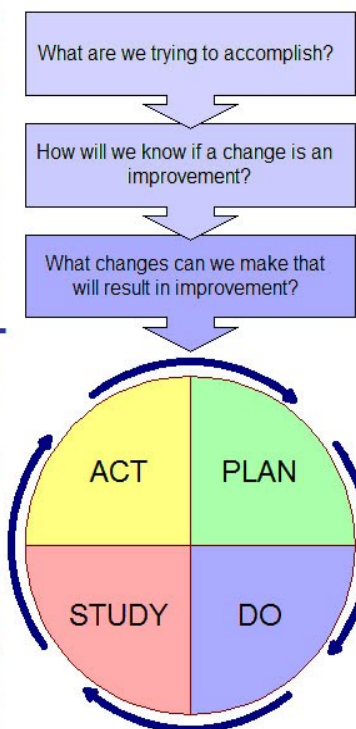


Appendix 1: PROMOTING VAGINAL BIRTH PROJECT CHARTER

PROJECT NAME	PROJECT OWNER	PROJECT SPONSOR
Promoting Vaginal Birth Project	Kristin Thorp	Dr. Christina Davidson
EMAIL	ORGANIZATIONAL UNIT(S)	
kristinthorp@texaschildrens.org	PFW Labor & Delivery	
PROJECT TEAM		
Dr. Christina Davidson, Lauren Shubert, Addy Babalola, Dr. Audra Timmins, Stephanie Gonzales-Hughes, Sharon Burks, Khanh Nguyen, Erin Gonzales, Sheena Glover, Tara Barrick, Courtney Thompson, Dr. Celeste Green, Dr. Chandler McGee, Dr. Matt Carroll		
PROJECT START DATE		
April 2023		

Model for Improvement



PROJECT OVERVIEW

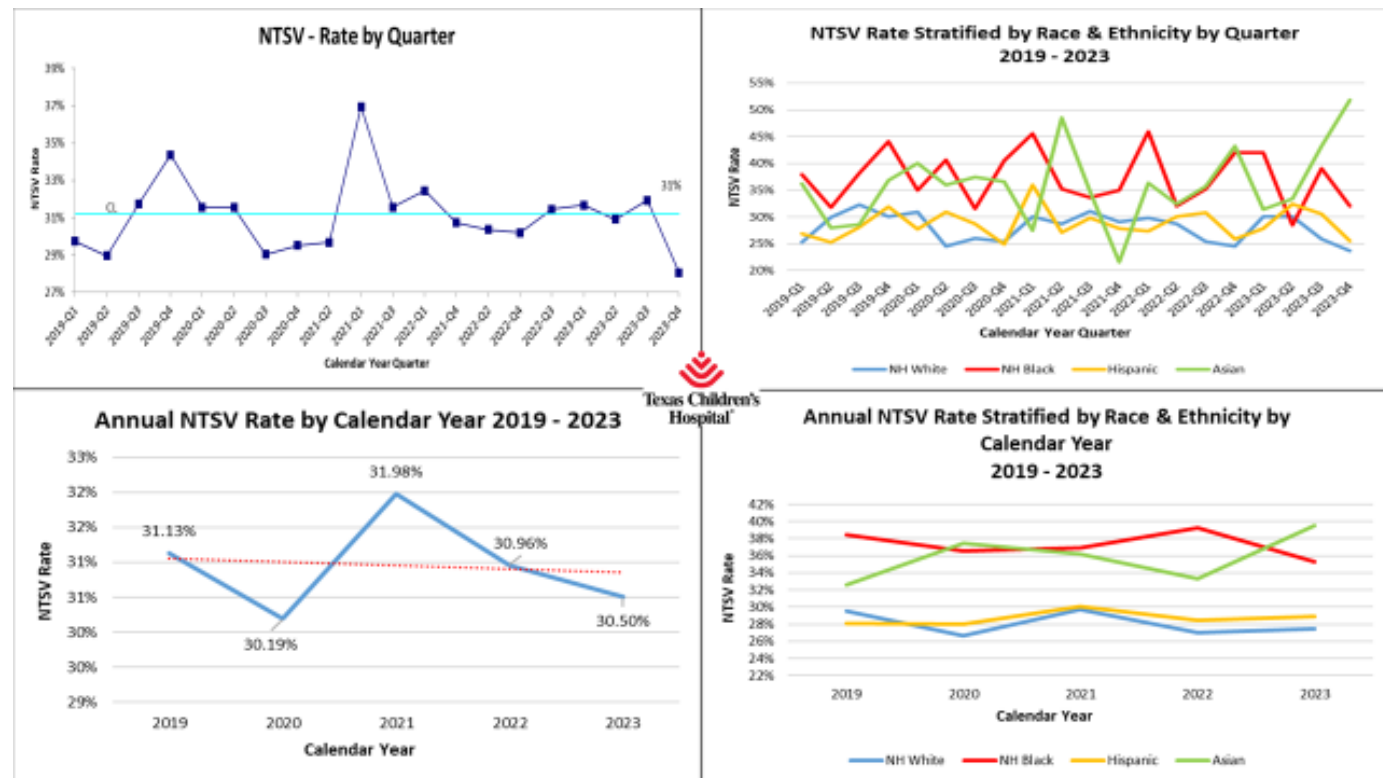
PROBLEM OR ISSUE	In the United States, there has been an increasing focus on reducing the overall number of medically unnecessary cesarean births, as they are associated with higher rates of severe maternal morbidity and mortality.
	The cesarean birth rate that reflects the specific population of first-time moms with potentially "low-risk" births, meaning that they have a single, full-term baby in the head-down position is called the NTSV cesarean birth rate. Additional insights regarding this disparity include the following: • There has been a dramatic rise in the cesarean delivery rate since 1995, attributable to an increase in primary cesareans as well as a decline in attempted trial of labor after cesarean (TOLAC). • >90% of U.S. women who require primary cesarean will have a subsequent repeat cesarean.

McGee C, Green C, Shubert L, Babalola A, Timmins A, Gonzales-Huges S, et al. Safe reduction of nulliparous, term, singleton, vertex cesarean delivery rates using multidisciplinary quality improvement efforts. O&G Open 2026.

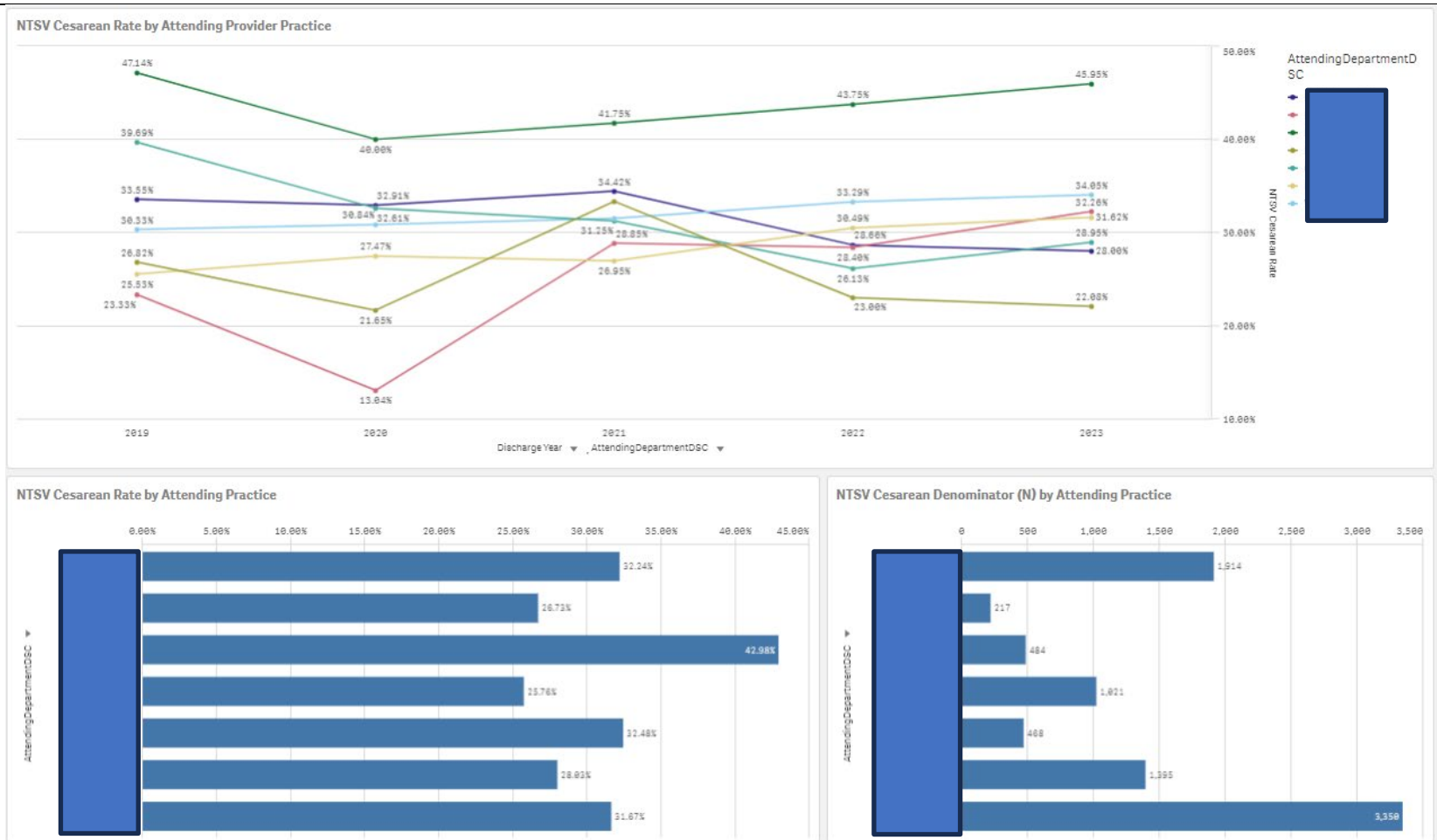
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- The rapid increase in the rate of cesarean births is without evidence of a concomitant decrease in maternal/neonatal morbidity or mortality, which raises significant concern that cesarean is overused.
- The primary cesarean increases the risk of maternal complications in the index pregnancy as well as future pregnancies. Cesareans are associated with higher rates of delivery-related maternal deaths and complications, and this disproportionately impacts Black women.
- Women who are Nulliparous, Term, and with a Singleton Vertex baby make up the NTSV population and are considered to be at “low risk” for needing cesarean delivery.
- NTSV cesareans are a measure of a hospital’s “low risk” cesarean rate. The Healthy People 2020 goal rate is 23.9% and the 2030 goal rate is 23.6%.
- The most effective approach to reducing overall complications related to cesarean deliveries is to avoid the first cesarean.



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- The NTSV cesarean rate at the Pavilion for Women is ~30% (i.e., almost 1/3 of NTSV births are delivered by cesarean).
- Pavilion for Women NTSV cesarean rates vary by provider practice and by race and ethnicity. Non-Hispanic Black and Asian women at the Pavilion for Women have higher rates of NTSV cesareans, as compared to their Hispanic and Non-Hispanic White counterparts.

PURPOSE OF PROJECT	This project will seek to identify opportunities to safely reduce the rate of primary cesarean deliveries and eliminate racial disparities by ensuring adherence to evidence-based interventions to promote vaginal births.
BUSINESS CASE	Complex surgical procedures can have significant and costly social and economic consequences that includes higher obstetric complications, which can lead to increase recovery times and longer hospitals stays, as well as increased rates of NICU admissions.
METRICS	The metrics that will be utilized to determine success include the following: overall NTSV cesarean rate, primary cesarean delivery rate, overall cesarean delivery rate, compliance for cesarean indication based on ACOG criteria and prevalence of SMM disparities associated with NTSV cesarean deliveries
EXPECTED DELIVERABLES	Implementation strategies for this project will include: Data report outs, labor huddles, EMR documentation improvements, provider report cards and new education interventions to support natural labor.

IDENTIFY INEQUITIES: Which groups are currently most advantaged and most disadvantaged by the issues this proposal seeks to address? How are they affected differently? What quantitative and qualitative evidence of inequity exists?

Groups affected	List known disparities based on available data (sources referenced below)	Additional considerations
Black, Indigenous, people of color (BIPOC)	In the US, higher NTSV cesarean rates are observed amongst non-Hispanic Black women by 5% and Hispanic women by 1% compared with non-Hispanic White women. Racial/ethnic differences in cesarean delivery rates have generally been observed time over time, even for women considered at low risk.	A cross-sectional study found that delivery-related mortality in US hospitals decreased for all racial and ethnic groups, age groups, and types of delivery during 2008 to 2021, while SMM prevalence increased for all patients. Higher rates were observed for racial and ethnic minority patients of any age.

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	In a geographically and racially diverse cohort enrolled in a randomized trial limited to nulliparous people who were verified to be low-risk in the 38th week of gestation, non-Hispanic Black and Hispanic people had higher RRs for cesarean birth compared with non-Hispanic White people. For both non-Hispanic Black and Hispanic individuals, these inequities were driven by an increased RR for cesarean birth for nonreassuring fetal status. Furthermore, cesarean birth may account for approximately 16% of the excess maternal morbidity among non-Hispanic Black and Hispanic people in this cohort. Non-Hispanic Black and Asian women at the Pavilion for Women have higher rates of NTSV cesareans as compared to their Hispanic and Non-Hispanic White counterparts. (Displayed in above graphs)	This intended to showcase the impact of improved quality of care standards provided during deliveries in hospitals.
Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, and others whose identities are not reflected (LGBTQ+)	No known data	
People who speak and/or read a language other than English	No known data	Consider stratifying PFW data
Immigrants	No known data	
Refugees	No known data	
People with mental illness	No known data	
People with disabilities	No known data	
Age 35 and above	No known data	Consider stratifying PFW data This may influence the way we engage with younger mothers vs older mothers
Religious minorities	No known data	
Other		

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EXAMINING THE CAUSE

How did the problem arise? What factors may be producing and perpetuating inequities associated with this initiative? Does the project address root causes? If not, how could it?

Provider decision and assessment, Care team members communication and collaboration, Staff comfort and training on natural birth techniques & labor positions, patient preference, patient involvement in decision making, increased inductions, increased epidurals, provider comfort with counseling VBAC

Based on findings from a secondary analysis of a randomized trial of expectant management compared with induction of labor in low-risk nulliparous people at term, the finding that a relatively subjective indication for cesarean birth (non-reassuring fetal status) accounts for the difference in cesarean rates for low-risk non-Hispanic Black and Hispanic people raises several possible interpretations. First, the higher rate of cesarean birth due to fetal tracing among non-Hispanic Black and Hispanic people may stem from the inequitable use of a subjective indication for cesarean owing to clinician bias, whether conscious or unconscious. This cohort of low-risk nulliparous people lacks the most common risk factors (e.g., chronic hypertension, diabetes, fetal growth restriction) for placental insufficiency and accordingly greater risk of fetal intolerance of labor. Consequently, one would expect that abnormal fetal tracings leading to cesarean birth should be randomly distributed across racial and ethnic groups. We hypothesize that various potential biases (and likely a combination) during intrapartum management could explain this phenomenon. For instance, clinical obstetric teaching about the relationship between placental insufficiency and race may create an educational bias that leads clinicians to act prematurely on the fetal tracing of a non-Hispanic Black person that they might manage expectantly for a White person. Communication bias, in which clinicians word their concerns about fetal status differently depending on the mother's race or ethnicity, may lead a person to more readily agree to a cesarean birth or feel more pressured to do so. Power dynamics and the birthing person's sense of agency may also play a role; people of color have reported lower birth satisfaction, increased stress in labor, and higher rates of mistreatment intrapartum.¹¹

Potential root causes to be addressed by the project:

1. Communication: bedside huddles, commit to sit
2. Intrapartum management: checklist for labor management to promote adherence to evidence-based labor management principles, Pitocin audits
3. Scheduled caesareans: <39 week workgroup to review scheduled primary caesareans to ensure adherence to ACOG-supported indications

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CLARIFYING THE PURPOSE
What does the project seek to accomplish? Will it reduce/maintain/increase disparities or discrimination?

This project will seek to identify opportunities to safely reduce the rate of primary cesarean deliveries by promoting vaginal births and eliminate disparities observed across racial and ethnic groups.

IDENTIFYING AND ENGAGING DIVERSE AND MULTIDISCIPLINARY STAKEHOLDERS: Which historically disenfranchised/marginalized groups may be most affected by and concerned with the issues related to this proposal? How will you involve and represent them in a meaningful way in the development of this proposal?

We’ve observed that this disparity is highest in our non-Hispanic Black population. Partnering with the patient and their support partners (family, doula, etc.) to collaborate with the entire care team (primary nurse, charge nurse, provider) about the assessment/management/diagnosis when decided on a cesarean section. We can also include involving our Patient Advisory Council to engage further support and garner additional feedback.

We are currently soliciting patient feedback on their perception of respectful care during the birth admission and reviewing our data by race and ethnicity.

PROJECT DESCRIPTION: Document your current thinking about the activities of the project (e.g., design a new process, improve an existing product or service, etc.). Which pilot population, and/or demonstration unit will the project take place?

- Project will be piloted on PFW Labor and Delivery units amongst all patients, not just our NTSV patients
- Stratify out data and present the data to our Labor and Delivery units and talk to through most meaningful environment to present data
- Perform a gap analysis and implement elements of the AIM Safe Reduction of Cesarean Birth bundle.
- Design a Labor Huddle process to engage members of the care team and the patient/support partners in decision-making.
- Design a process to communicate provider specific rates back to the providers in a meaningful way
- Review charts for ACOG criteria based on cesarean indication listed
- Engaging nursing partners regarding natural labor support techniques
- Assign education for providers and nurses on respectful maternity care: AWHONN SBARs, Diversity Science training on Dignity in Pregnancy and Childbirth
- Develop patient education tools to be shared during prenatal care and at time of scheduling of induction of labor about what might happen during labor and delivery to establish realistic expectations about the length of the labor process and pain during labor, especially during an induction

ACTION ITEMS: Describe your initial steps toward accomplishing your goal. (Schedule a workgroup meeting, research best practice interventions, etc.)

- NTSV Checklist
- Regular work group meetings
- Gap analysis
- Share USNWR NTSV Data – Dr. Davidson has shared aggregate data at department meetings and has met individually with each practice leader to share their practice’s rates
 - Promoting Vaginal Birth: Labor Huddle Guide, Script, Cesarean Birth for Labor Arrest Checklist (Last version developed 12/14/23) – *pilot 1-2 in house provider groups*
 - *Person centered birthing care (whiteboard, plan, what is next?) – create and purpose*
 - Audit 6 months of NTSV Charts May 2023-October 2023, Was ACOG criteria met for said indication (start 12/19/23) – Drs. McGee, Green, Carroll and Grace (RN)
 - Develop a process to distribute scorecards for the providers
 - Improve the documentation in the Delivery Summary

EXPECTED OUTCOMES AND BENEFITS: How will this project benefit our patients, our community, and/or our healthcare team?

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This project will empower our patients, nurses, and providers to advocate for a safe vaginal birth. It will equip our care team members with the tools and resources they need to support their decision-making and patient support. It will also reduce the disparities within our system. Reducing the NTSV cesarean rates should also lead to an overall reduction in future morbidity and mortality from complications in subsequent pregnancies.

CONSIDERING ADVERSE IMPACTS

What positive/adverse impacts or unintended consequences could result from this project? What positive impacts on equity and inclusion, if any, could result from this project? Which groups could be negatively affected? How will adverse impacts be anticipated, prevented, or minimized?

- Delay in necessary cesarean deliveries may cause an increase in the rate of severe unexpected newborn complications or an increase in maternal complications such as hemorrhage, infection/sepsis
- Increased 3rd and 4th degree lacerations
- Increased charting burden for nurses and providers
- Increase in reported events (safety scoops or family advocacy complaints) related to negative interactions when there is a difference in opinion
- Increased disparities amongst populations that aren't as affected by disparity (i.e. NH White and Hispanic increase in NTSV rate)

SMARTIE GOALS AND AIM STATEMENT: Use the SMARTIE goals template to write an effective AIM Statement from SMARTIE objectives. Include: What is the problem or opportunity? By how much will you improve? What is the date by which you will achieve the level of improvement you've set out to accomplish? Who is the customer or population who will benefit from the improvement? Where does the project begin and end? Does the objective seek to address condition-specific disparities?

Global AIM statement: Reduce the rate of NTSV cesarean deliveries and eliminate racial and ethnic disparities in the rates by December 31, 2024.

Project AIM statement: By implementing the Promoting Vaginal Birth interventions, we will increase adherence to ACOG criteria for NTSV cesarean indications and reduce the rate of non-medically indicated NTSV caesarean deliveries by 80% as well as the Black-White and Asian-White disparity by 50% by December 31, 2024.

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HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?

OUTCOME MEASURE(S): How can you measure progress and know if you've successfully met your overall goal? List the measure(s) you ultimately want to affect as a result of this project.

- A decrease in the overall NTSV cesarean rate
- A decrease in the primary cesarean delivery rate
- A decrease in the overall cesarean delivery rate
- Increased compliance for cesarean indication based on ACOG criteria
- An elimination of disparities

PROCESS MEASURE(S): How will you know if the steps toward your overall goal are performing as expected? List the measure(s) that will tell you if the system is performing as planned to affect the outcome measure. What positive/adverse impacts or unintended consequences could result from this project? What positive impacts on equity and inclusion, if any, could result from this project? Which groups could be negatively affected? How will adverse impacts be anticipated, prevented, or minimized?

- Rate of adherence to ACOG criteria for NTSV cesareans for each of the following criteria: failed induction of labor, active phase arrest, 2nd stage arrest, and scheduled cesareans
- % of L&D nurses and providers who receive education on the Labor Dystocia Checklist
- % of patients with NTSV cesarean who have a documented bedside huddle in their chart that details communication regarding labor progression and indication for cesarean
- % of patients with NTSV cesarean who have pre-op documentation using a smart-phrase to describe indication for cesarean and adherence to ACOG criteria
- Number of provider data report cards
- Pre-Education Knowledge Check versus Post-Implementation Knowledge Check – Natural labor support
- % of patients admitted for induction of labor who received the patient education materials

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BALANCING MEASURE(S): Changes designed to improve one part of the system may cause new problems in other parts of the system. List the measures that will tell you whether you are introducing problems elsewhere in the system and how you plan to monitor those problems.

- Newborn complication Rate – severe unexpected complications of the term newborn
- Patient Reported Experience Measure (PREM) Results (Respectful & Equitable Care)
- Number of Patient grievances
- 3rd and 4th degree episiotomies
- SMM from hemorrhage and sepsis
- Safety scoop submissions specifically to L&D/NTSV; newborn complications

ENSURING VIABILITY AND SUSTAINABILITY: Is the project realistic, adequately funded, with mechanisms to ensure successful implementation and enforcement? What provisions are in place to ensure ongoing data collection, transparent reporting of metrics, stakeholder participation, and accountability?

Yes; An assigned data team will provide updates to project team on a routine basis

WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN IMPROVEMENT?

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INITIAL ACTIVITIES: Consider starting by exploring the process or system you are trying to improve with tools such as interviews, direct observation, cause and effect diagrams, driver diagrams, and process maps/flowcharts

Process map/flowcharts on identifying a NTSV C-section, key driver diagrams to identify cesarean indications or variances in process, interviews with physicians and nursing regarding documentation, direct observation

PDSA 1: Data sharing

- Presented the NTSV data at department and quality meetings *Completed by Davidson*
- Obtain clinic specific NTSV rates and meet with each practice leader for shared knowledge and discuss opportunities for improvement; *Completed 9/2023.*

Quality & Safety team to share the data stratified by race and ethnicity with the nursing team (NTSV, Primary CD rate)

CHANGE IDEAS: What ideas do you have for initial tests of change (Plan-Do-Study-Act cycles)?

- ACOG Cesarean Indication Audits & Provider Report Cards
- Train nursing partners to support physiologic coping during labor and oxytocin titration
- Intrapartum labor management checklists and documentation tools
- Labor huddles
- Implement review and approval process for scheduled NTSV cesareans via the <39 week induction workgroup to ensure they satisfy ACOG criteria

PREPARED BY	TITLE	DATE
Lauren Shubert, MBA, RNC-OB Adewunmi Babalola, MPH	Quality & Patient Safety Manager Quality Improvement Specialist	2.23.24

McGee C, Green C, Shubert L, Babalola A, Timmins A, Gonzales-Huges S, et al. Safe reduction of nulliparous, term, singleton, vertex cesarean delivery rates using multidisciplinary quality improvement efforts. *Obstet Gynecol* 2025;147.

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Appendix 1 is the project charter that was developed by the Promoting Vaginal Birth Workgroup

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Appendix 2: Physician Scorecards

Example physician scorecard that was sent via secure email to each physician with at least four NTSV cesareans performed during the audit time period. The scorecard detailed each physician's indication for NTSV cesarean and how many did not meet ACOG criteria for that indication. Medical record numbers and a detailed overview of audit results were provided upon request.

Dear Dr. X,

You are receiving this email because you performed at least 5 NTSV cesarean deliveries during an audit period of May through October 2023. The Nulliparous, Term, Singleton, Vertex (NTSV) population is considered to be at “low risk” for needing a cesarean delivery, thus NTSV cesareans are a measure of a hospital's “low risk” cesarean rate. This is an important national metric since the primary cesarean increases the risk of maternal complications in the index pregnancy as well as future pregnancies. Thus, **the most effective approach to reducing overall complications related to cesarean deliveries is to avoid the first cesarean.**

The purpose of this audit was to review the indications and clinical criteria for NTSV cesarean deliveries at PFW in an effort to identify opportunities to safely reduce our NTSV cesarean rate and avoid non-medically indicated NTSV cesareans. All charts of NTSV cesareans during the audit time period were reviewed to determine the indication for cesarean and if the clinical criteria for cesarean were consistent with ACOG criteria for labor arrest and scheduled primary cesareans. This determination was made by reviewing the documentation in progress notes from prenatal clinic visits and the intrapartum labor course. The references used to determine adherence to ACOG criteria are attached to this email and the specific criteria can be found in the table below.

Below you will find your individual report/scorecard during this audit period: the first column lists the indication for cesarean; the 2nd column includes the number of NTSV cesareans you performed for each indication; and the 3rd column lists the number of NTSV cesareans in each category that DID NOT meet ACOG criteria. As you can see, **of the 14 NTSV cesareans you performed during the audit period, 7 of them DID NOT satisfy/meet ACOG criteria. Please review the ACOG criteria for cesarean delivery in the table below and attachments and consider making practice changes to safely reduce the number of NTSV cesareans performed.**

Please let me know if you have any questions.

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Nulliparous Term Singleton Vertex Cesareans

Physician Scorecard: Dr. George Madjitey

May – October 2023

Indication	Total Number of NTSV Cesareans	Number of NTSV Cesareans NOT Meeting ACOG Criteria
Failed Induction of Labor	2	2
Active Phase Arrest	4	2
Second Stage Arrest	5	2
Scheduled	1	1
Non-reassuring Fetal Heart Rate	2	0
Total	14	7

ACOG's Indications for Cesarean Delivery	Criteria & Definitions
Failed Induction of Labor	☐ Cervix <6 cm ☐ Membranes ruptured ☐ Oxytocin administered for at least 12-18 hours after membrane rupture
Active Phase Arrest	☐ Cervix ≥ 6 cm ☐ Membranes ruptured ☐ No cervical change after at least 4 hours of adequate uterine activity (>200 MVUs) OR at least 6 hours of oxytocin administration with inadequate uterine activity
Arrest of Descent (Second Stage Arrest)	☐ Cervix 10 cm ☐ Membranes ruptured ☐ > 3 hours of pushing in a nulliparous patient or > 2 hours of pushing in a multiparous patient (can be identified earlier if lack of fetal rotation or descent despite adequate contractions, pushing efforts, and time)
Scheduled	- Elective after patient counseling - Prior uterine surgery/myomectomy - Fetal anomaly precluding safe vaginal delivery - Placenta previa, vasa previa - EFW 4,500g with maternal diabetes or EFW 5,000g without maternal diabetes

NTSV = nulliparous, term, singleton, vertex

ACOG = American College of Obstetricians and Gynecologists

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Appendix 3. Patient education infographic on expectations for induction of labor

This infographic was emailed to all patients scheduled for induction of labor and was available in every labor and delivery room to be used as a visual aid when discussing induction upon admission for delivery.

Induction of Labor



What is an induction of labor?
An induction means that your care team will use medication or other methods to *start the labor and delivery process* and to keep it going, rather than the body starting labor on its own.

Do I need an induction of labor?
You should talk to your doctor or midwife about whether an induction of labor is right for you. There are many reasons to have an induction. Some of these reasons are:

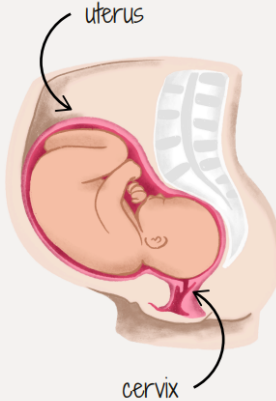
- You have a medical problem like high blood pressure, diabetes, heart disease, or an infection
- Your baby has a medical problem or they are not growing big enough inside of you
- You are more than 1 week past your due date
- You chose to be induced

Your Body in Labor
Your baby is inside of your uterus. The uterus is a round organ that is made out of muscle. The muscles of the uterus squeeze during labor to move your baby out of your body.

The squeezing of these muscles is called a *contraction*.

At the bottom of your uterus is your cervix. The cervix is a small hole that needs to open so that the baby can be born. The cervix will dilate to about 10 cm (the size of a large bagel!) so that the baby can pass through.

Around the baby is a bag of water called the amniotic sac. This bag of water will break during your labor so that the baby can be born.



Expectations for Inductions

How long does an induction of labor take?
Every person is different and an induction may take hours or up to 1-2 days. Your induction is likely to take longer if you are having your first baby. It might take longer if you are being induced many weeks before your due date.

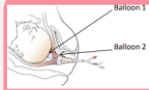
Risks & Benefits
There are risks and benefits to having an induction. If your doctor or midwife has talked to you about an induction, it is likely that an induction could be a good idea for you. This is a good topic to discuss with your healthcare team.

C-section Risk
Induction of labor does not guarantee a vaginal birth. A C-section (surgical birth) may be needed if your cervix is not opening up or if your baby is not doing well with contractions. This risk is also present when labor is not induced. Our goal is always to make sure both you and your baby stay safe and healthy!



How will I be induced?

Your doctor or midwife will discuss a plan of induction with you that best meets your and your baby's needs. Choice of induction method can depend on how open (dilated) your cervix is. Here are a few induction options:

Cytotec (misoprostol)  A small pill that works to soften your cervix may be administered either by mouth or placed vaginally next to your cervix. Softening your cervix makes it more ready for labor. Multiple doses may be needed.	Cervidil (dinoprostone)  A vaginal insert with time-released medication helps to soften, thin, and dilate your cervix. This is placed next to your cervix by your provider or nurse and usually stays in place for up to 12 hours.	Cook® Cervical Ripening Balloon  A long, flexible tube with 2 empty balloons on top is placed inside your cervix. The balloons are filled with sterile water and presses on your cervix from both sides to help it open and start contractions.	Pitocin (oxytocin)  Oxytocin is a natural hormone that your body makes to help deliver your baby. Pitocin is a medication form of this hormone that makes contractions stronger, longer, and come faster. This is given through an IV.	Amniotomy (break your water)  Your healthcare provider may poke a small hole in your bag of water (amniotic sac). Breaking your water helps the baby's head push on your cervix and this can tell your body to release more hormones to make more contractions.
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Appendix 4. Patient education infographic on coping with labor pain and “comfort cart”

This infographic was available in every labor and delivery room to be used as a visual aid when discussing management of labor pain upon admission for delivery. The comfort cart was situated at the labor and delivery nurse’s station, available for all patients.



McGee C, Green C, Shubert L, Babalola A, Timmins A, Gonzales-Huges S, et al. Safe reduction of nulliparous, term, singleton, vertex cesarean delivery rates using multidisciplinary quality improvement efforts. *Obstet Gynecol* 2025;147.

The authors provided this information as a supplement to their article.

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Appendix 5: hospital guideline checklists, algorithm, and documentation tools

Intrapartum Management

A. Induction of labor (see algorithm)

- ☐ Unfavorable cervix and membranes intact → cervical ripening
 - ☐ Balloon
 - ☐ Balloon + Pitocin
 - ☐ Balloon + misoprostol (do not use in TOLAC)
 - ☐ Cervidil (do not use in TOLAC)
- ☐ Favorable cervix and/or membranes ruptured → Pitocin
- ☐ AROM as soon as safe and feasible
- ☐ Consider IUPC in latent labor to titrate MVUs >200 if unable to increase Pitocin because of contraction frequency

B. Augmentation of labor for labor dystocia (no or inadequate cervical change)

- ☐ Pitocin: initiate at 2 mU/min and increase by 2mU/min every 30 mins
- ☐ AROM
- ☐ IUPC if contracting every 2-4 minutes to titrate MVUs >200

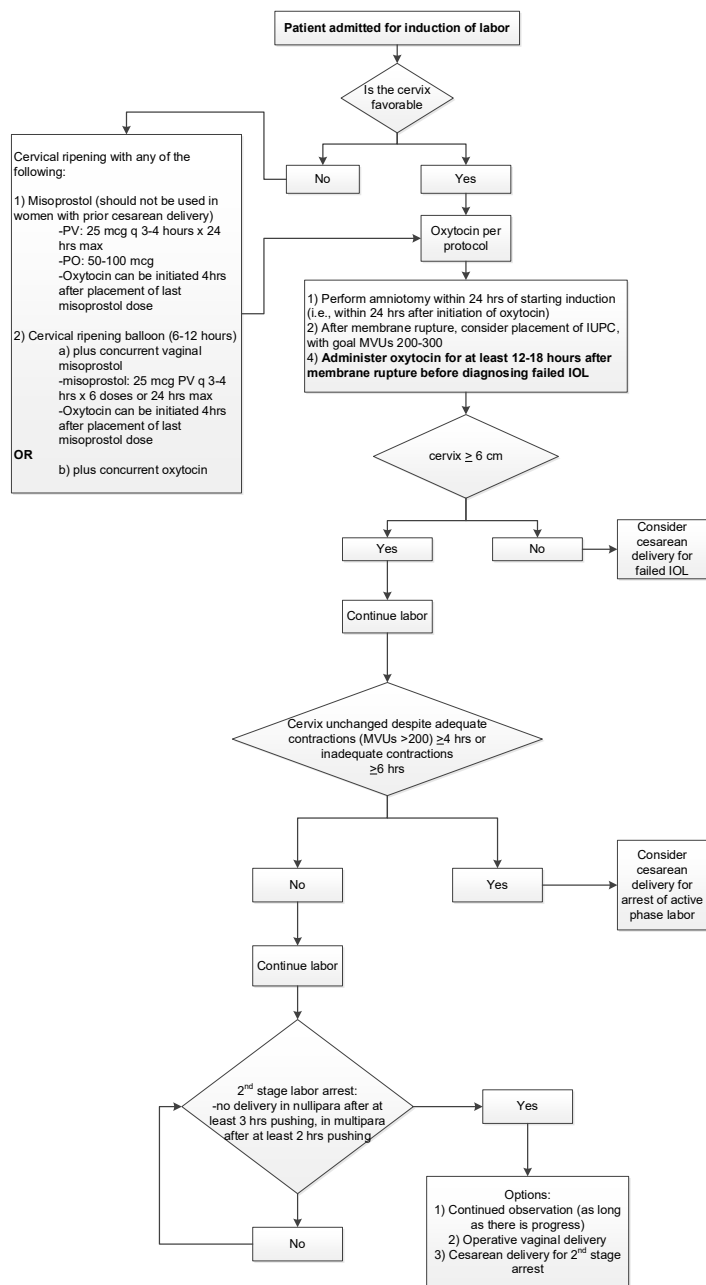
C. Second stage

- ☐ Attempt manual rotation if OP or OT
- ☐ Assess for/offer operative vaginal delivery if at least +2 station for concerning FHR, maternal exhaustion, slow descent, and/or maternal request

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Arrest of Labor Diagnostic Criteria

A. Failed Induction (all boxes should be checked):

- ☐ Cervix <6 cm
- ☐ Membranes ruptured
- ☐ Oxytocin administered for at least 12-18 hours **after** membrane rupture

B. Active Phase Arrest (all boxes should be checked):

- ☐ Cervix ≥ 6 cm
- ☐ Membranes ruptured
- ☐ No cervical change after at least 4 hours of adequate uterine activity (>200 MVUs) **OR** at least 6 hours of oxytocin administration with inadequate uterine activity

C. Second Stage Arrest (all boxes should be checked):

- ☐ Cervix 10 cm
- ☐ Membranes ruptured
- ☐ > 3 hours of pushing in a nulliparous patient or > 2 hours of pushing in a multiparous patient (can be identified earlier if lack of fetal rotation or descent despite adequate contractions, pushing efforts, and time)

D. Above criteria not met:

- ☐ Through shared-decision making with the patient, the decision was made to move to cesarean even though criteria were not met.
- ☐ Shared-decision making was well documented and it was documented that the patient was counseled on ACOG criteria for cesarean delivery.

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Smart phrase examples for reason for cesarean

Failed IOL

@name@ was admitted for IOL for ***. I counseled her on my recommendation for cesarean delivery for failed induction of labor because ALL of the following criteria have been met:

- ☐ Cervix <6 cm
- ☐ Membranes ruptured
- ☐ Oxytocin administered for at least 12-18 hours after membrane rupture

@name@ understands and agrees with the plan.

Arrest of Active Phase Labor

@name@ was admitted in labor. I counseled her on my recommendation for cesarean delivery for arrest of active phase labor because ALL of the following criteria have been met:

- ☐ Cervix ≥ 6 cm
- ☐ Membranes ruptured
- ☐ No cervical change after at least 4 hours of adequate uterine activity (>200 MVUs) OR at least 6 hours of oxytocin administration with inadequate uterine activity

@name@ understands and agrees with the plan.

Arrest of Descent/2nd Stage Labor

@name@ was admitted in labor and progressed to complete dilation. I counseled her on my recommendation for cesarean delivery for arrest of descent/2nd stage labor because ALL of the following criteria have been met:

- ☐ Cervix 10 cm
- ☐ Membranes ruptured
- ☐ > 3 hours of pushing in a nulliparous patient or > 2 hours of pushing in a multiparous patient OR lack of fetal rotation or descent despite adequate contractions, pushing efforts, and time

Cesarean Delivery When ACOG Criteria Not Met

@name@ was admitted in labor and progressed to ***. We reviewed her labor course and I counseled her that she does not meet ACOG-supported criteria for cesarean for labor dystocia at this time. Through shared-decision making with the patient, the decision was made to move to cesarean even though criteria were not met. I further counseled her on the risks of cesarean delivery compared to vaginal delivery, including, but not limited to increased risk of bleeding, infection, and damage to nearby structures. I also counseled her that, given the high repeat cesarean delivery rate, future pregnancies are at increased risk of complications such as placenta previa, placenta accreta spectrum disorder, uterine rupture, and hysterectomy, all of which increase with each subsequent cesarean delivery.

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