



SAFE REDUCTION OF PRIMARY CESAREAN BIRTH: A QUALITY IMPROVEMENT INITIATIVE



**SAFE REDUCTION
OF PRIMARY
CESAREAN BIRTH**
FLORIDA PERINATAL
QUALITY COLLABORATIVE

**Florida
HEALTH**

 **AIM**
ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Florida Perinatal Quality Collaborative

The Safe Reduction of Primary Cesarean Birth Initiative toolkit is intended to provide guidance to hospitals and obstetric providers in the development of individualized policies, protocols, practices, and materials to safely promote vaginal deliveries at Florida delivery hospitals and reduce unindicated NTSV (Nulliparous Term Singleton baby in Vertex presentation) cesareans. This toolkit is not to be construed as a standard of care; rather it is a collection of resources that may be adapted by local institutions to develop and implement their quality improvement initiative. The toolkit is based on the framework from the [Alliance for Innovation on Maternal Health \(AIM\) Safe Reduction of Primary Cesarean Birth Patient Safety Bundle](#) and will be updated as more resources become available.

Suggested Citation:

Florida Perinatal Quality Collaborative. (2026). *Safe Reduction of Primary Cesarean Birth Initiative Toolkit: A Quality Improvement Initiative*. Tampa, FL: The Chiles Center at University of South Florida College of Public Health.

Acknowledgements:

The FPQC gratefully acknowledges and thanks our state partner organizations, including the Florida Agency for Healthcare Administration, American College of Obstetrics and Gynecology District XII, Florida Association of Women's Health, Obstetrics and Neonatal Nurses, Florida Department of Health, Florida Association of Healthy Start Coalitions, Florida Hospital Association, and the Alliance for Innovation on Maternal Health. The creation of this toolkit would not have been possible without the volunteer members of the Safe Reduction of Primary Cesarean Birth Advisory Committee listed on pages 2-3 of this toolkit.

Funding:

This quality improvement (QI) initiative is funded in part by the Florida Department of Health with funds from the Title V Maternal and Child Health Block Grant from the U.S. Health Resources and Services Administration and the Centers for Disease Control and Prevention.

Contact:

Florida Perinatal Quality Collaborative
The Chiles Center
University of South Florida College of Public Health
3111 East Fletcher Avenue
Tampa, FL 33613-4660
E-mail: fpqc@usf.edu
Website: FPQC.org

Copyright:

© 2026 Florida Perinatal Quality Collaborative. All Rights Reserved.

The material in this toolkit may be reproduced and disseminated in any media in its original format, for informational, educational, and non-commercial purposes only. Any modification or use of the materials in any derivative work is prohibited without prior permission of the Florida Perinatal Quality Collaborative.

Safe Reduction of Primary Cesarean Birth Initiative Advisors

- Lisa Acosta, RN, South Miami Hospital
- Melanie Altizer, MD, MBA, FACOG, St Mary's Medical Center
- Sharmane Andrews, CNO, Jackson Memorial Hospital UM
- Tenesha Avent, MPH, CCHW, March of Dimes
- Elizabeth Barrera, RN, South Miami Hospital
- Susan Bednar, RN, Holmes Regional Medical Center
- Christina Bennet Wiley, CNM, UF Health Gainesville
- Maria Boyd, RN, AdventHealth Wesley Chapel
- Julie Brandt, RN, Homestead Hospital
- Jessica Brumley, CNM, PhD, TGH Division of Midwifery, Obstetrics and Gynecology, FPQC Clinical Lead
- Ashley Cain, MD, USF Health MFM
- John Caravello, MD, Broward Health
- Brenda Carvalho, MSN, RNC-OB, C-EFM, Mease Countryside Hospital
- Jaleesa Clark, RN, Bayfront Baby Place
- Nancy Collins, MD, MBA, FACOG, Adventhealth Orlando
- Alexandra Cornelius, PhD, Florida International University
- Julie Crum, FL Department of Health
- Kay Epps, MSN, RNC-OB, C-OBE, C-EFM, IBCLC, UF Health North
- Tayler Etheridge, MSN, RN, RNC-OB, C-EFM, UF Health Gainesville
- Saige Evans, OTD, OTR/L, Women's & Girls Pelvic Health Institute
- Shon Ewens, Healthy Start Coalition
- Riz Fareeduddin, MD, Advent Health for Women (support our Central Florida Division)
- Kimberly Fryer, MD, MSCR, AdventHealth Winter Haven
- Bridget Funk, PhD, C-ONQS, CNE, RN-BC, Sarasota Memorial Hospital
- Adolfo Gonzalez-Garcia, MD FACOG, HCA Florida Northwest, FPQC Clinical Lead
- Lindsay Greenfield, MSN, APRN, Tampa General Hospital
- Cole Greves, MD, FACOG, Orlando Health Winnie Palmer
- Mandi Gross, JD, FPQC Family Lead
- Amy Haddon, MSN, RN, BayCare Health System
- Amber Hagenbuch, MSN, RNC-OB, EFM, ONQS, Orlando Health Bayfront Hospital
- Karen Harris, MD, MPH, HCA Florida North Florida
- Anastasia Hawkins, DO, UF Health Jacksonville (Shands)
- Washington Hill, MD, Sarasota Memorial Hospital
- Vanessa Hux, MD, Lakeland Regional Health
- Kathleen Johnson, MSN, NE-BC, CRN, LSSBB, Baptist Health
- Helen Kuroki, MD, MS-HQS, Women's Care Florida
- David Lagrew, MD, Hoag Hospital California
- Carol Lawrence, PhD, RNC-OB, CBC, FGCU College of Nursing
- Jenny Leistl, RN, St. Joseph's Women's Hospital
- Rosalina Mallar, RN, HCA Florida Kendall
- Lisa Mango, MS, RNC-OB, , Orlando Health Winnie Palmer

- Wayne McCreath, MD, Memorial Healthcare System
- Christina Naylor, MSN, Florida Blue
- Minyon Outlaw, CNM, Orlando Health Winnie Palmer
- Ankita Patel, MPH, CLC, REACHUP, Inc.
- Jennifer Powell, RN, MSN, CPHQ, BayCare Health System
- Paloma Prata, MBA, MS, Healthy Start Coalition
- Samantha Ramkhelawan, APRN, Pasco Federally Qualified Health Centers
- Kylie Rowlands Perez, MS, CNM, RNC-OB, EFM, CLC, SANE-A, Mount Sinai Medical Center
- Brittaney Sargent, OTD, OTR/L, Bloom Pelvic Therapy
- Lori Shea, MBA, BSN, RNC-OB, C-ONQS, FACHE, Lakeland Regional Health
- Ira Sites, MD, Morton Plant Hospital
- Kenyatta Smith, , Florida AHCA
- Heather Stephenson, RN, NCH Naples
- Kim Streit, MBA, MHS, Florida Hospital Association
- Kelli Tice, MD, Florida Blue
- Megan Tirone, MD, MPH, FACOG, St. Joseph's Women's Hospital, Winter Haven Women's Hospital
- Nancy Travis, MS, RN, BC, CPN, CBC, C-ONQS, FAWHONN, AWHONN
- Melissa Vergeson, MA, AHCA
- Angel Watson, MPH, RHIA, FL Department of Health
- Andra Wilke, DNP, RN, RNC-OB, C-EFM, CHSE, UF Health Jacksonville

FPQC Leaders and Staff

- Lori Reeves, MPH, Executive Director, Florida Perinatal Quality Collaborative
- Cole Greves, MD, MBA, FACOG, FPQC Associate Director for Maternal Health
- Margie Boyer MS, RNC, C-EFM, C-ONQS, FAWHONN, FPQC Lead Nurse Consultant
- Linda A. Detman, Ph.D., FPQC Associate Director-Programs & Operations, Research Associate, USF Chiles Center
- Estefania Rubio, MD, MPH, CPH, USF Chiles Center, FPQC Associate Director of Healthcare Data and Informatics
- Estefanny Reyes Martinez, MPH, CPH, USF Chiles Center, FPQC Quality Improvement Analyst
- Sara Stubben, MPH, CPH, USF Chiles Center, FPQC Quality Improvement Analyst
- Shelby Davenport, MPH, CPH, CHES, USF Chiles Center, FPQC Quality Improvement Analyst
- Alexa Mutchler, MPP, USF Chiles Center, FPQC Data Analyst
- Leomar White, MPH, CPH, USF Chiles Center, FPQC Data Analyst

Introduction

The Safe Reduction of Primary Cesarean Birth Initiative Toolkit is a dynamic document that includes up-to-date clinical, public health practice, scientific and patient safety recommendations. Information presented here should not be used as a standard of care. Rather, this is a collection of resources that can be adapted by local institutions to develop and implement this quality improvement initiative.

The overall goals of the Safe Reduction of Primary Cesarean Birth Initiative Toolkit are:

1. Support hospitals and care teams in implementing evidence-based, patient-centered labor and birth practices that promote vaginal birth and safely reduce unindicated NTSV cesarean births.
2. To guide and support hospitals in implementing a multidisciplinary team approach using data and a community of change to assess local NTSV cesarean birth patterns, identify modifiable drivers, strengthen evidence-based labor management and interdisciplinary communication, support shared decision-making, and promote safe vaginal birth while ensuring maternal and neonatal safety.

This toolkit will provide resources that enable maternal and obstetric healthcare providers, staff at healthcare facilities and collaborating providers and services to develop their own Safe Reduction of Primary Cesarean Birth Initiative policies and protocols with a focus on safely reducing NTSV cesarean birth.

Hospitals should establish interdisciplinary teams with necessary skill sets and identified roles in screening, care, education, and follow-up for patients with NTSV births. Administration, nursing, obstetric providers, anesthesiologists, pharmacists, social work/case managers, community providers, and others are all critical partners in the interdisciplinary team approach necessary for quality improvement (QI) and the provision of quality care. Participating hospitals should plan to:

- Train and practice as teams in order to support and gain new competencies.
- Develop individualized protocols and processes for each facility that incorporate resources available within that facility.
- Create a QI team composed of a core set of members from the disciplines involved.
- Review current policies and data, decide the priorities for improvement, and develop a work plan to address hospital needs.
- Strive to engage patients and families.

Background

The Florida Perinatal Quality Collaborative (FPQC) is launching its second initiative focused on reducing primary cesarean birth with the October 21st, 2026, kickoff of the Safe Reduction of Primary Cesarean Birth initiative. Our first promoting vaginal birth (PROVIDE) initiative in (2017 – 2022) resulted in significant improvements in maternal outcomes. However, despite the improvements achieved during the initiative, NTSV cesarean rates for nulliparous women at term gestation in Florida have been climbing.

Hospital primary cesarean delivery rates, which drive the overall cesarean rate among low-risk first-birth deliveries in Florida, range from 7.35% to 59.8%. Clinical practice patterns may contribute to this variation and suggests opportunities for improvement. Approximately 90% of pregnant patients with a prior cesarean birth go on to have a repeat cesarean birth. With each subsequent cesarean, patients face increasing cumulative

risks, including hemorrhage, infection, operative injury, abnormal placentation, hysterectomy, longer recovery, and other complications in future pregnancies as well as higher financial costs.

Initiative Foci

Standardization of care practices related to:

1. Building an interdisciplinary **unit culture and clinical alignment** that supports vaginal birth, including review of cesarean practices and outcomes.
2. **Engaging patients** and families through education, birth preferences, informed consent, and shared decision-making.
3. Promoting **labor support and physiologic birth**, including mobility, pain-management options, and doula integration.
4. Standardizing **latent labor management**, admission criteria, cervical ripening - including outpatient cervical ripening when appropriate - and induction practices.
5. Standardizing assessment and management of induction, labor arrest, second-stage challenges, and fetal malposition before considering cesarean birth.
6. Standardizing **fetal heart rate assessment and response**, including team communication and management of abnormal patterns.

Initiative Goal

By June 2028, Safe Reduction of Primary Cesarean Birth hospitals will:

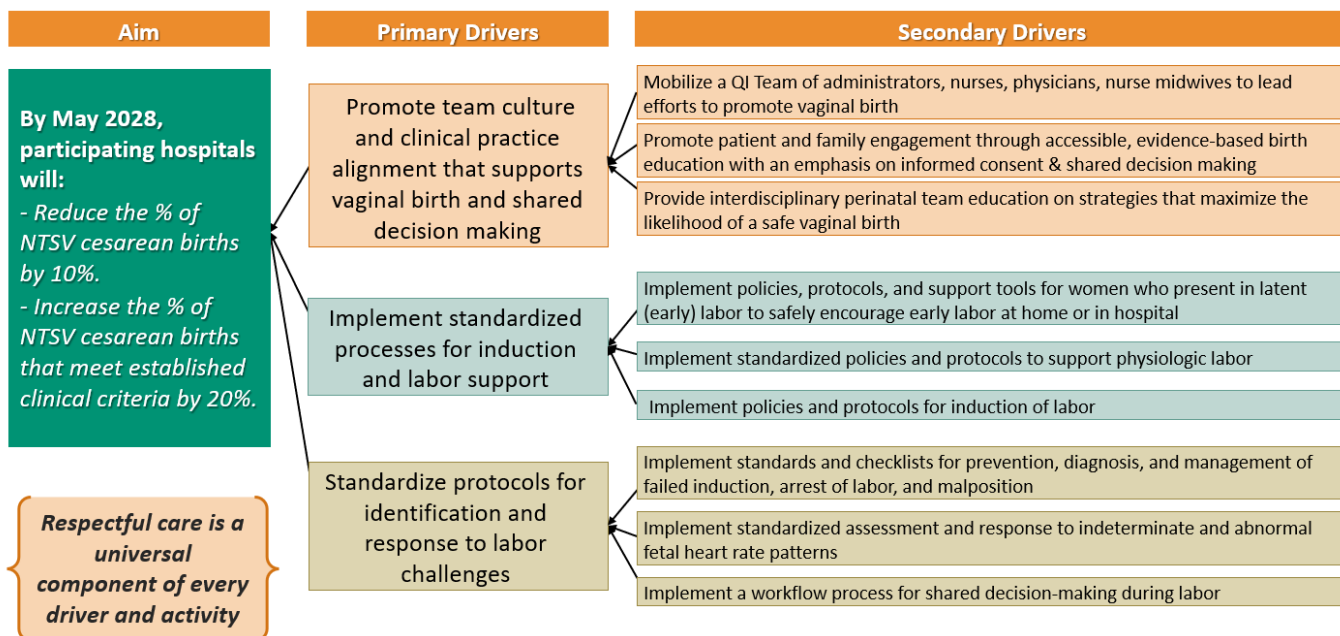
1. Reduce the percent of NTSV cesarean births by 10%.
2. Increase the percent of NTSV cesarean births that meet established clinical criteria by 20%.

The initiative will embed respectful care within all components and activities. Baseline data will be set up after the first quarter of hospital data is received by FPQC. Participating hospitals will use the Safe Reduction of Primary Cesarean Birth Initiative toolkit to implement needed changes in their hospital.

Key Driver Diagram

Safe Reduction of Primary Cesarean Birth - Key Driver Diagram

Global aim: Support hospitals and care teams in implementing evidence-based, patient-centered labor and birth practices that promote vaginal birth and safely reduce unindicated cesarean births.



The Safe Reduction of Primary Cesarean Initiative Toolkit

Using elements from the [AIM Safe Reduction of Primary Cesarean Birth Patient Safety Bundle](#), FPQC has adapted content around the following components:

- **Primary Drivers:** Major processes, operating rules, or structures that will contribute to moving toward the aim. Respectful care is a universal part of every driver and activity. Reporting & systems learning is captured through our data collection system.
- **Secondary Drivers:** Broad concepts (e.g., “move steps in the process closer together”) that are not yet specific enough to be actionable but that will be used to generate specific ideas for change.
- **Potentially Better Practices:** Actionable, specific ideas for changing a process. Potentially better practices can come from research, best practices, or from other organizations that have recognized a problem and have shown improvement on a specific issue related to that problem.

Disclaimer

This toolkit is considered a resource. Readers are recommended to adapt the guidelines and resources based on their local facility’s level of care and patient populations served and are also advised not to rely solely on the guidelines presented here. This toolkit is a working draft and living document. As more recent evidence-based strategies become available, hospitals and providers should update their guidelines and protocols accordingly. The FPQC will also send out updates as well as revise these materials. Please note the version number in the footer.



SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL
QUALITY COLLABORATIVE

Safe Reduction of Primary Cesarean Birth Initiative Toolkit

Driver 1: Promote team culture and clinical alignment that supports vaginal birth and shared decision making			
Secondary Driver	Potentially Better Practices	Evidence/Rationale	Tools/Resources
1a: Mobilize a QI Team of administrators, nurses, physicians, nurse midwives to lead efforts to promote vaginal birth	- Utilize an interdisciplinary NTSV Cesarean review committee that includes clinical leaders and administrators to implement bundle and look for data and outcome trends by nurse/provider/group and recognize those with low/high rates to encourage ongoing physician engagement. - Identify and visibly designate laboring NTSV patients in the EHR and/or on the labor unit to promote awareness and encourage use of practices that support vaginal birth	Quality-Improvement Strategies for Safe Reduction of Primary Cesarean Birth (ACOG Committee Statement 17, 2025) Safe Reduction of Nulliparous, Term, Singleton, Vertex Cesarean Delivery Rates Using Multidisciplinary Quality Improvement Efforts. (McGee et al., 2026) National Partnership for Maternal Safety: Consensus Bundle on Safe Reduction of Primary Cesarean Births- Supporting Intended Vaginal Births (Lagrew et al. 2018)	IHI Project Planning Form - See the toolbox for Hospital Charter examples - See the toolbox for hospital examples of NTSV identification materials
1b: Promote patient and family engagement through accessible, evidence-based birth education with an emphasis on informed consent & shared decision making	- Work with patients and their support networks (include doulas if available and requested) on the creation of flexible birth-preference worksheets that include decisions they may need to make during labor and birth including education about various options. - Utilize understandable, patient-facing tools for communicating risks and benefits of interventions and procedures	Partnering with Doulas in Clinical Settings (ACOG Committee Statement 31, 2026) Effective Patient-Physician Communication (ACOG Committee Statement 23, 2025)	ACOG 2026 Birth Preferences Example FL Telehealth - See the toolbox for Hospital Birth Preferences examples



SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL
QUALITY COLLABORATIVE

	that may affect the need for a cesarean birth and provide examples from the patient perspective.	Continuous Labor Support Position Statement. (AWHONN, 2026). Intrapartum doula support and cesarean delivery rates: A systematic review and meta-analysis. (Dias et al., 2025) 99 A meta-analysis on the impact of doula care on Cesarean section rates. (Achebe et al., 2024)	
1c. Provide interdisciplinary perinatal team education on strategies that maximize the likelihood of a safe vaginal birth	• Provide hands-on training for all labor and delivery nurses on nonpharmacologic labor support techniques and management of labor malposition • Provide fetal monitoring assessment education to all midwives, physicians, and nurses during onboarding for new hires and at least every two years for all clinical staff. • Align policies and procedures to integrate doulas into labor and delivery care teams.	Safe Reduction of Nulliparous, Term, Singleton, Vertex Cesarean Delivery Rates Using Multidisciplinary Quality Improvement Efforts. (McGee et al., 2026) Continuous Labor Support Position Statement. (AWHONN, 2026). Intrapartum Fetal Heart Rate Monitoring: Interpretation and Management (ACOG Clinical Practice Guideline 10, 2025) Fetal Heart Monitoring (AWHONN Position Statement, 2024)	• Intermittent Auscultation ACNM reference • FPQC Labor Support Training Modules • <i>See the toolbox for Fetal Monitoring Training options</i>



SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL
QUALITY COLLABORATIVE

Driver 2: Implement standardized processes for induction and labor support			
Secondary Driver	Potentially Better Practices	Evidence/Rationale	Tools/Resources
2a: Implement policies, protocols, and support tools for women who present in latent (early) labor to safely encourage early labor at home or in hospital	- Establish evidence-based admission criteria that incorporate cervical dilation (e.g., prioritizing active labor thresholds such as ~6 cm), clinical presentation, hospital capacity, and individual patient needs. - Provide training for triage staff and clinicians on accurate assessment of labor progress, including differentiation between latent and active labor. - Implement clear guidance on early labor support options, including supportive coaching and techniques for patients and their support of people when admission is not yet indicated.	First and Second Stage Labor Management (ACOG Clinical Practice Guideline No. 8) Use of an early labor lounge to promote admission in active labor. (Paul et al. 2017)	Latent Labor Slides from PROVIDE - See toolbox for Hospital examples of walking paths
2b: Implement standardized policies and protocols to support physiologic labor	- Standardize labor pain management and support practices by integrating patient-centered education, clinician training, and access to evidence-based nonpharmacologic and pharmacologic options. - Standardize and actively support mobility in labor for all patients, including those with elevated BMI, by ensuring access to appropriate equipment (e.g., wireless monitoring, peanut ball, squat bars, etc.) and staff training for safe implementation. - Implementing a policy/procedure/guideline to standardize intermittent auscultation for low-risk laboring patients.	Approaches to Limit Intervention During Labor and Birth (ACOG Committee Opinion No 766) Fetal Heart Monitoring (AWHONN Position Statement, 2024) Intrapartum Anesthesia and Analgesia(AWHONN Clinical Practice Guideline, 2020) Continuous Labor Support (AWHONN Position Statement, 2018) Implementing Labor Induction with a Commitment to Physiologic	CMQCC Key Strategies - See toolbox for Hospital protocols on fetal monitoring and intermittent auscultation



SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL
QUALITY COLLABORATIVE

		Birth (ACNM Position Statement, 2025) Evaluating the Impact of the Second-Stage and Pushing Duration on Maternal and Neonatal Outcomes: a systematic review and meta-analysis (Aboukhater et al. 2025) Intermittent Auscultation for Intrapartum Fetal Heart Rate Surveillance. (Ostrem-Niemcewicz et al. 2026)	
2c: Implement policies and protocols for induction of labor	• Develop standardized, evidence-based approaches to induction of labor processes, such as use of Bishop scores to assess cervical readiness, dual agents for cervical ripening if indicated and early amniotomy when feasible to ensure optimal opportunities for success. • Develop standard protocols for safe outpatient induction initiation, including strategies to support cervical ripening.	AWHOHN Cervical Ripening and Labor Induction and Augmentation 6th Edition (Simpson, K. R., 2025) Cervical Ripening in Pregnancy (ACOG Clinical Practice Guideline 9, 2025) Methods for the induction of labor: efficacy and safety. (Sanchez-Ramos et al. 2024) Prevention of Group B Streptococcal Early-Onset Disease in Newborns (ACOG Committee Opinion No. 797, 2019)	• Evidence Based Induction of Labor Clinical Practice Guide • Evidence Based Induction of Labor Procedure • <i>See toolbox for Hospital Examples of Cervical Ripening Policies</i>



SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL
QUALITY COLLABORATIVE

		<i>There are no data to suggest that artificial rupture of membranes increases the risk of neonatal disease when appropriate intrapartum antibiotic prophylaxis is given and, therefore, amniotomy is reasonable to perform if clinically indicated.</i> Early amniotomy after cervical ripening for induction of labor: a systematic review and meta-analysis of randomized controlled trials. (De Vivo et al. 2020) Bishop Scores (Wormer et al., 2024)	
Driver 3: Standardize protocols for identification and response to labor challenges			
Secondary Driver	Potentially Better Practices	Evidence/Rationale	Tools/Resources
3a: Implement standards and checklists for prevention, diagnosis, and management of failed induction, arrest of labor, and malposition	- Establish evidence-based unit criteria for failed induction and arrest of labor - Use a pre-cesarean (Pro SVD) checklist completed by physicians/CNMs and nurses in real time to ensure criteria are met in all cases	First and Second Stage Labor Management (ACOG Clinical Practice Guideline No. 8, 2024) Quality Improvement Strategies for Safe Reduction of Primary Cesarean Birth (ACOG Committee Statement No. 17, 2025)	ARPQC Pre-Cesarean Communication Tool CMQCC Appendix G – Guide to Second Stage Management of Malposition
3b: Implement standardized assessment and response to indeterminate and abnormal fetal heart rate patterns	Standardize evidence-based unit guidelines for identification and management of abnormal fetal heart rate patterns	Intrapartum Fetal Heart Rate Monitoring: Interpretation and Management (ACOG Clinical Practice Guideline No. 10, 2025)	Toolkit: FPQC Cat II Algorithm Guidelines - See toolbox for additional Cat II algorithm examples



SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL
QUALITY COLLABORATIVE

	○ Ensure guidelines are in easily accessible locations and regularly reviewed ● Conduct periodic interdisciplinary reviews of fetal heart rate strips to allow nurses and providers to practice communication and decision-making in these situations	Fetal Heart Monitoring (AWHONN Position Statement, 2024) A Standardized Approach for Category II Fetal Heart Rate with Significant Decelerations: Maternal and Neonatal Outcomes (Shields et al., 2018) Intrapartum management of category II fetal heart rate tracings: towards standardization of care (Clark et al., 2013) When Evidence Fails to Change Practice: Examining the Persistence of Continuous Fetal Monitoring (De Vries et al., 2025)	
3c: Implement a workflow process for shared decision-making during labor	● Implement multiple decision huddles about labor progress with provider, nurse, patient, and support persons	Informed Consent and Shared Decision-Making in Obstetrics and Gynecology (ACOG Committee Opinion No. 819, 2021) Shared Decision-Making in Midwifery Care (ACNM Position Statement, 2022) Shared Decision-Making in Perinatal Care (Breman et al., 2024)	● AHRQ The SHARE Approach ● Ariadne Labs TeamBirth Labor and Delivery Planning Board



SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL
QUALITY COLLABORATIVE

		Effect of TeamBirth on Patient Trust and Autonomy During Childbirth in Oklahoma (Griffith et al., 2025)	
--	--	---	--