SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL QUALITY COLLABORATIVE

Data Webinar

October 27th, 2026



Welcome!



Please mute yourself



If you have a question, please enter it in the chat or raise your hand (via Zoom reactions)



This webinar is being recorded

Meet the Data Team



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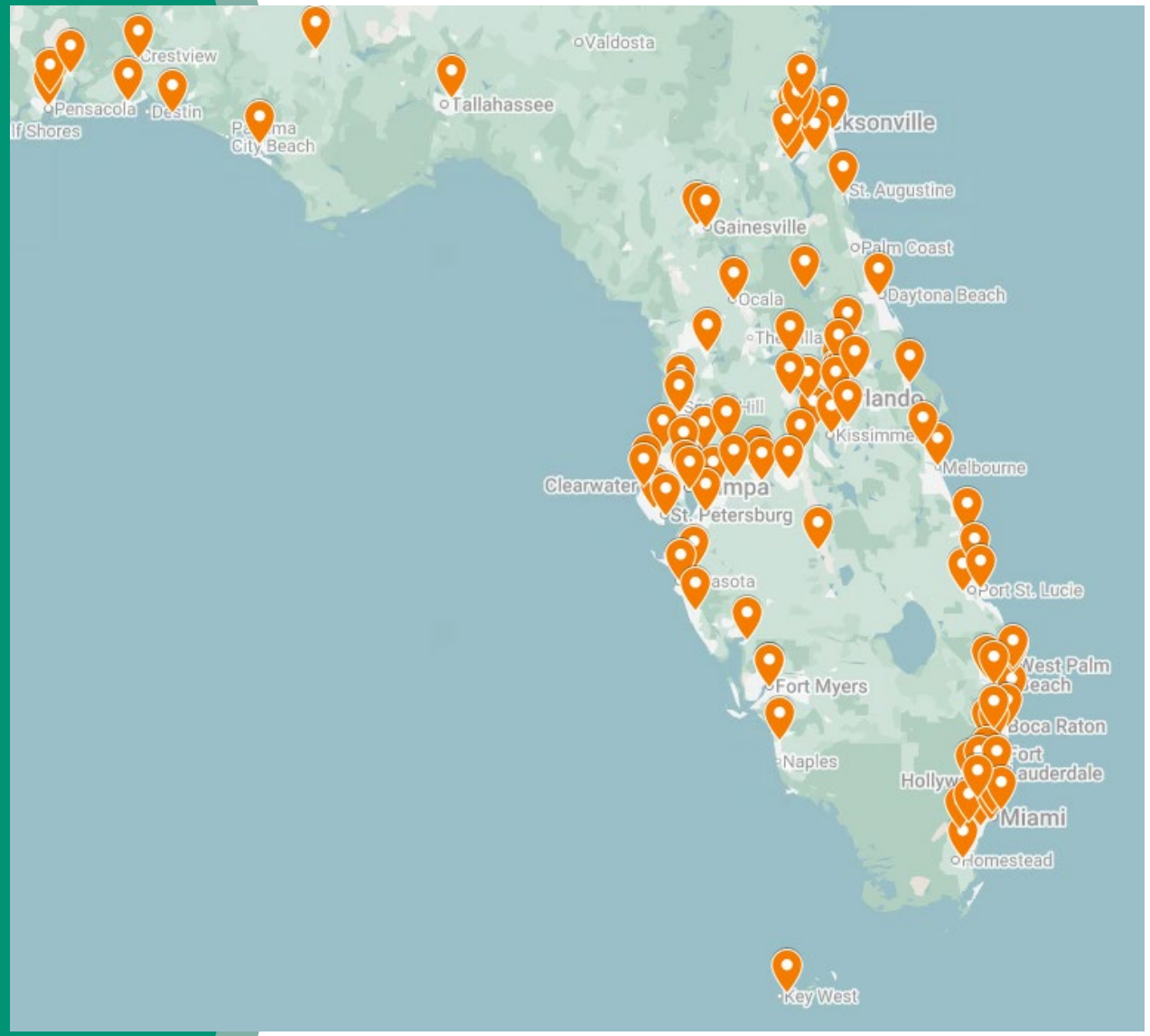
SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL QUALITY COLLABORATIVE

SRPCB Hospitals:

96% (100) of FL maternity hospitals

95% of births in FL, 2024



Safe Reduction of Primary Cesarean Birth Aim

By May 2028, participating hospitals will:

- **Reduce NTSV cesarean births by 10%**
- **Increase NTSV cesarean births that meet established clinical criteria by 20%**



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.*

Aim	Primary Drivers	Secondary Drivers
By June 2028, participating hospitals will: *- Reduce the % of NTSV cesarean births by 10%.* *- Increase the % of NTSV cesarean births that meet established clinical criteria by 20%.*	Promote team culture and clinical practice alignment that supports vaginal birth and shared decision-making	Mobilize a QI Team of administrators, nurses, physicians, nurse midwives to lead efforts to promote vaginal birth
		Promote patient and family engagement through accessible, evidence-based birth education with an emphasis on informed consent & shared decision-making
		Provide interdisciplinary perinatal team education on strategies that maximize the likelihood of a safe vaginal birth
	Implement standardized processes for induction and labor support	Implement policies, protocols, and support tools for women who present in latent (early) labor to safely encourage early labor at home or in hospital
		Implement standardized policies and protocols to support physiologic labor
		Implement policies and protocols for induction of labor
	Standardize protocols for identification and response to labor challenges	Implement standards and checklists for prevention, diagnosis, and management of failed induction, arrest of labor, and malposition
		Implement standardized assessment and response to indeterminate and abnormal fetal heart rate patterns
		Implement a workflow process for shared decision-making during labor

Respectful care is a universal component of every driver and activity

Data Submitted to FPQC

Patient-Level Data

- Abstracted patient data
- Submitted ***monthly***
- Due by the 15th of the following month

Hospital-Level Data

- Includes:
  - Staff training
  - Update on structural measures
- Submitted ***quarterly***
- Due by the 25th of the month following the quarter

All data is submitted through REDCap surveys *only*!

How to Collect Monthly Patient Data

Patient-Level Data - Inclusion Criteria

Inclusion Criteria:

Cesarean births among patients:

a) Nulliparous (parity 0),
b) At term (≥ 37 weeks),
c) Single gestation pregnancy, ***and***
d) Vertex (head down) fetal presentation

For those using an EHR report, utilize the **Joint Commission's methodology** for the **PC-02 indicator** to help identify these cases.

! Patient must meet all four inclusion criteria to be eligible for submission !

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Patient-Level Data - Exclusion Criteria

Exclusion Criteria:

- If newborn birthweight ≥ 4,500 g (patient without diabetes) or ≥ 4,000 g (patient with diabetes)
- Record has a documented medical indication for cesarean that precludes vaginal delivery

1. Maternal or fetal hemorrhage
2. Hypertensive emergencies not responding to treatment
3. Placental or umbilical cord abnormalities that preclude vaginal delivery
4. Maternal or fetal anatomical conditions that mechanically obstruct vaginal delivery
5. Active genital HSV lesions or HIV viral load > 1,000 copies/mL

Important: Utilize coding guidance from CMQCC on excluding patients with obstructed labor and Herpesviral infection.

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Patient-Level Data – Sampling Instructions

1. Apply inclusion and exclusion criteria
2. Arrange eligible charts *chronologically by delivery date*
3. Select up to 20 records per month
    - **20 or fewer eligible records:** Submit all eligible records
    - **21-39 eligible records:** Submit the *first* 20 eligible records
    - **40+ eligible records:** See next slide

Sampling Instructions – 40+ Eligible Records

Determine Sampling Interval

$$Sampling\ Interval = \frac{Total\ eligible\ records}{20} \rightarrow$$

Round down to nearest whole number

Example: 65 total eligible records ÷ 20 = 3.25. Round down to 3. Select every 3rd record.

Select Cases

- Start with the record at your interval
- Continue selecting records at that interval until 20 cases are selected

Example continued: Select 3rd, 6th, 9th, etc. record.

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Identifying Eligible Charts

Inclusions

- Nulliparous
- Term

Chart Review

- Cesarean
- Singleton
- Vertex

Chart Review or ICD-10 Codes

Exclusions

- Birthweight → *Chart Review*
- Medical Indications for Cesarean → *ICD-10 Codes*

See The Joint Commission Appendix A, Table Number 11.09: Multiple Gestations, Abnormal Presentations, and Conditions Justifying Cesarean Delivery

Patient-Level Data Collection Form

- **Assign Study ID # 001 to the first patient whose data will be submitted to FPQC**
- **Number consecutively all patients submitted to FPQC *throughout the initiative***

Delivery Month: _____ Delivery Year: _____ **Study ID #** _____							
Insurance: *(check all that apply)*	☐ Medicaid/Public ☐ Private ☐ Tricare	☐ Uninsured/self-pay ☐ Unknown	Race: *(check all that apply)*:	☐ Asian ☐ Black ☐ White	☐ Other: _____ ☐ Declined ☐ Unknown	Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Declined	
Delivery GA: _____ **whole weeks only*		Newborn weight: _____ grams			Managed by:	☐ CNM ☐ OB hospitalist ☐ Private physician	
Maternal age: _____		Delivery BMI: _____					

Demographic information helps to:

- Inform case composition and track population change overtime
- Disaggregate measures to identify differences between population groups

Patient-Level Data Collection Form

ON ADMISSION	
Patient status at admission: ☐ Admitted already in labor ☐ Augmented labor ☐ Not in labor: induced ☐ Not in labor: scheduled cesarean ☐ Not in labor: spontaneous rupture of membranes ☐ Previously admitted antepartum	
Membranes on admission: ☐ Intact ☐ Ruptured	**Outpatient** cervical ripening: ☐ Yes ☐ No
Bishop score at admission: _____ ☐ Not documented Score type: ☐ Traditional ☐ Simplified	Cervical dilation at admission: _____ cm ☐ Not Documented

Labor Classification

- Induction = use of pharmacological or mechanical methods to ***initiate*** labor. These are given ***before labor begins*.**
- Augmentation = stimulation of uterine contractions (using pharmacological methods or artificial rupture of membranes) ***after*** onset of spontaneous labor or contractions following spontaneous rupture of membranes.

Classify labor according to how it *began*!
Stimulation after spontaneous labor = augmentation
Stimulation before labor started = induction

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Patient-Level Data Collection Form

LABOR MANAGEMENT	
Cervical dilation (at time of cesarean decision): _____ cm ☐ Not documented	Was oxytocin used to induce or augment labor? ☐ Induction ☐ Augmentation at _____ cm ☐ No
Time from first documented cervical dilation ≥6 cm to delivery: _____ Hours _____ Minutes ☐ Did not reach ≥6 cm	
Did the patient receive any intermittent auscultation during labor?	☐ Yes ☐ No ☐ Not eligible
Was a cesarean decision checklist using ACOG/SMFM labor guidelines completed?	☐ Yes ☐ No
Was a pre-cesarean decision huddle (with nurse **and** doctor) completed? **Huddle must include review of ACOG/SMFM labor guidelines and the cesarean decision checklist.*	☐ Yes ☐ No
Was there documentation of patient engagement in shared decision-making regarding the delivery decision?	☐ Yes ☐ No
Timing of early postpartum encounter scheduled prior to discharge?	☐ ≤ 7 days ☐ 8-14 days ☐ 15-21 days ☐ Not scheduled ☐ Patient transferred to higher level of care

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Shared Decision-Making Tools

My Birth Preferences

Choose what matters to you. Circle options you want. Cross out what you do not want. Write down notes or other ideas.

Support	Choices	Key Fact
Who will support me and make my birth a positive experience? Who will take care of my other kids when I am at the hospital?	Partner · Friend · Family member · Doula · Who takes care of my other kids · Postpartum support Notes: _____	A doula is a trained person who gives emotional support before, during, and after birth. Having a doula can help labor go faster, make it more likely you will have a vaginal birth, and lower the need for pain medicine.[1]
Environment	**Choices**	**Key Fact**
What kind of space helps me feel calm and safe? What things might make me feel stressed?	Music · Peace and quiet · Low lights · Aromatherapy (essential oils) · Fan · Less people in the room Notes: _____	Care providers in your room during labor and birth can include nurses, doctors, midwives, doctors in training (residents), and students. You can ask who is in the room. You can ask for less people or other preferences. In an emergency, more providers may come in to help keep you and your baby safe.
Comfort	**Choices**	**Key Fact**
What kinds of touch, words, or comfort feel good to me? Are there things I do not want like certain touch or noise?	Walk, dance, and change positions · Deep breathing · Birth ball or peanut ball · Massage · Hot or cold packs or compresses · Tub or shower Notes: _____	Moving and changing positions can help labor go faster.[2] Try dancing, walking, lying on your side, squatting, being on hands and knees, or sitting in a chair or on a birth ball.
Pain Relief	**Choices**	**Key Fact**
How do I want to deal with pain in labor? How do I usually deal with pain?	No medicines · Ask for medicine if I want it · Tub or shower · Laughing gas · IV medicine · Epidural anesthesia Notes: _____	Your plan can change during labor. You may start with one option and decide to try something different later. Choose what feels right in the moment.

Partner to Decide

Your choice: plan a vaginal or cesarean birth?

This decision aid is for you if you had a cesarean birth in the past and it is safe for you to labor for your next birth.

What are my choices?

V — Plan a VBAC

C — Schedule a repeat cesarean birth

What is a planned VBAC?

VBAC stands for vaginal birth after cesarean. Planning a VBAC means you plan to labor and you want a vaginal birth. Also called LAC (labor after cesarean) and TOLAC (trial of labor after cesarean).

What is a scheduled repeat cesarean?

You and your care team pick a date for your cesarean birth. This is usually before your due date. Also called a C-section.

What makes VBAC a safe option?[1]

- You only had 1 or 2 prior cesarean births
- Your past cesarean(s) used a low cut on the inside (uterus)
- Your uterine scar(s) never opened
- There are no medical reasons that makes labor unsafe
- Your care team could switch to a cesarean birth in labor if needed

What are the chances of having a VBAC if I want one?[2]



around 7 out of 10*

Chances are higher if...

- you had a vaginal birth before[3]
- your labor starts on its own[3]
- you are really motivated to have a VBAC[3]
- you have good labor support (like a doula)[4]
- you are less than 40 weeks pregnant[3]

*A "VBAC success calculator" may be used to estimate your chances of having a VBAC if you want one.

Who chooses if I plan a vaginal or cesarean birth?

- It is **your choice** to plan a VBAC or schedule a cesarean birth and you can change your mind.
- Your care provider may suggest one option or the other. You can ask about their reasons and get a second opinion if you wish.
- If your choice is not offered with your care team you can look for other care provider and hospital options.

Sources: 1. Vaginal birth after cesarean delivery. ACOG Practice Bulletin No. 205. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019; 133:e110-27. 2. Guise JM, Eden K, Emeis C, et al. Vaginal birth after cesarean: new insights. Evid Rep Technol Assess (Full Rep). Mar 2010;(191):1-37. 3. Landon MB, Leindecker S, Spong CY, et al. The MFMU Cesarean Registry: factors affecting the success of trial of labor after previous cesarean delivery. National Institute of Child Helath and Human Development Maternal-Fetal Medicin Units Network. Am J Obstet Gynecol 2005;193:1016-23. 4. Lemon LS, Quinn B, Young M, et al. Quantifying the association between doula care and maternal and neonatal outcomes. Am J Obstet Gynecol 2025; 232(4):387.e1-43.

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Patient-Level Data Collection Form

PRIMARY CESAREAN INDICATION

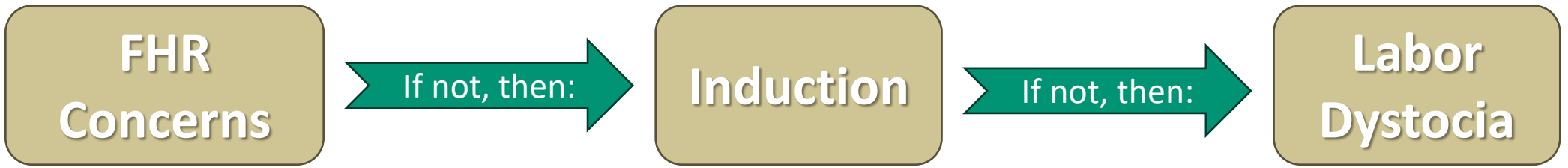
Chart-documented **primary** cesarean indication:

☐ Cesarean after induction ☐ Labor dystocia/Failure to progress ☐ Fetal heart rate concerns

☐ Suspected Macrosomia → EFW: _____ ☐ Maternal request

↳ **Based on the primary cesarean indication, complete the appropriate section on the next page.**

Choose only **one** – the **primary** indication!



Patient-Level Data Collection Form

Cesarean After Induction	
Reason for induction: ☐ Elective ☐ Hypertensive disorder ☐ Post term/post dates ☐ Other maternal indication ☐ Fetal indication ☐ Other: _____	Time from start of induction to delivery: _____ Hours _____ Mins
Bishop score at the start of induction _____ ☐ Not documented Score type: ☐ Traditional ☐ Simplified	If Bishop score ≤8 (traditional) or ≤5 (simplified) at start of induction, was cervical ripening used? ☐ Yes, mechanical method ☐ Yes, dual agents ☐ Yes, pharmacologic methods ☐ No

Patient-Level Data Collection Form

Cesarean After Induction	
Cervix Dilation at the Time of Cesarean Decision:	
If <6 cm: Was oxytocin administered for at least 12–18 hours after membrane rupture before failed induction was diagnosed?	☐ Yes ☐ No
If ≥6 cm: Was there at least 4 hours with adequate uterine activity OR at least 6 hours with inadequate uterine activity and with oxytocin?	☐ Yes ☐ No
If fully dilated at the time of cesarean decision: Were there 3 hours or more of pushing?	☐ Yes ☐ No

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Patient-Level Data Collection Form

Cesarean After Labor Dystocia or Failure to Progress	
Cervix Dilation at the Time of Cesarean Decision:	
If ≥6 cm: Check the *one* reason for cesarean that applies:	□ Membranes ruptured and no cervical change x 4 hours with Adequate Uterine activity (e.g., > 200 MVU) □ Membranes ruptured, oxytocin administered, and no cervical change for 6 hours with Inadequate Uterine activity (e.g., < 200 MVU) □ None of the above
If fully dilated at the time of cesarean decision: Were there 3 hours or more of pushing?	□ Yes □ No

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Patient-Level Data Collection Form

Cesarean After Fetal Heart Rate Concerns	
What was the FHR concern/indication? ☐ Antepartum testing results which precluded trial of labor ☐ Category III FHR tracing ☐ Category II FHR tracing: ☐ Recurrent variable decelerations ☐ Minimal/absent FHR variability without significant decelerations ☐ Other concern: _____	**Corrective and evaluative measures used (select all that apply)** ☐ Basic resuscitation: maternal position change or maternal fluid bolus ☐ Reduced/stopped oxytocin or uterine stimulants ☐ Amnioinfusion with recurrent variable decelerations after other measures failed ☐ Elicited stimulation (scalp, vibroacoustic, abdominal wall) with minimal/absent FHR variability ☐ None
Uterine tachysystole? ☐ No ☐ Yes →	If yes: Corrected uterine tachysystole (decrease/discontinue uterine stimulants, fluid bolus, terbutaline or nitroglycerin and/or other)? ☐ Yes ☐ No

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Patient-Level Data Collection Form

Maternal Request	
When was maternal request first documented?	☐ Prior to admission (scheduled) ☐ During latent labor ☐ During active labor
Documented reason for the request *(check all that apply)*	☐ Fear/anxiety related to labor or birth ☐ Previous trauma or adverse birth experience ☐ Concern about maternal or infant safety ☐ Desire for predictability/control ☐ No reason documented ☐ Maternal exhaustion ☐ Concern about labor pain ☐ Pelvic floor concerns ☐ Other: _____
Counseling/shared decision-making documented *(check all that apply)*	☐ Benefits and risks of vaginal and cesarean birth discussed ☐ Vaginal birth recommended as safe and appropriate ☐ Labor analgesia options discussed ☐ Patient reaffirmed request after counseling ☐ None documented

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Patient-Level Data Collection Form

See back of the patient-level data form for helpful definitions and tools.

Sampling Instructions

After applying inclusion and exclusion criteria, arrange eligible NTSV cesarean births chronologically by delivery date and select up to 20 records per month:

- 20 or fewer eligible births: Submit all eligible records.
- 21–39 eligible births: Submit the first 20 eligible records.
- 40 or more eligible births: Divide the number of eligible births by 20 and round down to the nearest whole number to determine the sampling interval. Starting with the record at that interval, select every corresponding record until 20 records are selected. For example, 65 ÷ 20 = 3.25 → select records 3, 6, 9, and so on.

Definitions

Primary indication for cesarean: If the cesarean delivery had fetal heart rate concerns requiring delivery, then choose "FHR Concerns." If not, but the patient had an induction, then choose "Induction." If neither of these, but the patient had labor dystocia, then choose "Labor Dystocia."

EFW: Estimated fetal weight

Classifying Labor

Induction of labor - The use of pharmacological or mechanical methods to initiate labor. These medications and/or interventions are given **BEFORE** labor begins.

Augmentation of labor - The stimulation of uterine contractions using pharmacologic methods or artificial rupture of membranes to increase their frequency or strength **AFTER** the onset of spontaneous labor or contractions following spontaneous rupture of membranes.

Clarification for the abstractors: Classify labor according to how it began. Stimulation after spontaneous labor begins is augmentation. If labor was initiated using an induction method, subsequent stimulation remains part of the induced labor.

Bishop score – Traditional

Select one option per row. Unknown = 0 points.

Exam	0 points	1 point	2 points	3 points	Unknown	Total
Dilation	◻ Closed	◻ 1–2 cm	◻ 3–4 cm	◻ ≥ 5 cm	◻	_____
Effacement	◻ 0–30%	◻ 31–50%	◻ 51–80%	◻ ≥ 80%	◻	_____
Station	◻ −3	◻ −2	◻ −1, 0	◻ +1, +2	◻	_____
Consistency	◻ Firm	◻ Medium	◻ Soft		◻	_____
Position	◻ Posterior	◻ Mid	◻ Anterior		◻	_____

Total Bishop score (0–13): _____

Bishop score – Simplified

Exam	0 points	1 point	2 points	3 points	Unknown	Total
Dilation	◻ Closed	◻ 1–2 cm	◻ 3–4 cm	◻ ≥ 5 cm	◻	____
Effacement	◻ 0–30%	◻ 40–50%	◻ 60–70%	◻ ≥ 80%	◻	____
Station	◻ −3	◻ −2	◻ −1, 0	◻ +1, +2	◻	____

Total Simplified Bishop score (0–9): _____

Consistency with ACOG and SMFM guidelines

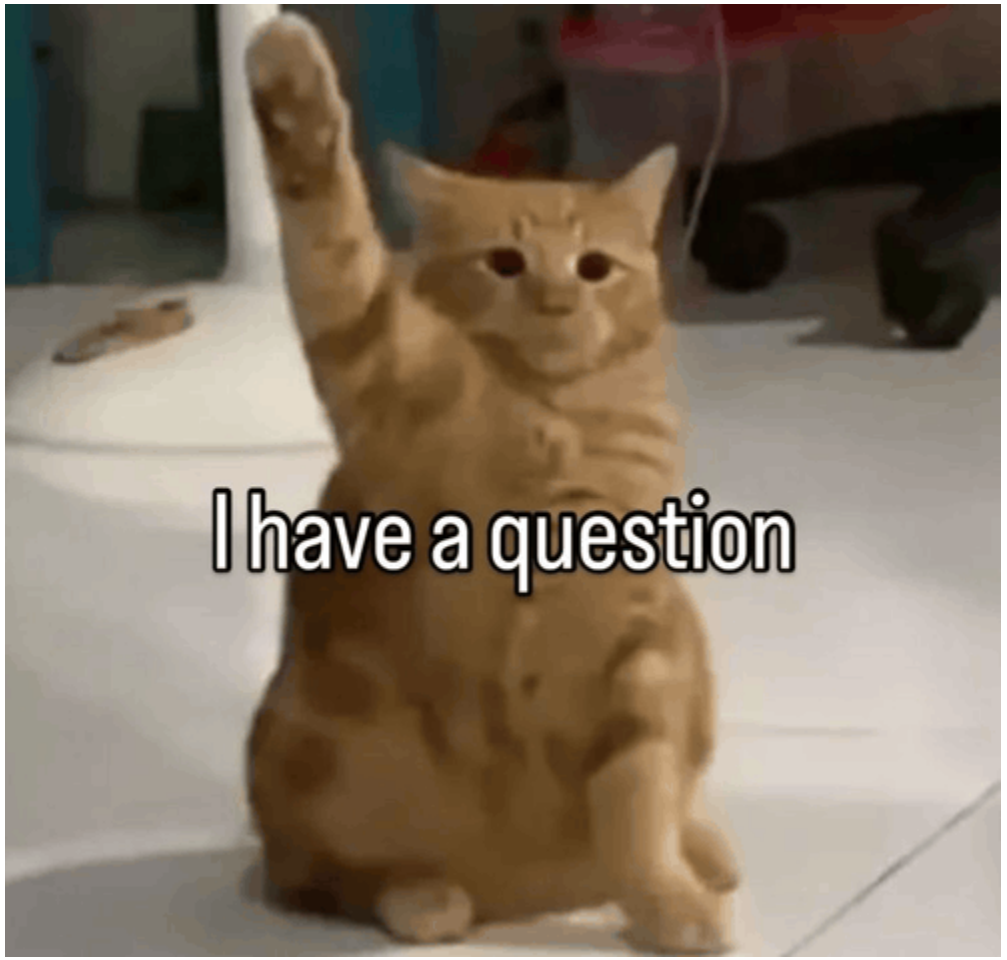
Primary indication	Chart review criteria	Reference
Induction	Look for Yes answers: • If <6 cm: at least 12–18 hours of oxytocin after rupture of membranes before failed induction diagnosed AND longer latent phase allowed (up to 24 hours or longer). • If 6–10 cm: at least 4h adequate uterine activity OR 6h inadequate uterine activity with oxytocin. • If completely dilated: ≥3h active pushing.	ACOG/SMFM criteria (Ob Gyn 2014; 123:693–711) CMQCC

Baseline Data – Patient-level

- Baseline patient-level data is **due December 15th**!
- Covers patients from **July – September**
- Follow standard inclusion/exclusion criteria, sampling methods, etc.
- Links sent after DUA is executed – but don't wait! Start pulling charts now.

Patient-Level Demo

Questions?



Hospital-Level Data

Hospital-Level Data

Interdisciplinary NTSV Review Committee	
Did your hospital's interdisciplinary NTSV Cesarean QI team ***meet during this reporting quarter*** to review a random sample of NTSV cesarean charts, initiative data and progress, provider-specific NTSV cesarean rates*, and goals for next quarter's bundle implementation?	☐ Yes ☐ No

FHR Tracing Reviews
During this reporting period, how frequently did your unit conduct interdisciplinary fetal heart rate tracing reviews, including participation from nurses and physicians/midwives, to support shared learning and consistent interpretation of fetal heart rate patterns?
☐ Daily ☐ Weekly ☐ Every other week ☐ Monthly ☐ Quarterly ☐ Not conducted this reporting period

***Review CMQCC's guidance on unblinding provider-level NTSV cesarean rates (link in Measurement Grid).**

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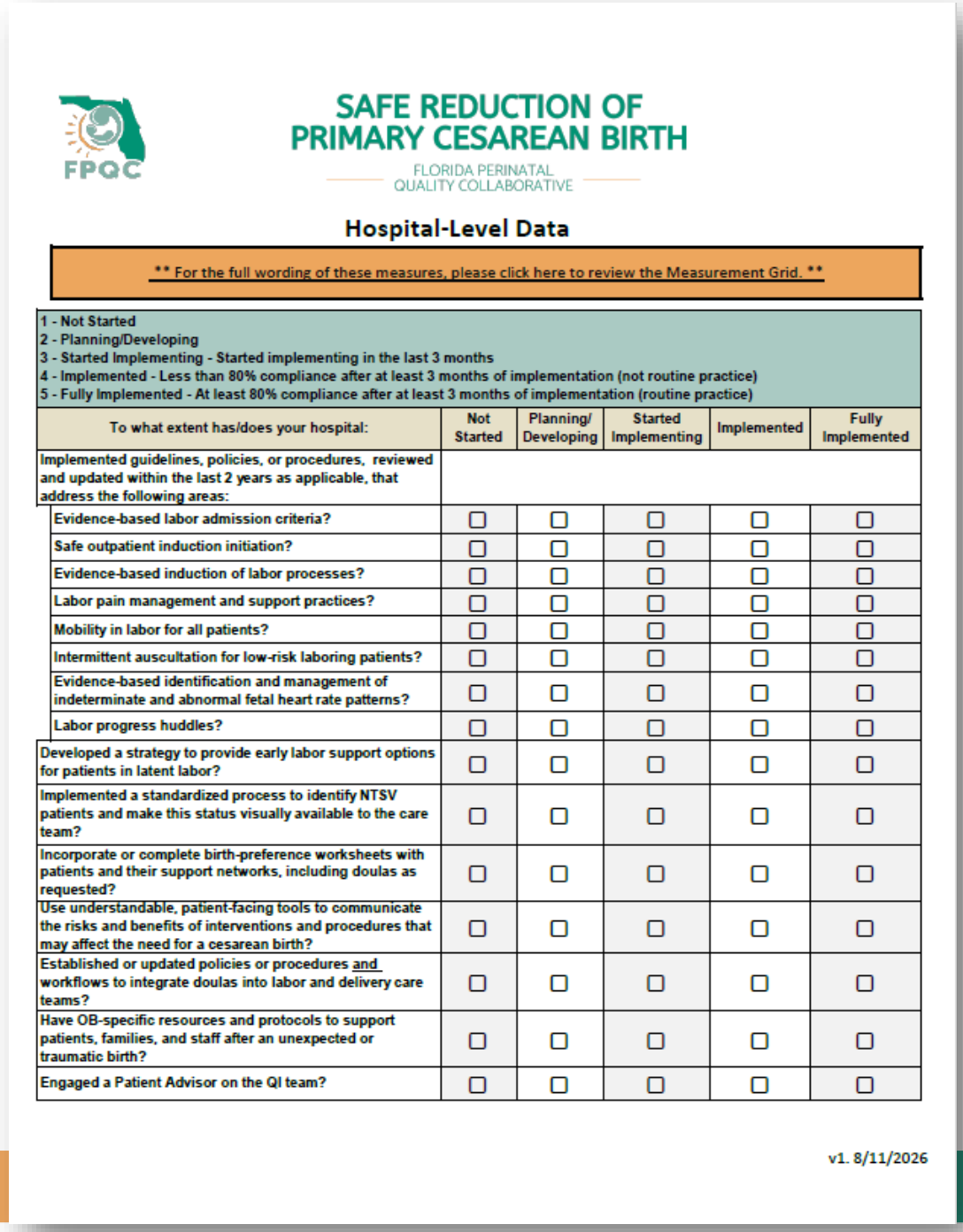
Hospital-Level Data

Staff Education and Training		
Please add the cumulative percentage of nurses, physicians & midwives that have been educated on the topics below.		
Since January 1st, 2026, what percentage of your staff has received education on…	Nurses	Physicians & Midwives
Respectful Care and commitment to Respectful Care practices?	_____ %	_____ %
Fetal monitoring assessment?	_____ %	_____ %
Accurate assessment of labor progress, including differentiation between latent and active labor?	_____ %	_____ %
ACOG/SMFM labor management guidance, safe reduction of primary cesarean bundle content, and unit-standard protocols?	_____ %	_____ %
Hands-on training on nonpharmacologic labor support techniques and management of labor malposition?	_____ %	



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SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL QUALITY COLLABORATIVE

Hospital-Level Data

** For the full wording of these measures, please click here to review the Measurement Grid. **

1 - Not Started
2 - Planning/Developing
3 - Started Implementing - Started implementing in the last 3 months
4 - Implemented - Less than 80% compliance after at least 3 months of implementation (not routine practice)
5 - Fully Implemented - At least 80% compliance after at least 3 months of implementation (routine practice)

To what extent has/does your hospital:	Not Started	Planning/ Developing	Started Implementing	Implemented	Fully Implemented
Implemented guidelines, policies, or procedures, reviewed and updated within the last 2 years as applicable, that address the following areas:					
Evidence-based labor admission criteria?	☐	☐	☐	☐	☐
Safe outpatient induction initiation?	☐	☐	☐	☐	☐
Evidence-based induction of labor processes?	☐	☐	☐	☐	☐
Labor pain management and support practices?	☐	☐	☐	☐	☐
Mobility in labor for all patients?	☐	☐	☐	☐	☐
Intermittent auscultation for low-risk laboring patients?	☐	☐	☐	☐	☐
Evidence-based identification and management of indeterminate and abnormal fetal heart rate patterns?	☐	☐	☐	☐	☐
Labor progress huddles?	☐	☐	☐	☐	☐
Developed a strategy to provide early labor support options for patients in latent labor?	☐	☐	☐	☐	☐
Implemented a standardized process to identify NTSV patients and make this status visually available to the care team?	☐	☐	☐	☐	☐
Incorporate or complete birth-preference worksheets with patients and their support networks, including doulas as requested?	☐	☐	☐	☐	☐
Use understandable, patient-facing tools to communicate the risks and benefits of interventions and procedures that may affect the need for a cesarean birth?	☐	☐	☐	☐	☐
Established or updated policies or procedures and workflows to integrate doulas into labor and delivery care teams?	☐	☐	☐	☐	☐
Have OB-specific resources and protocols to support patients, families, and staff after an unexpected or traumatic birth?	☐	☐	☐	☐	☐
Engaged a Patient Advisor on the QI team?	☐	☐	☐	☐	☐

v1. 8/11/2026

Quarterly updates on status of implementation of each structural measure

- Not Started
- Planning/Developing
- Started Implementing
- Implemented
- Fully Implemented

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Structural Measure Implementation

Implementation began within the past 3 months

Implementing for more than 3 months but not routine practice (<80%)

Implementing for more than 3 months and routine practice (80%+)

To what extent has/does your hospital:	Not Started	Planning/ Developing	Started Implementing	Implemented	Fully Implemented
Implemented guidelines, policies, or procedures, reviewed and updated within the last 2 years as applicable, that address the following areas:					
Evidence-based labor admission criteria?	☐	☐	☐	☐	☐
Safe outpatient induction initiation?	☐	☐	☐	☐	☐
Evidence-based induction of labor processes?	☐	☐	☐	☐	☐
Labor pain management and support practices?	☐	☐	☐	☐	☐
Mobility in labor for all patients?	☐	☐	☐	☐	☐
Intermittent auscultation for low-risk laboring patients?	☐	☐	☐	☐	☐
Evidence-based identification and management of indeterminate and abnormal fetal heart rate patterns?	☐	☐	☐	☐	☐
Labor progress huddles?	☐	☐	☐	☐	☐

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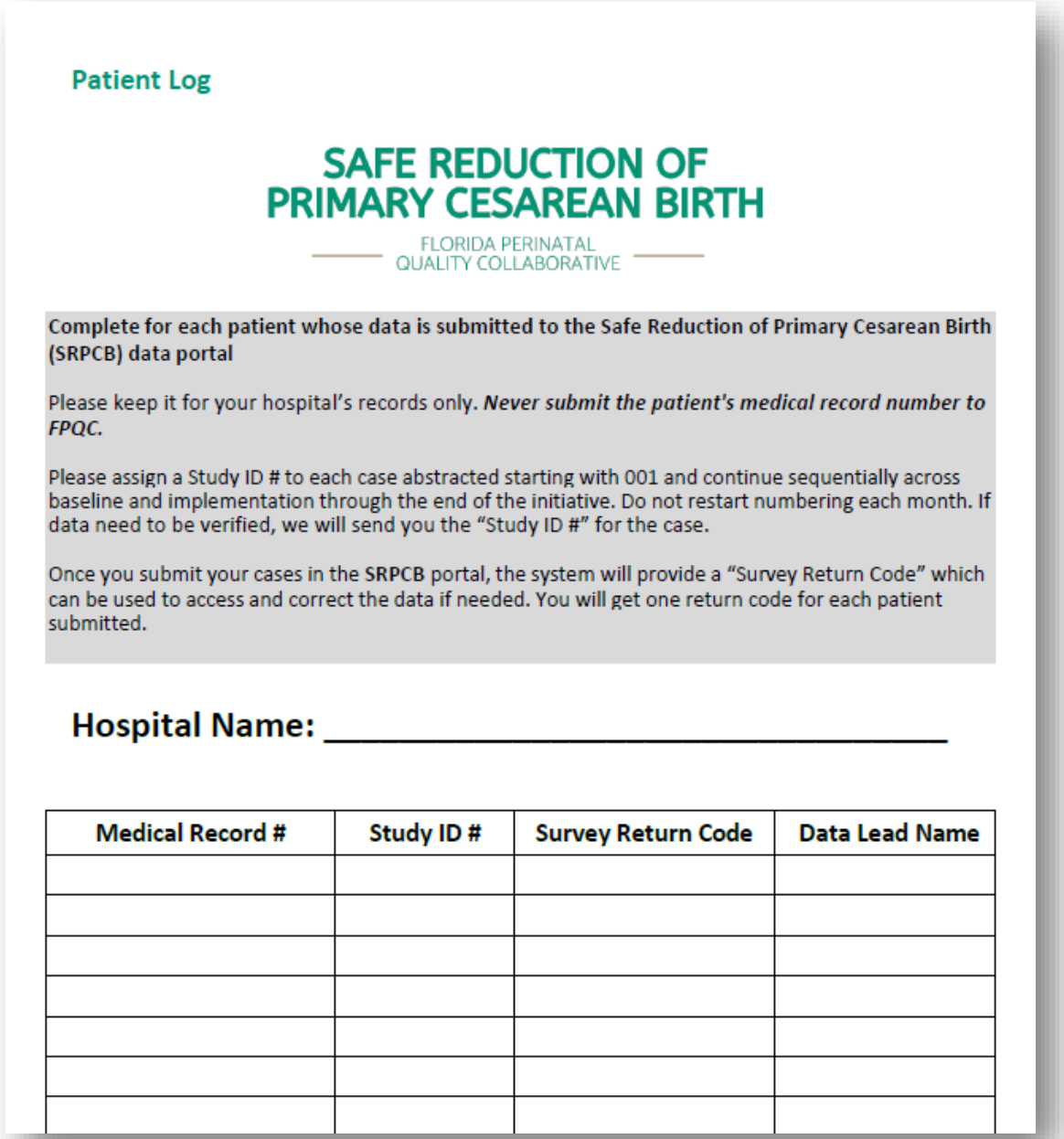
Baseline Data – Hospital-level

- Baseline hospital-level data is **due November 15th**!
- No need for a DUA – submit right away
- Link was sent last week

Tips to Keep in Mind

Maintain a Record of Cases



Patient Log

SAFE REDUCTION OF PRIMARY CESAREAN BIRTH

FLORIDA PERINATAL QUALITY COLLABORATIVE

Complete for each patient whose data is submitted to the Safe Reduction of Primary Cesarean Birth (SRPCB) data portal

Please keep it for your hospital's records only. ***Never submit the patient's medical record number to FPQC.***

Please assign a Study ID # to each case abstracted starting with 001 and continue sequentially across baseline and implementation through the end of the initiative. Do not restart numbering each month. If data need to be verified, we will send you the "Study ID #" for the case.

Once you submit your cases in the **SRPCB** portal, the system will provide a "Survey Return Code" which can be used to access and correct the data if needed. You will get one return code for each patient submitted.

Hospital Name: _____

Medical Record #	Study ID #	Survey Return Code	Data Lead Name

- Please keep a log of the patients whose data you submit to FPQC
- Include the patient's medical record number, the assigned study ID, and the return code
- This log is intended for your hospital use only. **Please do not send to us!**

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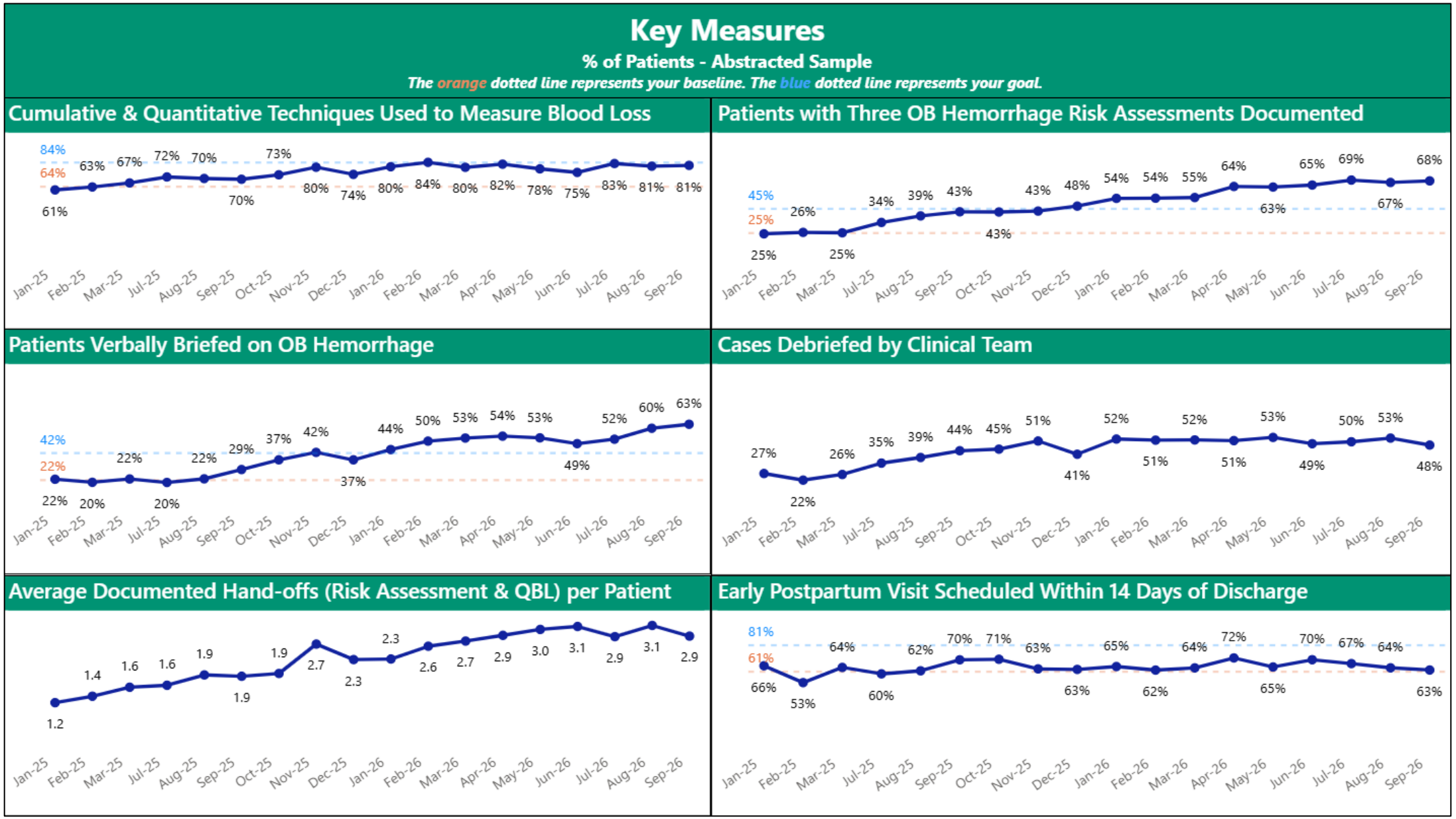
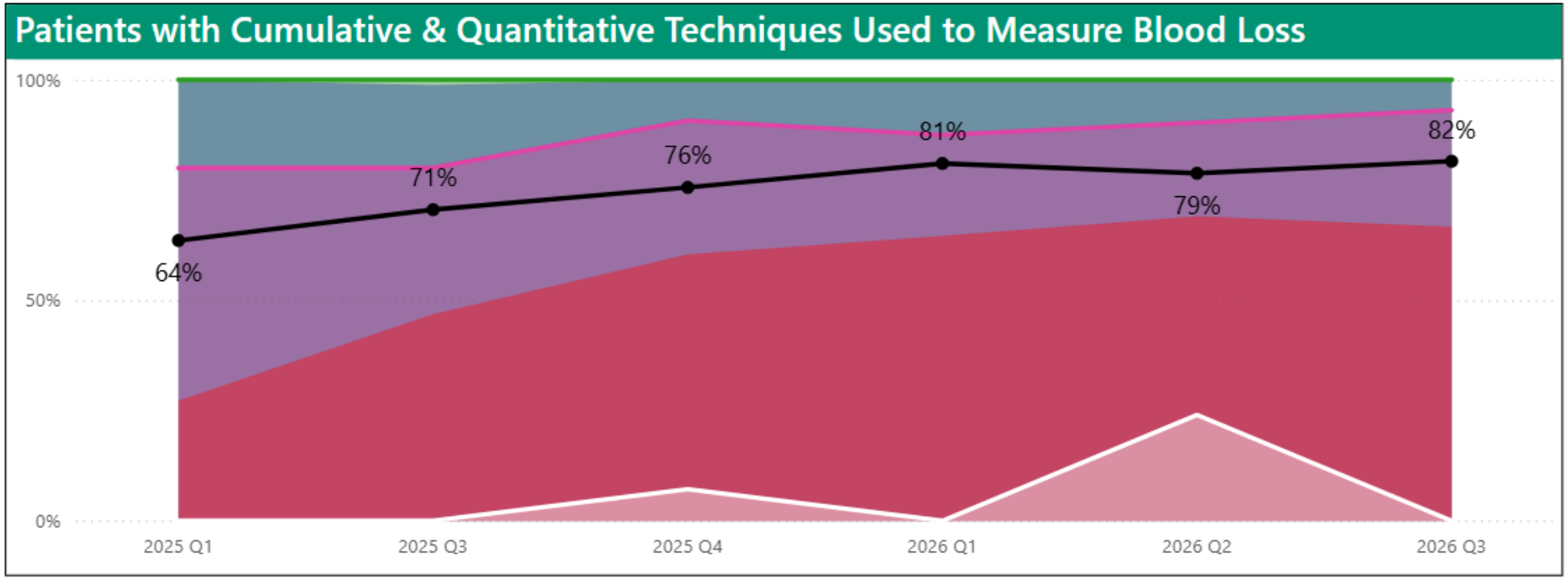
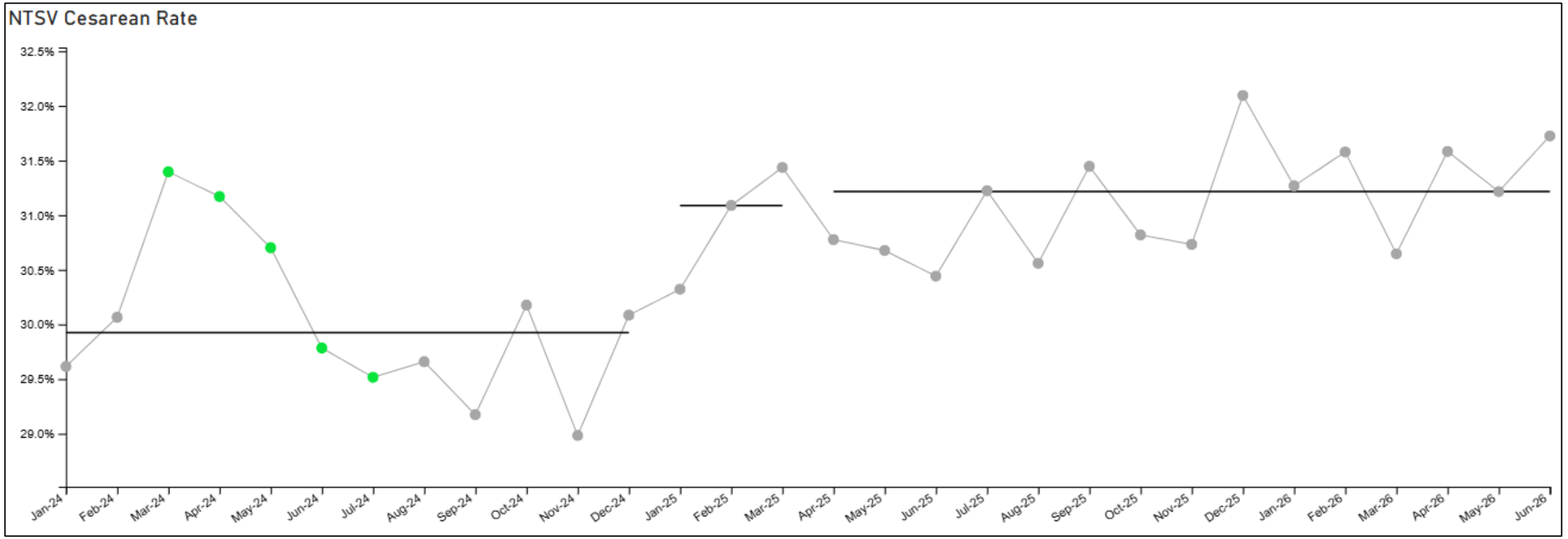
Example Graphs



Example Graphs



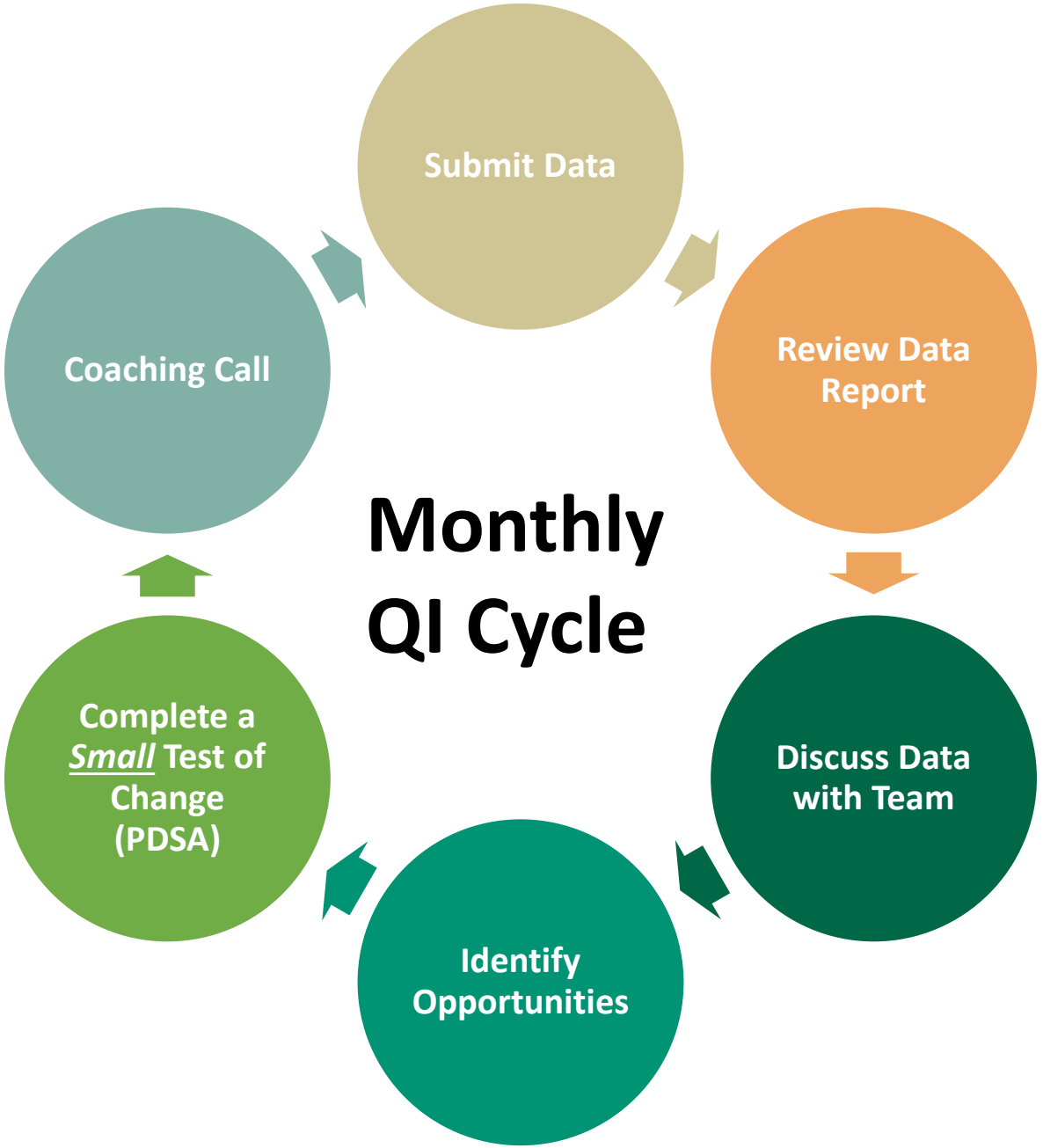
Example Graphs



- Source: FL Birth Certificate Data
- We will use this data to track your NTSV cesarean rate over time
- Ensure your birth certificate data is accurate: see trainings on our website.

Why Birth Certificate Data?

- Birth certificate **does not** exclude medically indicated cesareans
  - The PC-02 measure **does** exclude these
- PC-02 is not easily accessed by all; some use sampling.
- BC = Standard, population-based measure for comparison across all hospitals
- Published research shows small difference between PC-02 and BC after excluding medically indicated cesareans (1-3 percentage points).
- Use PQI to compare rates across same level of maternal care
- **We are looking for signals in changes (trends, shifts, etc.).**


Monthly QI Cycle
Submit Data
Review Data Report
Discuss Data with Team
Identify Opportunities
Complete a *Small* Test of Change (PDSA)
Coaching Call

Submission Due Dates

- Begin abstracting data in preparation for submission, don't wait until your DUA is fully executed.
- You will receive links to submit your data as soon as your DUA is fully executed.
  - Begin submitting data as soon as you get the links – no need to wait until the due date.
- **Baseline data period: July – September 2026**
  - Patient-level due December 15th
  - Hospital-level data due November 15th
- Ongoing data collection begins January 2027.

	Baseline Period	Baseline Due Date	Ongoing Frequency *(starts January 1st)*	Ongoing Due Date
Patient-Level	July – September 2026	December 15th	Monthly	The 15th of the following month
Hospital-Level	July – September 2026	November 15th	Quarterly	The 25th of the month following the quarter

Data Office Hours

Data office hours and voluntary with no set agenda – please come with questions!

Two opportunities for Office Hours:

- November 19th at 12:00pm
- December 7th at 12:00pm

Calendar invites will go out after this call

Questions?



Thank you!

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Florida Perinatal
Quality Collaborative