit you pick the right tool for the job

(and one you know how to use)

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

The Toolkit translates the AIM Safety Bundle for Safe Reduction of Cesarean into an easy-to-use "menu" of tools and practical approaches

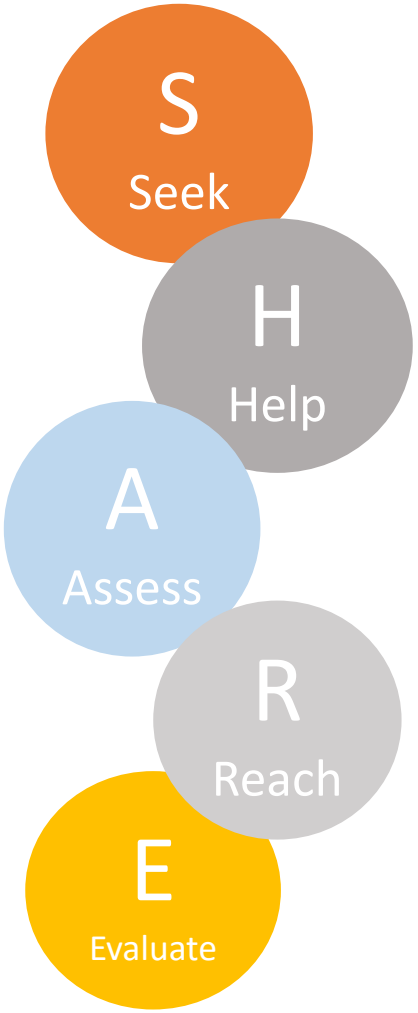
- Readiness
- Recognition and Prevention
- Response to Every Labor Challenge
- Reporting

PATIENT SAFETY BUNDLE

Safe Reduction of Primary Cesarean Births

Sharing in decision making:
The SHARE Model

Readiness



Seek the patient's participation

Help her explore each option and the corresponding risks and benefits

Assess what matters most to her

Reach a decision together and arrange for a follow up conversation

Evaluate her decision (revisit the decision and assess whether it has been implemented as planned)

The SHARE approach. Agency for Healthcare Research and Quality Website. http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html. Accessed December 1, 2015.

Shared Decision Making (continued)

PATIENT DECISION POINTS THAT IMPACT RISK OF CESAREAN
Choice of provider and/or facility for prenatal care and care at time of birth
Timing of admission to hospital (admission to labor and delivery while still in the latent/early phase is associated with an increased risk of cesarean)
Choice of fetal monitoring method (continuous monitoring is associated with an increased risk of cesarean)
Whether to have continuous labor support by a trained caregiver like a doula (continuous labor support improves chances of having a vaginal birth)
Induction of labor without medical indication

What about women who request a Primary Cesarean Birth?

It is important to communicate early and often during the prenatal period to alleviate any fears related to incomplete information

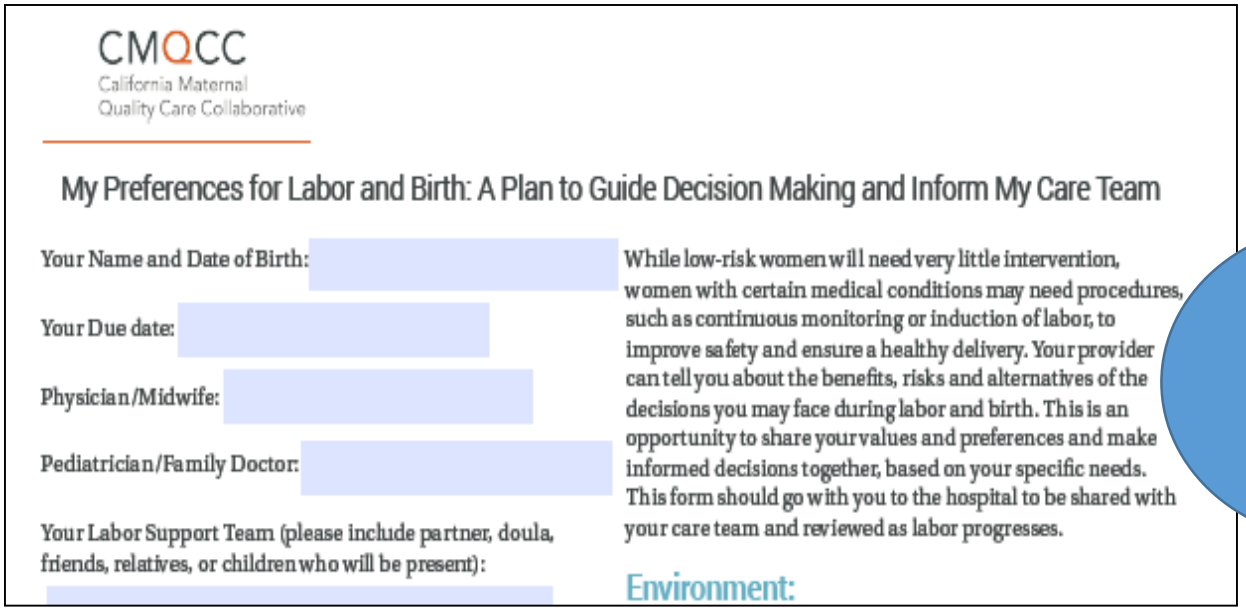
Fear of pain is a common concern. Work with her to identify good labor support personnel

Provider guidance is critical. Different approaches and attitudes reflect different rates

Incidence is less than 1%

Birth Preferences Worksheet

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



CMQCC
California Maternal
Quality Care Collaborative

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

Your Name and Date of Birth:

Your Due date:

Physician/Midwife:

Pediatrician/Family Doctor:

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

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:

Example available in the toolkit

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.

Examples of Tools

- 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

Implement Early Labor Supportive Care Policies and Active Labor Criteria for Admission

- Translation: Early labor at home. Let labor start on its own!
- **Physiologic onset of labor is critical to the success in labor,** and introduces moms and babies to protective hormonal pathways
- Women admitted in early labor are more likely to have a cesarean, and more likely to have routine interventions e.g. oxytocin even if not clinically necessary

Early admission support

- Admission policy or checklist for spontaneous labor
- Latent labor support and therapeutic rest policies
- Patient education materials to explain rationale for delayed admission, reduce anxiety and provide guidance on when to return to the labor and delivery unit
- Material with specific guidance for partners and family members as to how to best support the woman in early labor

Key Components of Labor Support

Recognition

Policies should encourage:

- Freedom of movement in labor
- Upright and ambulatory positioning
- Nonpharmacologic comfort measures
- Use of techniques and tools that facilitate fetal rotation, flexion, and descent for women with epidural anesthesia
- Maternal exercises and positioning that facilitate fetal rotation in women with and without epidural anesthesia

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

COMMITTEE OPINION

February 2019

Approaches to Limit Intervention During Labor and Birth

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 compromise, routine amniotomy is not necessary.
- The widespread use of continuous electronic fetal heart-rate monitoring has not improved outcomes when used for women with low-risk pregnancies.
- Multiple nonpharmacologic and pharmacologic techniques can be used to help women cope with labor pain.
- Women in spontaneously progressing labor may not require routine continuous infusion of intravenous fluids. For most women, no one position needs to be mandated nor proscribed.
- Obstetrician–gynecologists and other obstetric care providers should be familiar with and consider using low-interventional approaches for the intrapartum management of low-risk women in spontaneous labor.

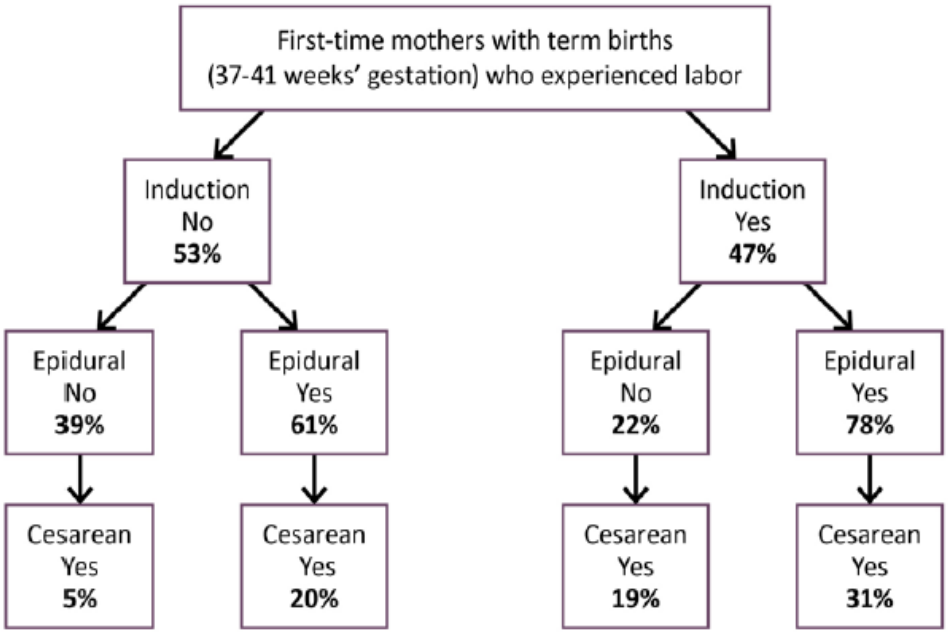
Promoting mobility in labor/birth

- 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

Interventions and their outcomes

Cascade of intervention in first-time mothers with term births who experienced labor

Base: first-time mothers with term births who experienced labor *n=750*



In this group, which included 85% of first-time mothers, the overall epidural rate was 69% and overall cesarean rate was 21%.

Declercq ER, Sakala C, Corry MP, Applebaum S, Herrlich A. *Listening to MothersSM III: Pregnancy and Birth*. New York: Childbirth Connection, May 2013.

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

CMQCC

Non-Pharmacologic Approaches Are Relevant To Every Laboring Woman

Recognition

- Continuous labor support
- Breathing and relaxation techniques
- Touch techniques and massage
- Positions to promote comfort
- Heat and cold therapy
- Hydrotherapy
- Sterile water injections
- Transcutaneous electric nerve stimulation

Doulas

Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula…Given that there are no associated measurable harms, this resource is probably underutilized."

– ACOG/SMFM Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery (2014).[3]

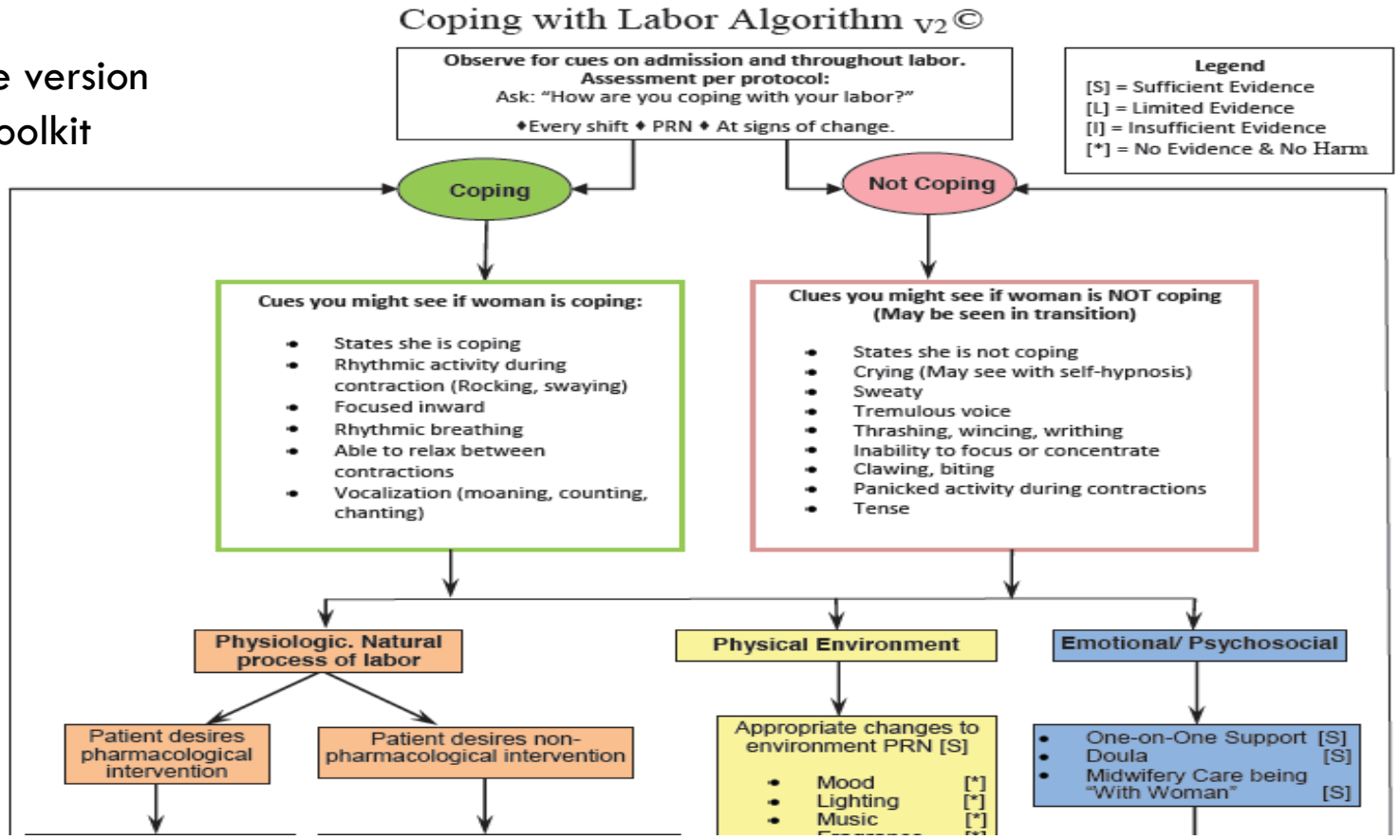
Continuous Labor Support During Childbirth

(Cochrane Review updated 2017)

- Improves outcomes for women and infants:
  - Increased spontaneous vaginal birth
  - Shorter duration of labor
  - **Decreased cesarean birth**
  - Decreased instrumental vaginal birth
  - Decreased use of analgesia
  - Decreased low 5-min Apgar score
  - Decreased negative feelings about childbirth experience

Coping Algorithm

Full size version
in the toolkit



PATIENT SAFETY BUNDLE

Safe Reduction of Primary Cesarean Births

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

Four Specific Areas that Standardization Can Significantly Improve

- Diagnosis of labor dystocia
- Use of oxytocin
- Response to abnormal heart rate patterns
- Induction of labor

Prevention and Management of Malposition

Response

- Avoid routine early amniotomy
- Employ preventive measures for women with epidural anesthesia
- Intrapartum maternal/fetal positioning
- Consider pushing positions
- Support maternal psyche and body
- Manual rotation
- Patience, patience, patience!

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Quality Care Collaborative

Appendix G

Second Stage Management of Malposition

Pre-Cesarean Checklist for Labor Dystocia available in Toolkit

Pre-cesarean Checklist for Labor Dystocia or Failed Induction

Patient Name:_____ MR#: _____

Gestational Age: _____ Date of C-section: _____;

Time: _____

Obstetrician: _____ ; Initial:_____

Bedside Nurse: _____ ; Initial:_____

Indication for Primary Cesarean Delivery:

____ 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)

____ 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

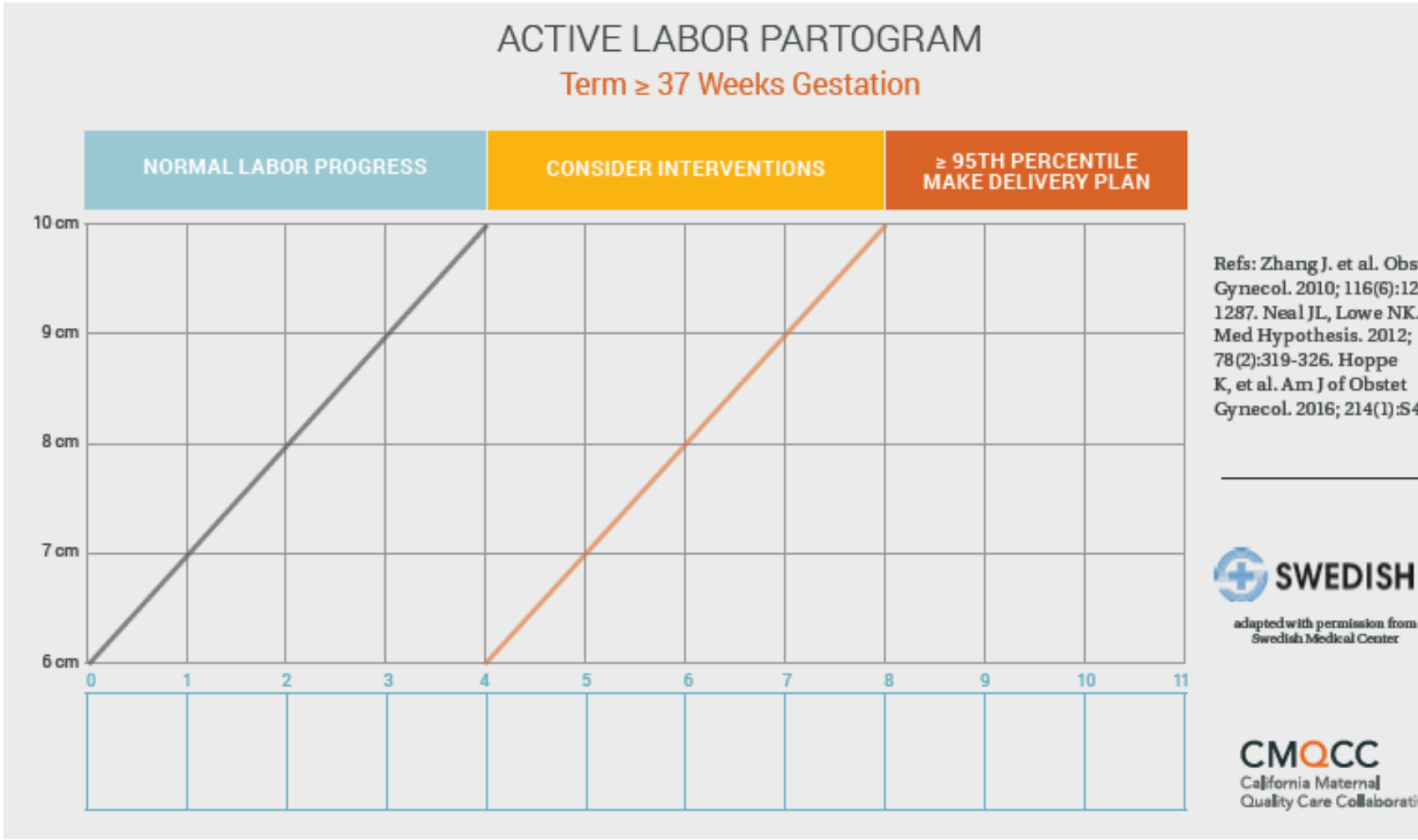
___ Multipara without epidural pushing for at least 2 hours

____ 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 Labor Partogram available in the Toolkit

Response



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.

Strategies

Reporting

- Provide timely feedback in persuasive manner
- Use comparative data which conveys a sense of urgency
- Present data for both hospital and providers
- Set achievable goals
- Tie descriptive "cold" data with patient stories and other successes

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

Provider-Level Cesarean Rates

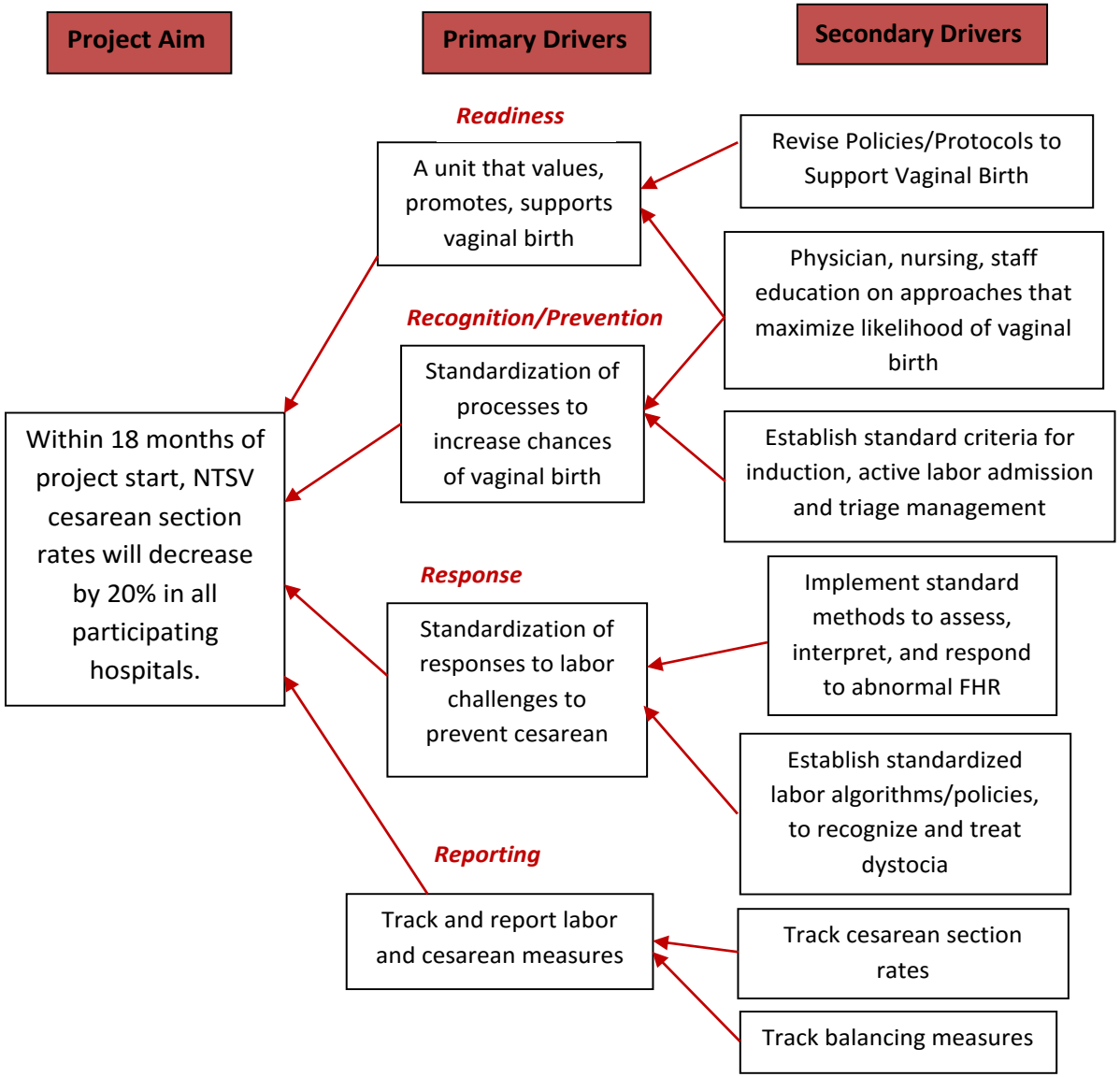
Screen Shot from the CMQCC Maternal Data Center

Note the two busiest providers had widely different rates

Period: Oct 2012 – Sep 2013 (12 months)

		NTSV Cesarean Section		Total CS	
	Total Deliveries	Rate	D	Rate	D
Oct 2012 – Sep 2013		27.6%	163090	33.2%	478231
Missing Provider	491				
Sample Medical Center	5844	32.2%	2369	37.9%	5844
G7xxxx	52	13.6%	22	9.6%	52
G6xxxx	47	36.8%	19	40.4%	47
G5xxxx	68	20.8%	24	42.6%	68
G8xxxx	60	15.4%	26	21.7%	60
A8xxxx	190	42.7%	75	44.7%	190
A6xxxx	52	35.0%	20	42.3%	52
A5xxxx	2	No Cases	0	100.0%	2
A4xxxx	114	35.3%	51	46.5%	114
A8xxxx	214	18.3%	82	28.0%	214
A9xxxx	481	36.2%	163	43.2%	481

PROVIDE Key Drivers



Recommended Key Practices

1. Improve access to and promote quality childbirth education, informed consent, and shared decision making
2. Implement institutional policies that uphold best practices in obstetrics, safely reduce routine interventions in low-risk women, and consistently support vaginal birth
3. Educate nurses and providers on intermittent auscultation/EFM and implement intermittent monitoring for low-risk women
4. Educate nurses on labor support skills that promote labor progress, labor support, pain management
5. Educate and encourage providers: external version, operative vaginal delivery, breech delivery

Recommended Key Practice

6. Establish standard criteria for induction, active labor admission and assess all women on admission
7. Encourage use of doulas and create doula-friendly policies
8. Increase access to non-pharmacological pain management/labor progression tools
9. Implement standard diagnostic criteria and responses to labor challenges and HR abnormalities
10. Track provider-level cesarean section rates and conduct case reviews to drive improvement

You do <u>not</u> need to do all of this at once

PROVIDE's 3 Focus Areas

- Hospitals will review baseline data and environment, and prioritize what needs improvement in the local setting
- May chose one, more or progressively as needed
- Based on Key Drivers of NTSV rates the 3 focus areas are:
  1. Induction
  2. Labor Dystocia/Failure to Progress
  3. Fetal Heart Rate Concerns
- Interventions/Strategies/Recommended Practices are evidence-based and individualized to the local setting

Partnering to Improve Health Care Quality
for Mothers and Babies

QUESTIONS?