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OB Breakout Session: We're in the Same Room Again! Harnessing QI Energy through our Togetherness

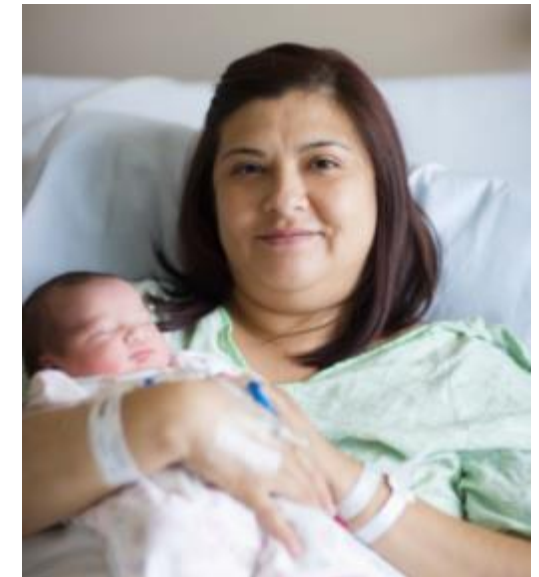
Thursday October 27th, 2:45-4:15 PM



OB Breakout Session Objectives

- Opportunity to focus on key strategies we will need to consider in the year ahead to move from systems change to clinical culture change and help all hospitals achieve initiative aims
- We will share applied QI examples, break down into small discussion groups and have a panel discussion with QI leaders with each section

**Please speak up with questions, comments
and your perspective!
Raise your hand for a microphone.**



OB Breakout Overview

- Birth Equity (BE)
- Promoting Vaginal Birth (PVB)
- Mothers and Newborns affected by Opioids (MNO)- OB
- Discussion of future initiatives

Speaker Panel:

- **Ann Borders, MD, MSc, MPH**
- **Zsakeba Henderson, MD, FACOG**
- **Lisa Kane Low, PhD, CNM, FACNM, FAAN**
- **Susan Ford MSN, CPNC-PC**



ILPQC Community Advisory Board, Aug 2022

- Tayo Bande – Chicago Birthworks
- Charity Bean – Doula Bean
- Amanda Henley – MCH Patient Advisor
- Cecilia Macias – MCH Patient Advisor
- Sandra Martell -
Winnebago County Health Department
- Tamela Milan-Alexander – MCH Patient
Advisor and EverThrive IL
- Erin Miller and Jennifer Graham –
Family Connects Peoria County
- Karie Stewart – Certified Nurse Midwife
U of I Health Services
- Erin Stout and Kim Glow –
Peoria County Bright Futures
- Susan Waltrip – Springfield WIC Office

Birth Equity

BE Aim: By December 2023, $\geq 75\%$ will have all key strategies in place



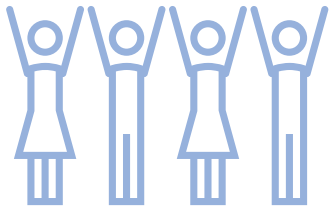
Optimize race and ethnicity
data collection and
review stratified data



Screen all patients for **social
determinants of health** and
link to needed services



Standardize postpartum
safety education and
schedule early postpartum
visit



Engage patients and
community members
for input



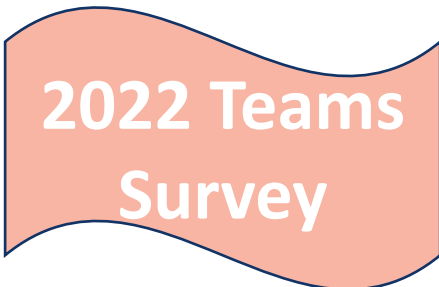
Implicit bias, respectful care
training for providers, nurses,
other staff



Share **respectful care
practices** and survey patients on
their care experience

Biggest success so far in implementing the BE Initiative

- Implementing social determinants of health (SDoH) screening on labor and delivery
- Healthcare team education on implicit bias
- Implementing the PREM survey



Challenges hospital teams identified to work on 2023

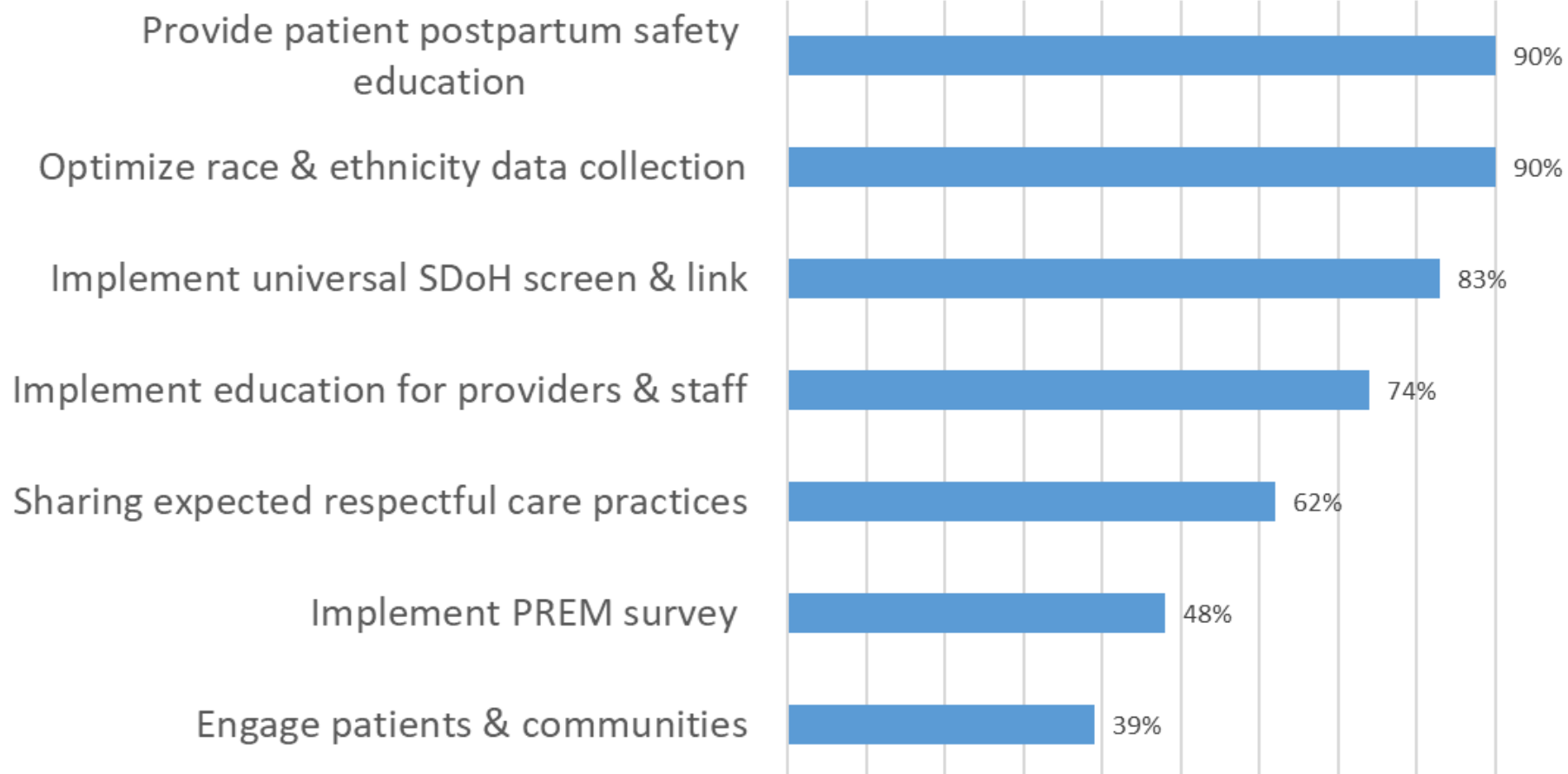
- Implementing SDoH screening for all patients
- Linking patients who screen positive for SDoH to community resources / identification of local resources
- Encouraging all patients to complete PREM survey
- Healthcare team buy-in



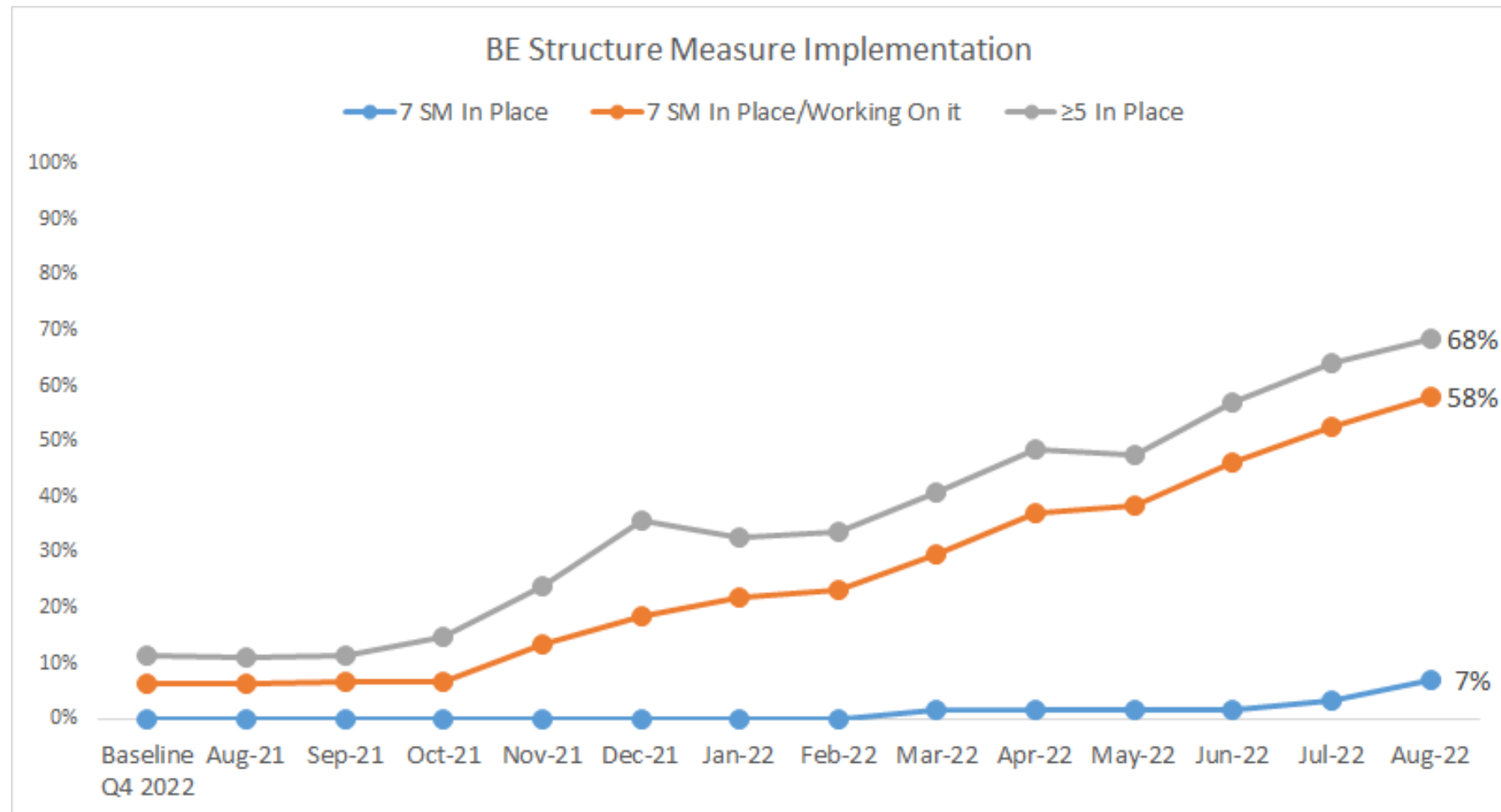
2022 Teams
Survey

Birth Equity strategies teams focused on in the past year

2022 Teams
Survey



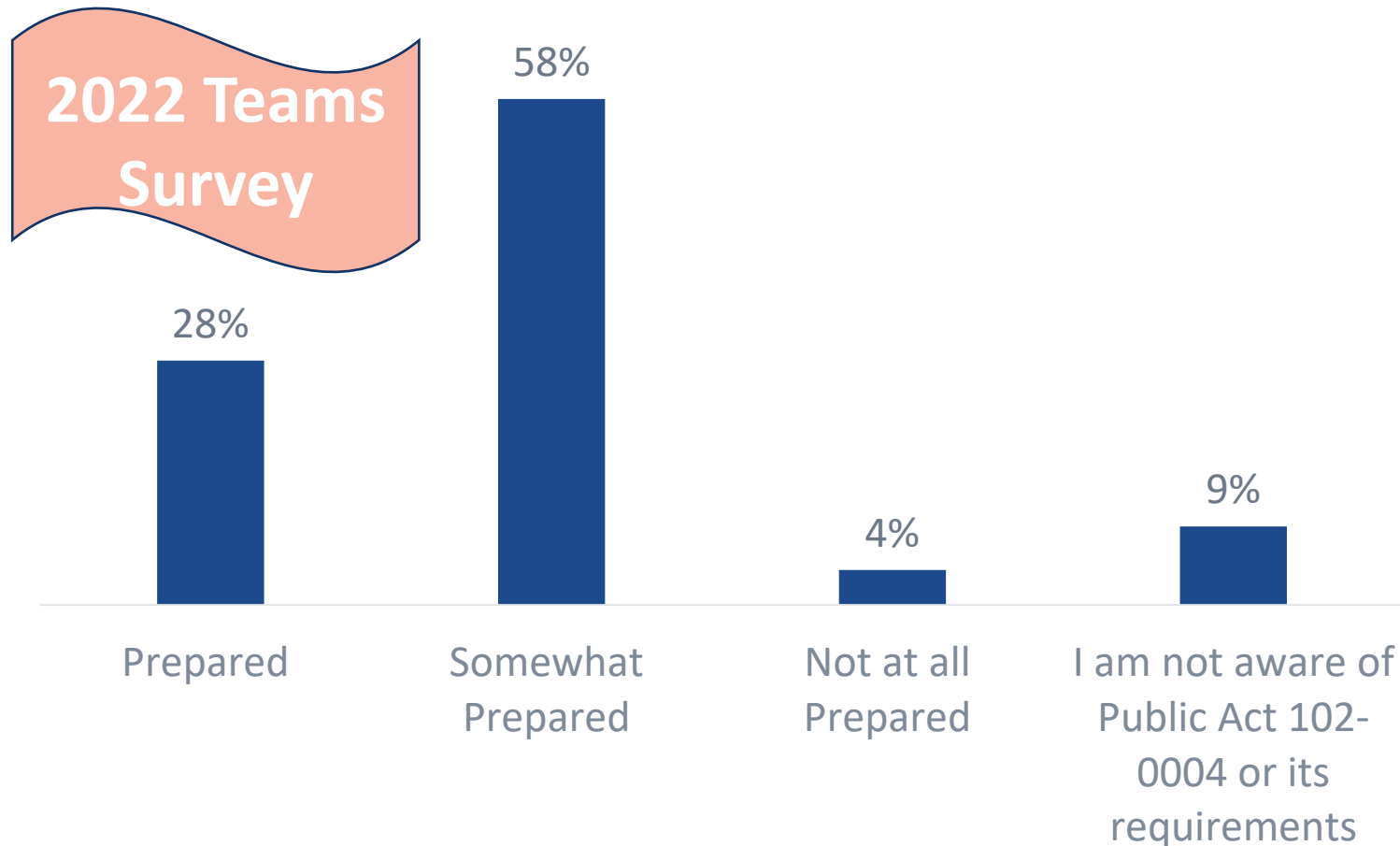
BE Structure Measures Implementation: Putting Systems Into Place



BE priority strategies in 2023 moving to culture change

Implicit bias education	<ul style="list-style-type: none"> • Grand Rounds • Laboring with Hope (thru 2/2023) • Diversity Science
SDoH	<ul style="list-style-type: none"> • Screen on L&D • Process flow for linking to resources
Respectful Care	<ul style="list-style-type: none"> • Hang poster • Sign off team • Engage clinical team members in activating RCP
PREM	<ul style="list-style-type: none"> • Implement • Review • Share • Act
Schedule 2-week postpartum visit	<ul style="list-style-type: none"> • Provider buy-in • Process flow • Data review
Engage patients and community	<ul style="list-style-type: none"> • Just get started • Get input • Keep listening

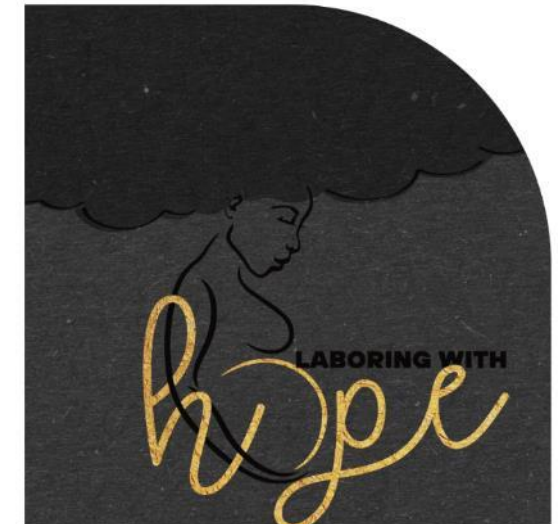
Hospital readiness to implement state mandated implicit bias training



Public Act 102-0004 requires implicit bias awareness training for health care professionals' license or registration renewals beginning January 1, 2023.

Implicit Bias Education and Hospital Team Buy-In

- Work with ILPQC to schedule and host BE Grand Rounds
- Combine with screening of *Laboring with Hope* **by 2/2023**
- Integrate Diversity Science e-modules into hospital Learning Management System **by 6/2023**



Birth Equity videos or films teams are using for education and buy-in

- Laboring with Hope (free access with ILPQC through February 2023)
- Kira Johnson's story
- Shalon Irving's story
- Patient stories from Hear Her campaign
- Aftershock
- ABC News--Racial Disparity US: Pregnancy Deaths are Preventable

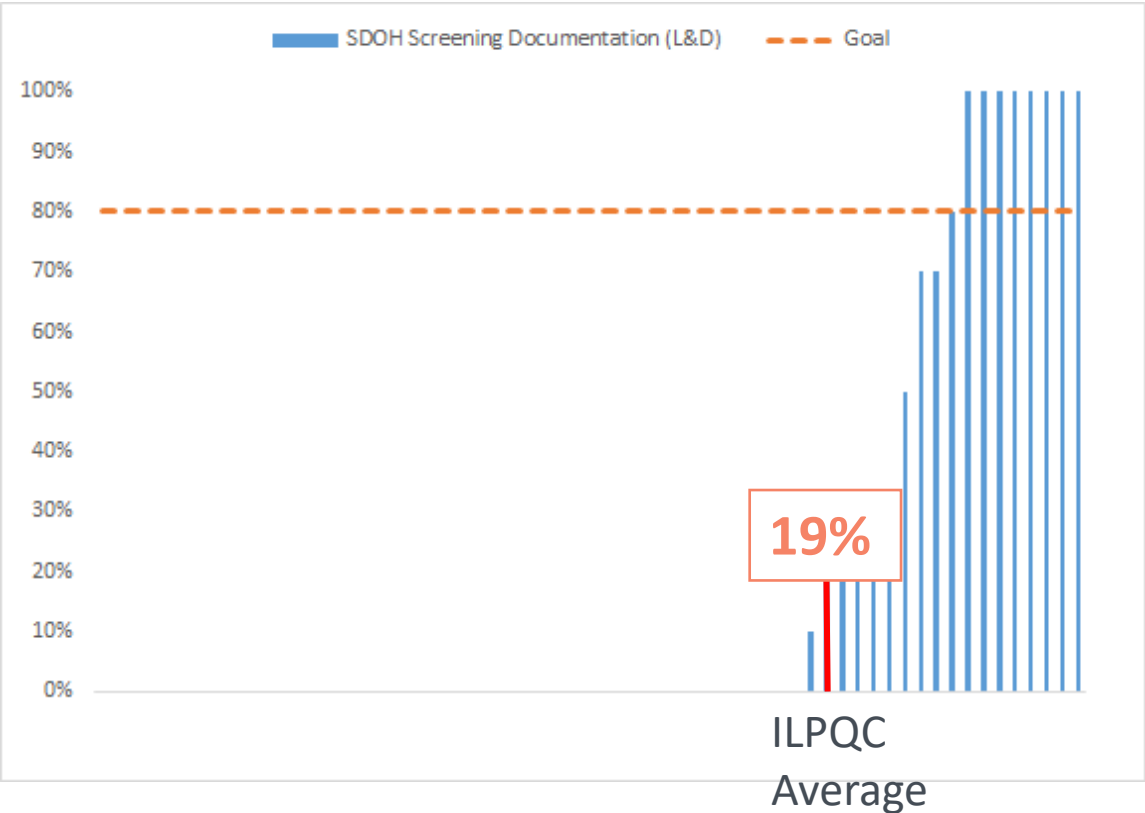


2022 Teams
Survey

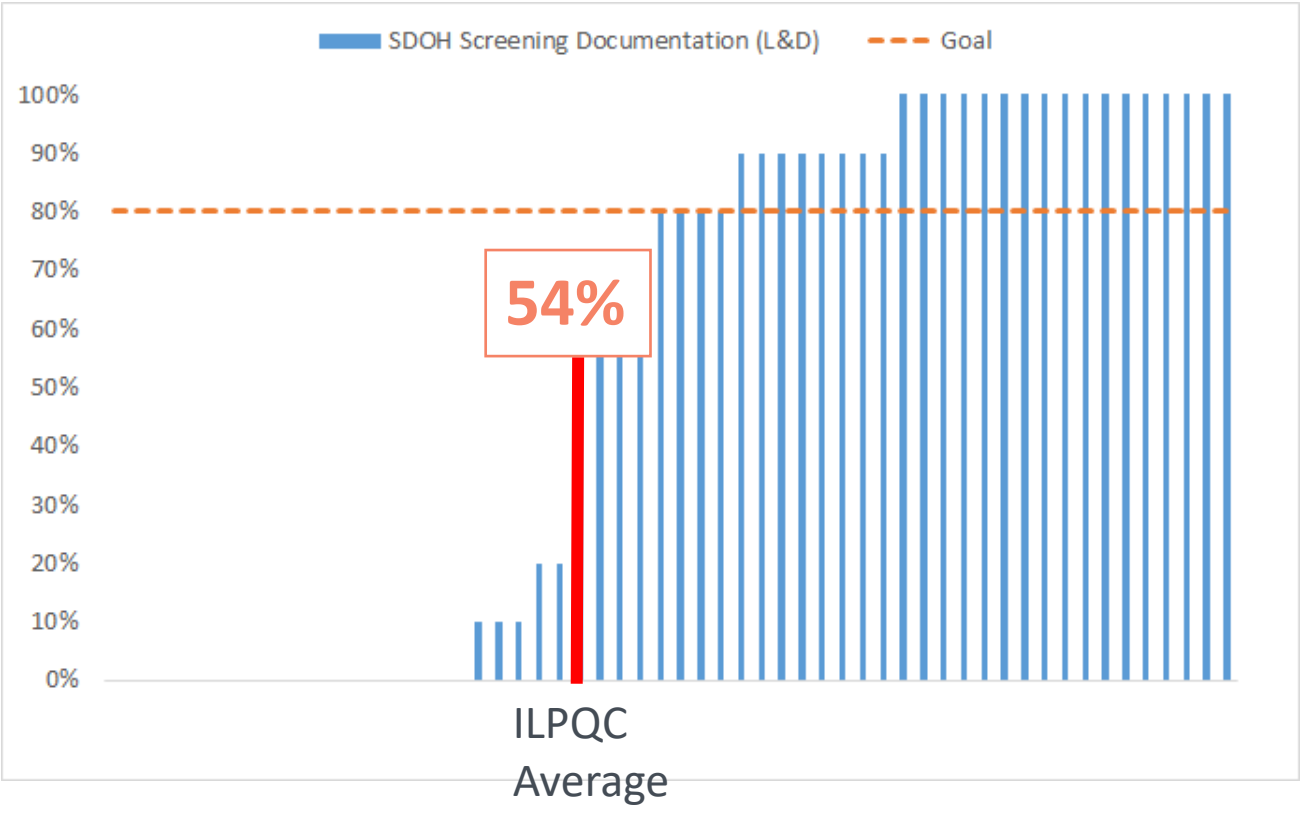


Percent of patients with SDOH Screening Documented on L&D, by hospital, Baseline vs August 2022

Baseline Q4 2020

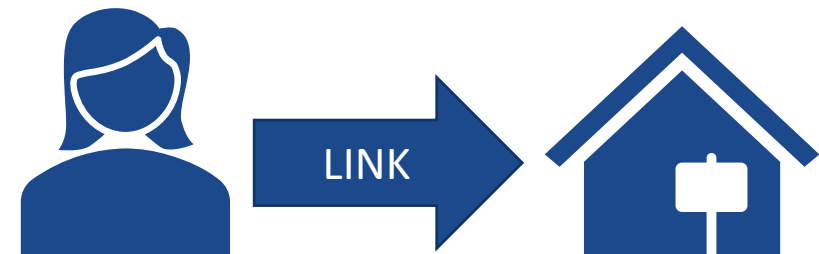
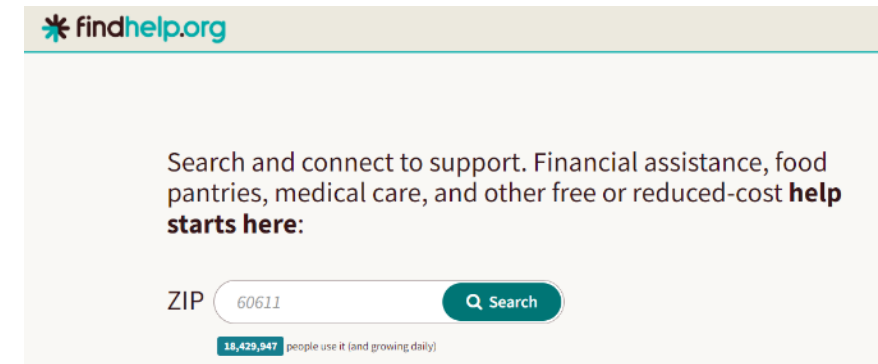
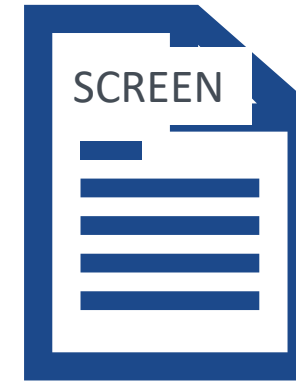


August 2022



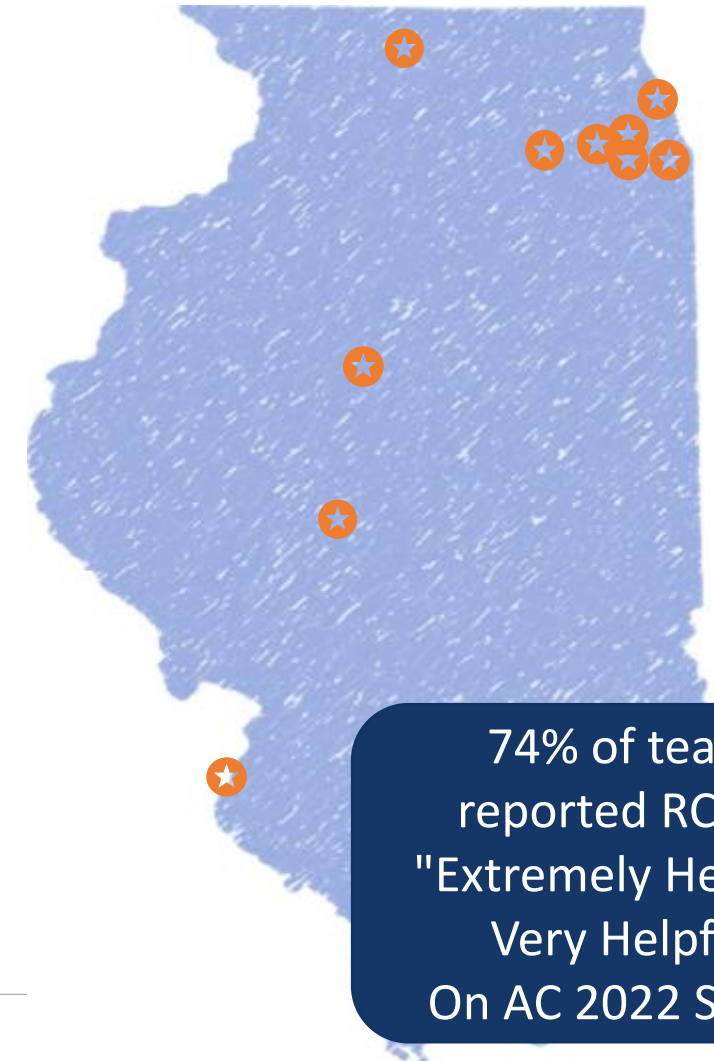
SDOH screening and linkage to resources

- Implement SDOH screening tool
- Identify local resources: **tip sheets** and **FindHelp.org**
- Evaluate **process flow** for linking patients who screen positive to resources
- Implement **missed opportunity review** for patients screened positive and not linked to resources




Regional Community Engagement Meetings (RCEMs) across Illinois

- 10 RCEMs February – July 2022
- 29 community member/patient panelists
- 66 (77%) of BE teams participated
- Contributed to the development of relationships between **hospitals and local community stakeholders**
- Nearly **250% increase** in teams working on patient/community engagement from start



74% of teams
reported RCEMs
"Extremely Helpful /
Very Helpful"
On AC 2022 Survey

Strategies to continue engaging patient advisors and community members for input in QI work



Invite to share at hospital grand rounds, organize patient focus group, or host a Community Meeting

Plan a followup Community Engagement Meeting with your perinatal network

Engage as member of your BE QI Team

Develop a patient community advisory board

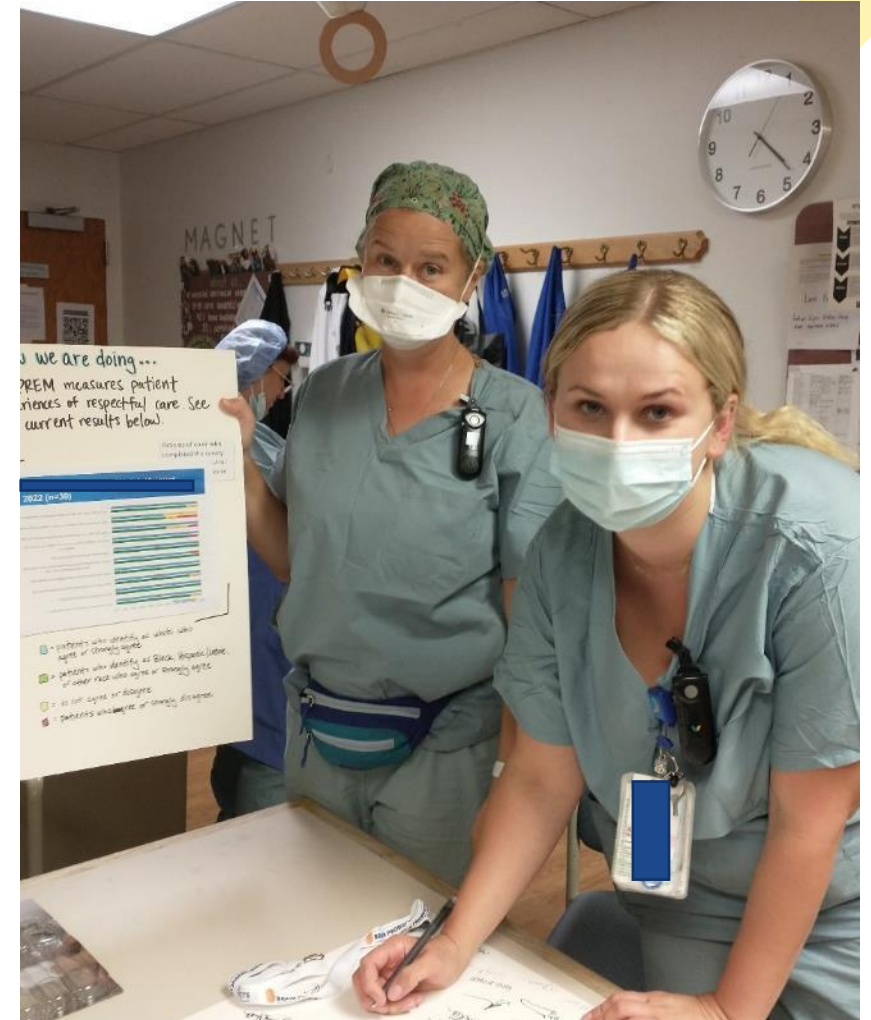
Respectful care buy-in key steps

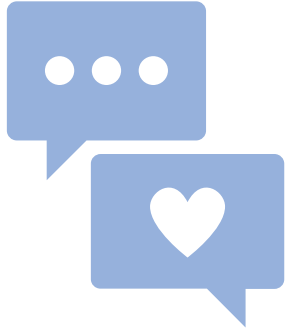
Post respectful care posters in clinical and patient areas

Review and activate respectful care practices with clinical team

Facilitate clinical team member sign-off on practices

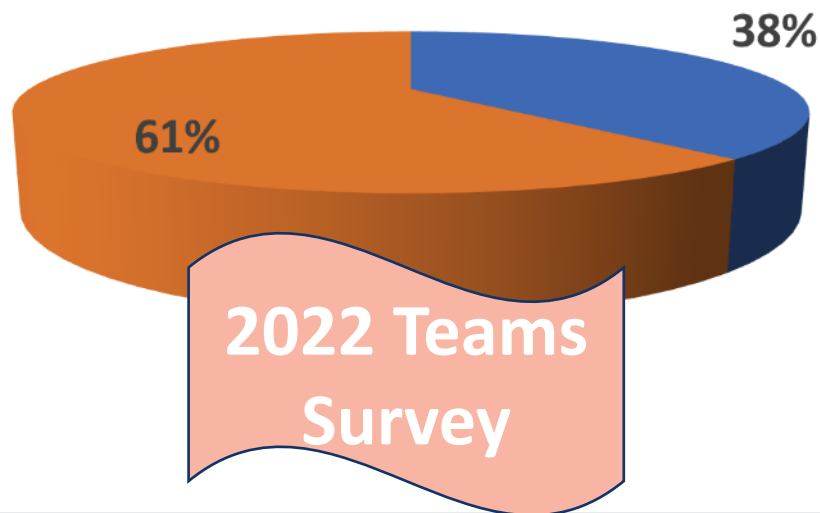
Share stratified PREM data



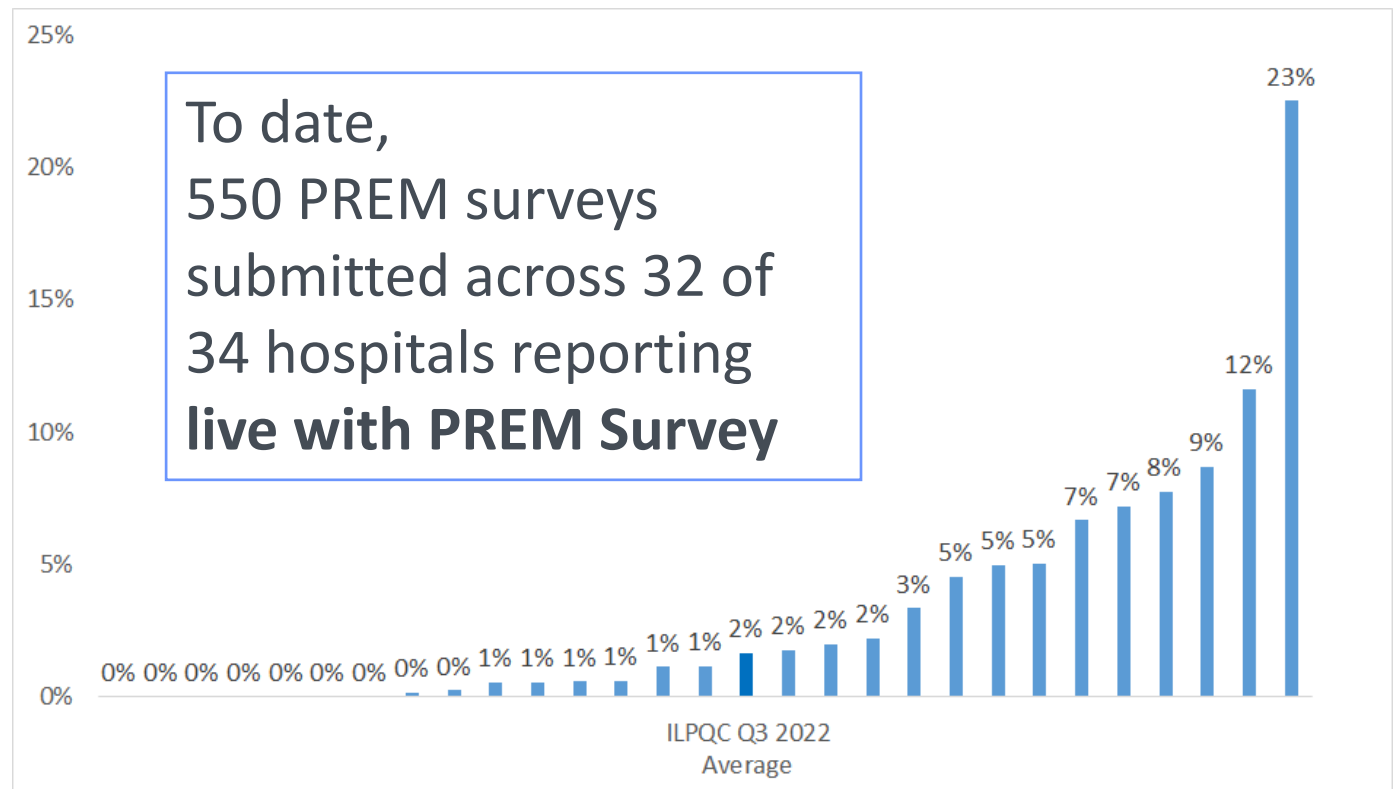


Active implementation of respectful care – where are we?

61% of teams providing expected Respectful Care Practices to patients

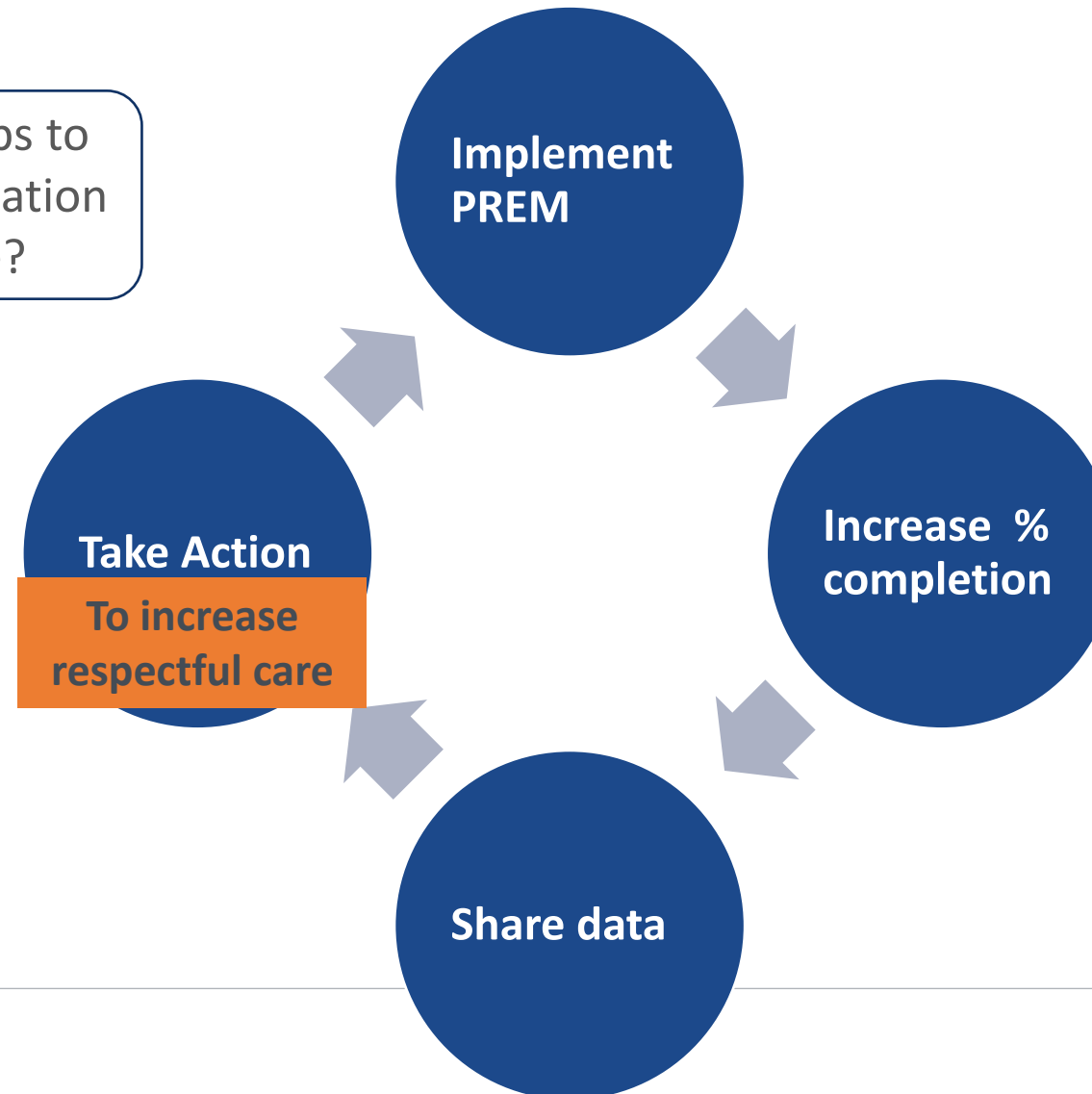


Q3 2022 PREM Completion by Hospital

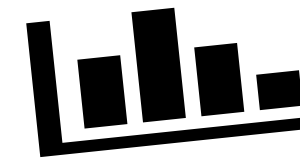


Active implementation of respectful care – where do we need to be?

What are key steps to active implementation of respectful care?



PREM Survey Data
100% patients reporting





Strategies to launch PREM



Process Flow



Build clinical
team buy-in

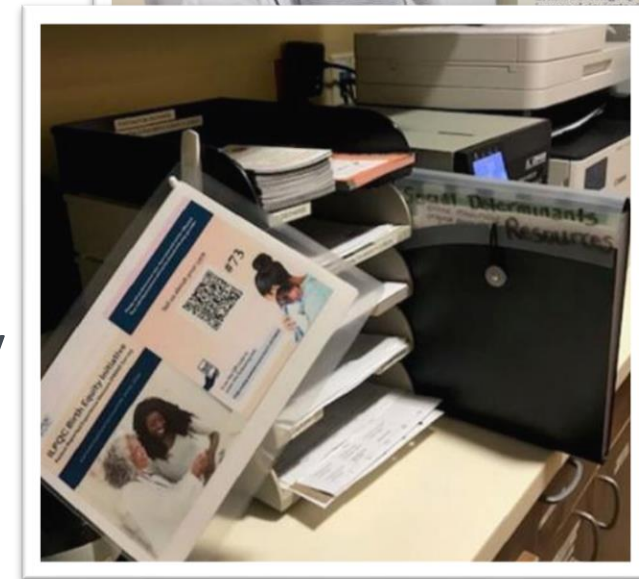
Customize
PREM QR code
and handout

Determine who
will present
PREM to
patients

Develop
process flow for
patient
completion

Strategies to optimize PREM Survey completion among all patients

- Identify care team member to request patient completes the PREM survey before discharge
- Identify tools to ensure access to QR code
 - Patient handout for nurse to provide patient before discharge with why PREM and how to complete
 - Tents with QR code at patient bedside
 - Laminated flyer with QR code posted in postpartum room
 - QR code in discharge folder
- **Monitor** completion rates and **Review** aggregate survey results through ILPQC PREM Reports (in REDCap) and share feedback with clinical team to increase completion and increase respectful care practices



PREM Survey Patient Handout

NEW – Now available!

- Tool to help facilitate patient's awareness of the PREM survey and increase PREM survey completion
- Nurse provides handout to patient to create a point of contact for PREM survey questions and communication about completion
- Direct links to patient for all currently available languages
- Customize with your hospital ID and logo



Tell us About Your Birthing Experience!

The purpose of this PREM survey is to give you an opportunity to share feedback on your labor and delivery and postpartum care.

Our goal is to provide respectful care for all patients and we need your feedback to make sure we are providing the care you need.

- Your survey responses will be anonymous (your name is not linked to your answers) and the survey should only take you a few minutes to complete.
- Choose your preferred language and scan the QR Code below to complete the PREM Survey.
- Please complete the survey before discharge. Let your nurse know when it is completed or if you have any issues. If you do not have a phone or other device available to take the survey, let your nurse know.

We are committed to providing you safe and respectful care.

Respectful care ensures that patients receive patient-centered care, feel respected and listened to, and the individual needs and preferences of all birthing people are valued and met.



English



Español



Italiano



Русский



Polski



Français



Supporting respectful care for all patients: The Illinois Perinatal Quality Collaborative (ILPQC) works with patients, physicians, midwives, nurses, hospitals, and community groups across Illinois to reduce maternal disparities and promote birth equity by ensuring all patients receive safe, high-quality compassionate, and respectful care.

Teams' strategies to share Respectful Care Practices

2022 Teams
Survey

Clinical care team

- Poster with our respectful care practices at each nurses' station throughout the unit
- All staff educated **on** respectful care practices and how to speak to patients about them
- All staff read and sign respectful care strategy poster
- Shared respectful care practices and initial PREM Survey data results in nurses break room with food

Patients

- Posted in each patient room and provided to prenatal class attendees
- Given in the patient admission folders

Strategies to encourage patients to complete the PREM Survey before discharge

2022 Teams
Survey

Goal for the
day on their
white board

Primary nurse
discusses and
follows up
with patient

Offer an
electronic device
to complete
survey on if they
do not have one

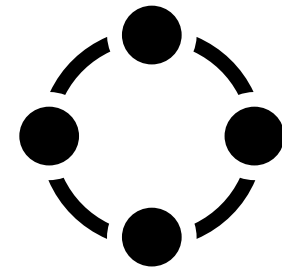
Hang QR
code in all
postpartum
rooms

Provider
reminders
throughout
stay

Place in every
patient's
admission folder

Group Activity: 30-60-90 Day Plan for PREM Survey Implementation (at any phase)

- Goal: Identify strategies with your table to develop a 30-60-90 day plan for implementing the PREM survey *and* increase % of patients that complete it before discharge
- Identify where people at your table are with respect to moving PREM survey implementation forward at their hospital
 - Implement PREM survey on postpartum before discharge
 - Increase % of patients completing PREM survey
 - Share PREM data back with clinical team members
 - Take action to increase respectful care FOR ALL to reduce disparities



Group Activity: 30-60-90 Day Plan for PREM Survey Implementation (at any phase)

- **Step 1: Split your table in two groups** (10 minutes for Step 1 and Step 2)

Group 1 work on steps needed to implement the PREM survey for postpartum patients and increase % patient completion before delivery discharge

Group 2 work on steps needed for reviewing and regularly sharing PREM reports with the clinical team to develop buy-in and actions needed to optimize respectful care for all patients

- **Step 2: Pull out your 30-60-90 day plan** from your folder and fill it out during your discussion and find worksheet with discussion questions on your table on back of the PREM patient hand out
- **Step 3: Come back to table and share** 30-60-90 day plan and strategies discussed with other group (5 minutes)

Birth Equity Panel Discussion

Panelists:

- Zsakeba Henderson, MD, FACOG
- Lisa Kane Low, PhD, CNM, FACNM, FAAN
- Susan Ford, MSN, CPNC-PC

Questions:

- How do we help teams achieve these initiative aims in 2023?
- What QI strategies could be most effective to drive culture change?
- Ideas to share from Table Discussions regarding PREM implementation?

Promoting Vaginal Birth

Moving from systems change to culture change to achieve success

PVB Aims and Measures

AIM

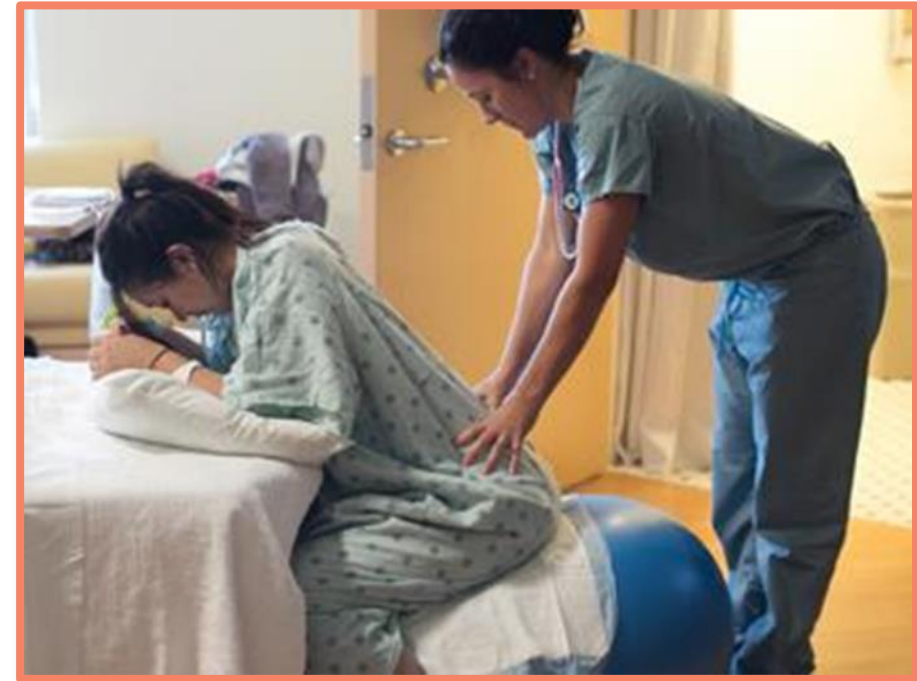
≥70% of hospitals will be at or below
the Healthy People goal of 23.6%
NTSV C-Section Rate

Measure

≥80% of NTSV
C-sections meet
ACOG/SMFM criteria
for cesarean

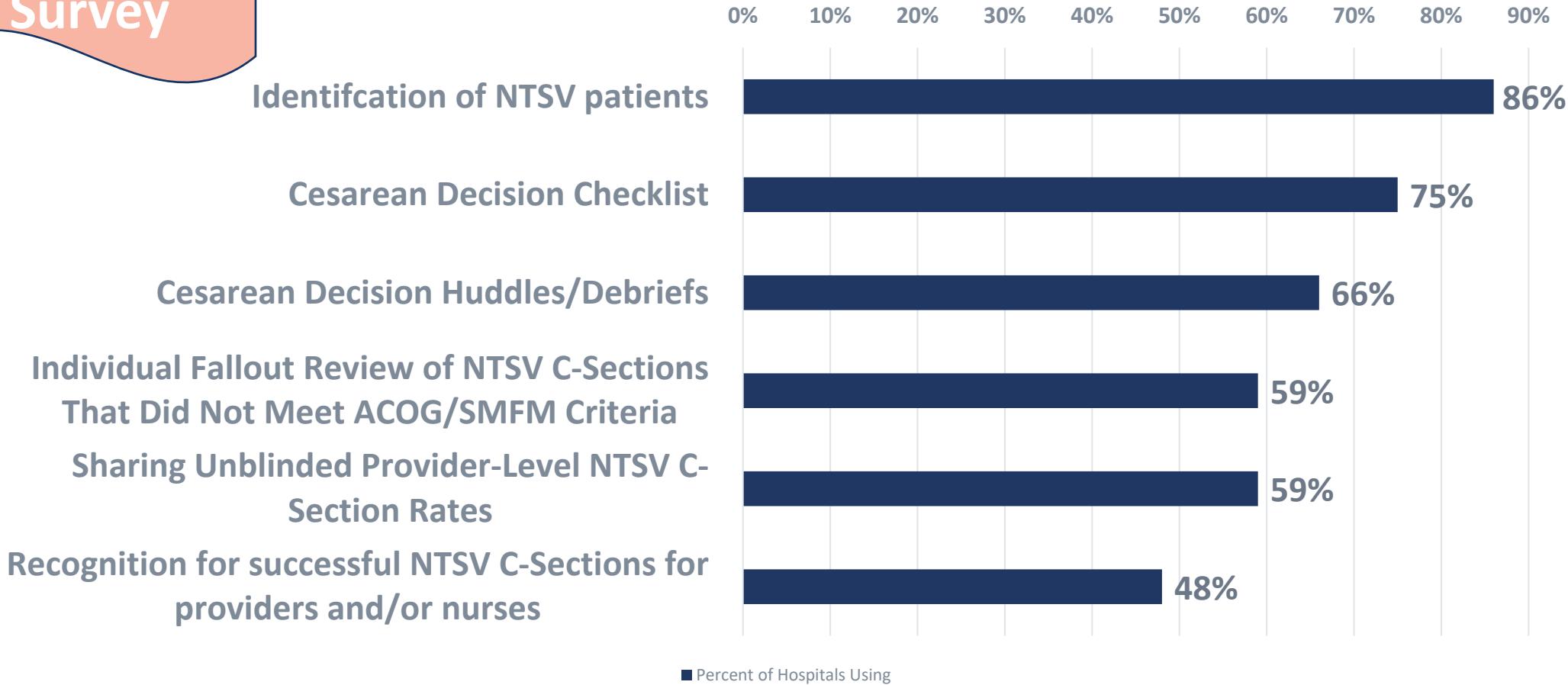
Measure

≥80% of physicians,
midwives, and nurses
educated



Most Utilized PVB Strategies

2022 Teams
Survey



PVB Strategies Reported By Teams

2022 Teams
Survey

Big focus on
nursing
education

Acknowledging nurses each
month with the most NTSV
deliveries

Labor support cards
illustrating positioning
and purpose

Sharing
unblinded
provider group-
level C-section
rates

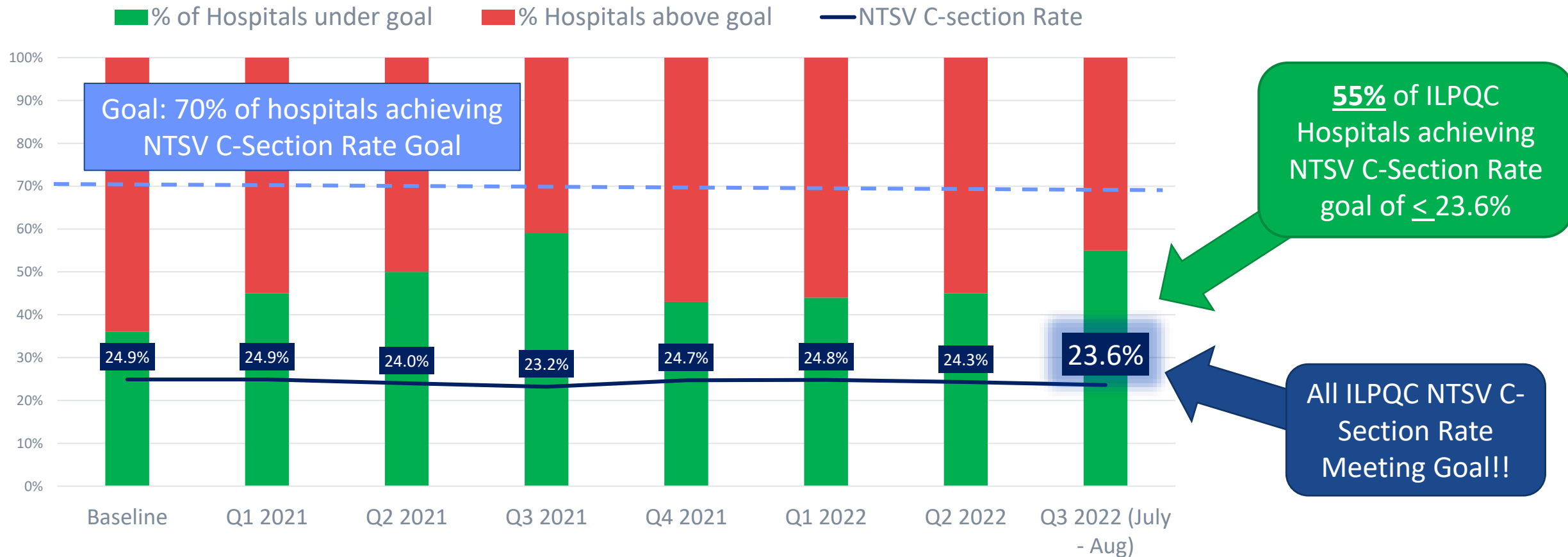
Sharing blinded data with
the department and
providers

Newsletter with
position of the month
and success stories

Use of AgileMD Pathways in the
EMR for labor management and
delivery decision huddles

All nurses and some physicians have
attended Spinning Babies and some are
additionally completing the Bundle Birth
education

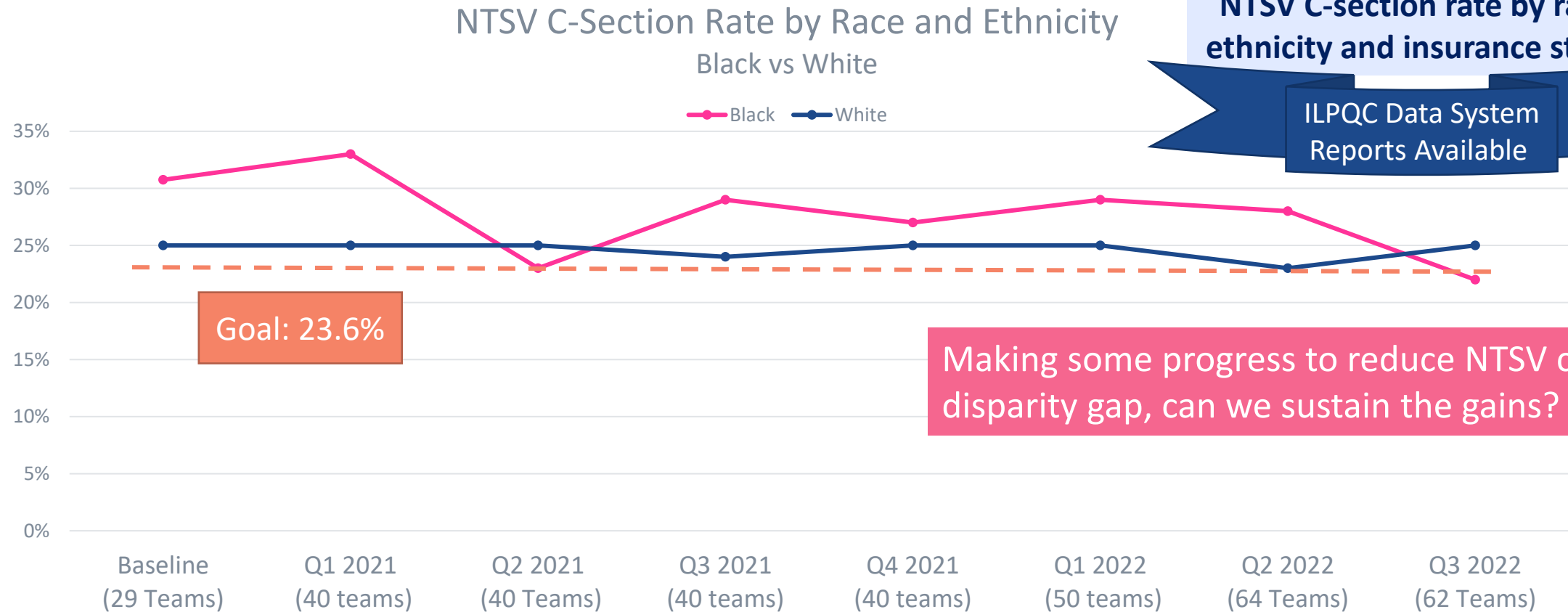
NTSV C-Section Rate PVB Hospitals baseline to Q3 2022



Addressing disparities: NTSV C-Section Rate by Race and Ethnicity

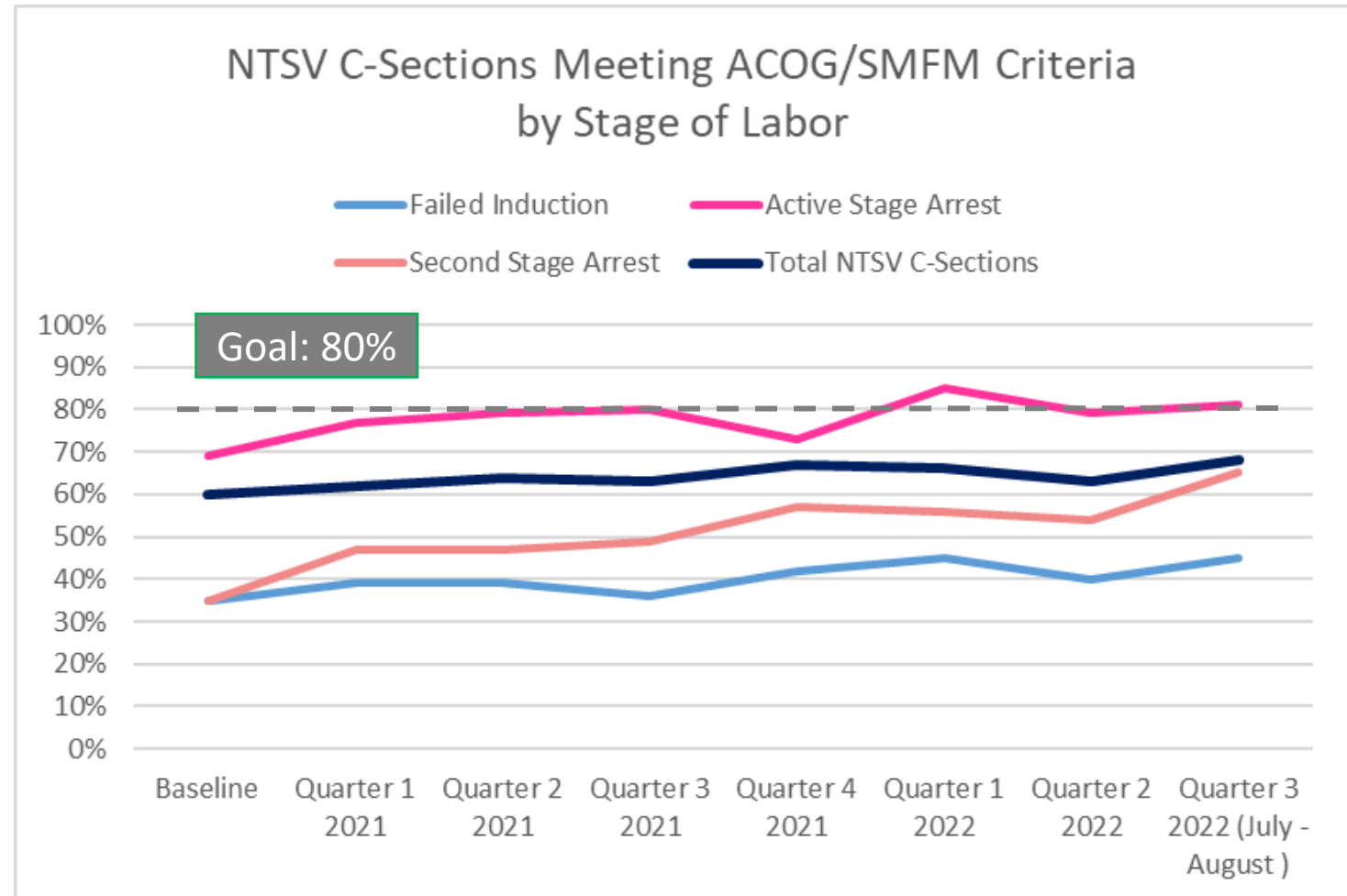
**71% of teams are tracking
NTSV C-section rate by race,
ethnicity and insurance status**

**ILPQC Data System
Reports Available**



Meeting ACOG/SMFM Criteria by stage of labor

- **2022 Success**
 - Second Stage Arrest: increase from 35% → 65%
 - Active Stage Arrest: increase from 69% → 81% (Goal >80%)
- **2023 Opportunities for Improvement :**
 - Failed Induction: only 45% of C-Sections meeting criteria



Improving % of NTSV C-sections meeting ACOG/SMFM Criteria

2022 Teams
Survey

Strategies Utilized:

Standards laminated at desk

Checklist on each patient chart

Sharing data at quality meetings

Labor positioning training

Huddles

Reviewing fallouts

Biggest Challenges:

Allowing time

Changing culture regarding longer duration of pushing

Provider buy-in

Nurse burnout

Legal worries for delaying delivery

PVB Key Strategies for Culture Change

Cesarean Decision
Huddles and Checklist



Clinical Team Education
and Buy-in



Sharing Unblinded Provider-
level NTSV C-Section Rates



Educating patients and
shared decision making



Fallout Reviews of cases not
meeting ACOG/SMFM Criteria



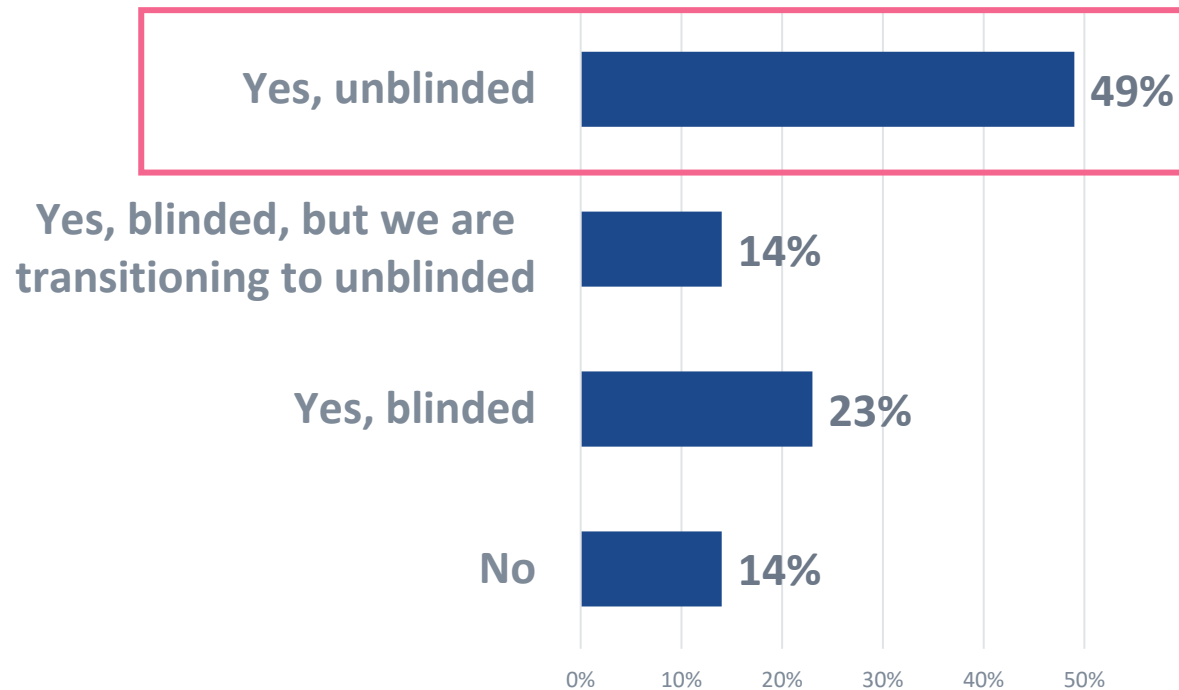
Labor Management
Support



Sharing Un-blinded Provider-Level NTSV C-Section Rates

2022 Teams
Survey

Are you sharing provider level NTSV C Section Rates with providers at your hospital?



• What was your process for sharing data?

- Monthly OB provider
- Department meetings
- Email to providers
- Women and Children Service Line Meetings
- Unblinded data posted in provider lounge
- Reviewed at quarterly meetings
- Yearly letter to providers
- Perinatal committee meetings

Sharing Un-blinded Provider Level NTSV C-Section Rates



Tips to get started with sharing **un-blinded** data:

Involve your
PVB Provider
Champion

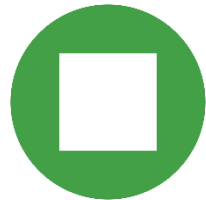
Explain the
“why” to
providers and
staff

Create a
process and
space to share
provider-level
data

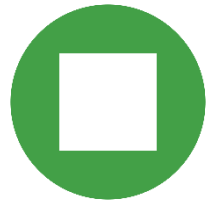
Implement
and
communicate
timeline

Key Resources and strategies for Sharing Provider-Level Data

CMQCC Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates



Step by Step Guidance and timeline to un-blinding data



Common Considerations and barriers to sharing un-blinded data



Troubleshooting and FAQs

Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates at Start of Project

Before the process of unblinding NTSV cesarean rates begins, it is important for teams to have a baseline understanding of their underlying practices. This can be determined through an examination of the drivers for primary cesarean rates, followed by a chart review of a sample to assure how well the providers follow the current ACOG guidelines for Relative to Progress and other key primary cesarean indications. Checking monthly cesarean rates and other key primary cesarean indications will not every case will follow the guidelines. Checklist will assist with that case that support providers in reducing cesarean rates.

The Readiness Assessment, Scorecard and Chart Audit Tool are all located at: <https://www.cmqcc.org/project/primarycesareanrates/>

1. Educate & Inform:

- Confirm physician champion plan to reveal rates
- Reveal BLINDED based
- Physician champion to reduction info session, or rates (provide timeline)
- Key discussion points:
 - Each physician
 - This aspect of the most results
 - The process is credentialing. Re been too product standardized. Or go
 - The project's the systems that
 - Physicians the physician rates
 - Reiterate fact below

The Implementation Guide

Table 1: Common Considerations with Provider-Level Rates

Problem	Risk	Solution
Low Volume	Low volume often leads to an increase in variation of the results, possibly causing significant concern for individual providers	Pool select data concerns with low volume leading to possibly wrong conclusions, consider making the sampling interval longer (e.g., 12 months instead of 3)
Provider lacking so other types of providers who cannot perform cesareans	Many women opt for C-sections to avoid labor, which is a common individual C-section rates	
Provider is held responsible for decisions of others (e.g., long labor that are held over from the previous shift or when consulting in the office precludes the current provider from achieving vaginal delivery (e.g., fetal distress, low birth weight, etc.))	This can cause an individual C-section rate to be higher than the overall rate, which could have negative impact on the provider	
Checklist entry errors in the birth certificate data or coding leading to wrong procedure or attributed provider	Fortunately, the information and documentation is significant to the provider	

2. Identify and activate champions

- Current physician champion should seek out up in support of unblinded data at the scheduled

includes:

- Structural leaders such as OB Dept chair, relevant committees Chairs
- Early adopter MDs who are well-versed

The Implementation Guide for The Tooling

Troubleshooting / FAQs

1. What do we do if we are at the point of unblinding the data and we still have one or a few outliers against it?

ANSWER: In general, this is actually rare in occurrence, but at some point it is necessary to proceed. Physician leaders should have been conversations that unblinding is going to occur and that the rates will stay within the department. There is a helpful to several the providers that common public pressure is progressing to the public where, as data provider rates are derived from publicly reported data, sooner or later these rates will be publicly available to patients and payers. Therefore it is better to go along with this sensitive agencies and work on obtaining appropriate rates and improving the quality of the data.

2. When about the Kaiser model (or other laborist model), where some physician rates don't reflect true attribution?

ANSWER: In models where providers work as a team, often better to have them consider improvement as a team and have open discussions about solutions at their department meetings. For example: Is anyone supporting breast-feeding? Is anyone consistently delaying the cesarean section to the next shift or waiting patients in labor phase?

The Maternal Data Center now also has the ability to track "labor provider." This requires a little extra manual data entry on a case-by-case basis (and does tracking by each hospital as to who was the actual "labor provider" for each patient, but will greatly improve the ability to track NTSV rates in institutions where attribution is difficult to sort out).

Additionally, the hospital is the coldest we have the ability to track consistency with ACOG guidelines for diagnosis of labor dystocia. For those who desire a proxy measure for provider inconsistency, provider-level data for "consistency with guidelines" is available through the data center, but does take extra additional chart review and coding. To do this:

- From the hospital landing page, click on the measure "NTSV Spontaneous Labor Arrest/CFD: Consistency with Guidelines." This will display the hospital trend via a run chart.
- Use the cross-down menu to adjust the time period, and then click on the data point in the run chart to drill down to the patient level. This will give a list of cases.
- Click on Provider ID to sort.

3. How frequently should we share provider level data?

The Implementation Guide for The Tooling to Support Vaginal Birth and Reduce Primary Cesarean

Key Resources and Strategies for Provider and Nurse Education + Buy In

 REDCap®

ILPQC PVB Dashboard

**Missed
Opportunity
Review**

- ☐ Review fallouts and debrief cases
- ☐ Present successful NTSV vaginal deliveries

**Provider Education
Posters**



- ☐ Hang education posters
- ☐ Email pdf versions to providers and nurses

 YouTube

**Labor
Management E-
modules**

- ☐ Send out an email with a different video each week
- ☐ Set up labor management skills day

PVB Grand Rounds



- ☐ Schedule a PVB Grand rounds
- ☐ Include learners (Residents, fellows, etc.)

ILPQC Labor Management Support Class

2022 Teams
Survey

How have you incorporated skills and key content into your unit?

Attended and
incorporated spinning
babies

Peanut balls and
new labor beds

Labor support
cards/handouts in
patient rooms and
shared in prenatal
classes

Comfort measures
flowsheet built into
EMR

Incorporated
into education
materials

Unit created TikTok
videos

New position on
bulletin board
each week

Consistent use of the Cesarean Decision Checklist and Huddles



Standard process to use the Cesarean Decision Checklist for every potential C-section

- Availability of checklist in patient's labor room or in EMR
- Standardization of who initiates the huddle and use of checklist
- Documentation of use of checklist



Standard process to perform Delivery Decision Huddles/Debriefs for every potential C-section

- Huddle performed with physician, nurse, any other care team members, and the patient to discuss potential C-section decision
- Use of checklist in huddle initiated by charge or bedside nurse

Cesarean Decision Checklist

2022 Teams
Survey

Most Helpful:

Better interdisciplinary communication between nurses and providers

All staff on same page

Consistent evidence-based decision making

Bringing awareness to newer RNs of the length of labor and keeping providers aware of interventions

Implementation Challenges:

Compliance with utilization

Physician Buy-In

Nurses not wanting to question providers' decision making

Consistent completion

Medical legal concerns

Key Resources and Strategies for Checklists and Decision Huddles

Integrate the checklist into your EMR

Include checklist with admission packet to L&D

Empower nurses to initiate use of checklist and huddles as a communication tool

Require documentation of use of checklist

Meet with providers who are resistant to use of checklist to better understand their concerns

Place patient sticker here

Delivery Provider: _____ Initials: _____

Labor & Delivery RN: _____ Initials: _____

Date & Time : _____

Failed induction: _____

Both boxes should be checked if cervix unfavorable (suggest Bishop Score < 8 for nullips and < 6 for multips) :

- ☐ Cervical Ripening used (when starting with unfavorable Bishop Scores as noted above).
- ☐ Oxytocin administered for at least 12-18 hrs after membrane rupture, without achieving cervical change and regular contractions. *Note: at least 24 hrs of oxytocin administration after membrane rupture is preferable if maternal & fetal statuses permit

Latent phase arrest (cervix < 6 cm): _____

Both boxes should be checked:

- ☐ Oxytocin administered for at least 12-18 hrs after membrane rupture, without achieving cervical change and regular contractions.
- ☐ A longer duration of the latent phase is preferable (24 hrs or longer if maternal & fetal statuses permit).

Active phase arrest (cervix ≥ 6 cm): _____

Both boxes should be checked:

- ☐ Membranes ruptured (if possible).
- ☐ No cervical change after at least 4 hrs of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hrs of oxytocin administration with inadequate uterine activity.

Second stage arrest (cervix 10 cm / pushing): _____

Both boxes should be checked:

- ☐ Fetal position known and rotation attempted if OP
- ☐ For nulliparous: 3hr or more of active pushing (4hr with epidural)
For multiparous: 2hr or more of active pushing (3hr with epidural)

- ☐ Although not fulfilling the above criteria for failed induction, labor dystocia, or arrest, my clinical judgment deems this cesarean delivery indicated

Fallout Review of NTSV C-Section Cases Not Meeting ACOG/SMFM Criteria



Identify cases not compliant with ACOG/SMFM guidelines in the PVB dashboard

Review chart and identify which ACOG/SMFM guidelines were not met

Utilize new Fallout Review Form to understand additional details of case

Provide feedback to clinical team that performed C-Section

Identify patterns among C-Sections not meeting criteria and areas to work on

Key ILPQC Resource for Fallout Review NTSV C-Section Cases Not Meeting ACOG/SMFM Criteria

- ILPQC has created a Fallout Review form to review NTSV C-Section Cases that do not meet ACOG/SMFM Criteria



Patient Sticker

Date of C/S _____
RedCap Record ID _____

Select primary indication for NTSV C/S as documented:

- ☐ Failed Induction (Cervix <6cm)
- ☐ Latent Phase (Cervix <6cm)
- ☐ Active Phase Arrest (Cervix \geq 6cm)
- ☐ Second Stage Arrest (Cervix 10cm/Pushing)
- ☐ Fetal Heart Rate Concern
- ☐ Other _____

PVB Opportunity Review/Debrief Key Steps:

1. Identify NTSV cases not meeting ACOG/SMFM criteria at least monthly.
2. Review PVB dashboard/ patient's medical record and complete the below form to understand why ACOG/SMFM criteria were not met.
3. Provide feedback to patient's clinical team regarding fallout review.
4. Use to improve understanding of why ACOG/SMFM criteria are not met to drive QI strategies.

Was ACOG/SMFM criteria for cesarean indication achieved for primary indication below?

FAILED INDUCTION (Cervix <6cm) (Both boxes should be checked yes to have met ACOG/SMFM criteria)

1. Was cervical ripening used for unfavorable cervix, Bishop Score <8 for nullips?
☐ Yes ☐ No ☐ Unknown If yes, type of cervical ripening? _____
2. Was oxytocin administered for at least 12-18 hours after membrane rupture, without achieving cervical change and regular contractions? (Note: at least 24 hrs of oxytocin administration after membrane rupture is preferable if maternal & fetal statuses permit) ☐ Yes ☐ No ☐ Unknown

LATENT PHASE (Cervix <6cm)

1. Not in labor, if <6cm does not meet criteria for arrest (cannot call c/s due to Arrest if less than 6 cm, active labor has not been achieved, consider giving more time).

Per ACOG/SMFM Guidelines as long as cervical progress is being made, a slow but progressive latent phase e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women is **not an indication for cesarean delivery as long as fetal and maternal statuses remain reassuring. Sufficient time should be allowed to enter the active phase*

ACTIVE PHASE ARREST (Cervix \geq 6cm) (Boxes should be checked yes to have met ACOG/SMFM criteria)

1. Cervix \geq 6cm ☐ Yes ☐ No ☐ Unknown
2. Were membranes ruptured (if possible)? ☐ Yes ☐ No ☐ Unknown
3. Was there no cervical change after at least 4 hrs of adequate uterine activity (e.g. strong to palpation or MVUs >200) or was there at least 6 hrs of oxytocin administration with inadequate uterine activity?
☐ Yes ☐ No ☐ Unknown

SECOND STAGE ARREST (Cervix 10cm/Pushing)

1. Was the fetal position known and rotation attempted if OP? ☐ Yes ☐ No ☐ Unknown
2. For nulliparous, was there 3 hours or more of active pushing (longer durations may be appropriate, e.g. with epidural or malposition) ☐ Yes ☐ No ☐ Unknown

FETAL HEART RATE CONCERN/INDICATIONS

1. What was the FHR concern/indication?
 - ☐ Antepartum testing results which precluded trial of labor
 - ☐ Category III FHR tracing
 - ☐ Category II FHR tracing (Were these specific types present?)
 - ☐ Recurrent variable decelerations ☐ Minimal/absent FHR variability w/out significant decelerations ☐ Late Decelerations
 - ☐ Other concern: _____
2. Were corrective and evaluative measures used: (select all that apply)
 - ☐ Maternal position change or maternal fluid bolus
 - ☐ Reduced or stopped oxytocin or uterine stimulants
 - ☐ Used amnioinfusion with recurrent variable decelerations after other measures failed
 - ☐ Elicited stimulation (scalp, vibroacoustic, or abdominal wall) with minimal or absent FHR variability
 - ☐ None
3. Did the patient have uterine tachysystole? ☐ Yes ☐ No ☐ Unknown
 - ☐ If yes, were appropriate interventions used: decrease or discontinue uterine stimulants, fluid bolus, terbutaline or nitroglycerin and/or other? ☐ Yes ☐ No ☐ Unknown

PVB Small Group Scenario by Table

- At your table you will find the following items:
 - *PVB Breakout Session Cases*
 - *PVB Fallout Review Form*
 - *PVB Items in Folder: Decision Checklist and Provider Education Posters*
- 1. Review the NTSV C-Section Case scenario (*10 minutes for Steps 1-3*)
- 2. Complete the Fallout Review Form as a table, determine whether ACOG/SMFM criteria was met for the chosen indication
- 3. Identify any opportunities for improvement
- 4. Assign roles at your table: QI Champions and clinical team (Nurse and Provider)
- 5. Role play debriefing the case and providing feedback on any missed opportunities, those without assigned roles identify strategies to improve provider buy-in (*5 min*)

PVB Small Group: Scenario 1

- **6:00 AM**
 - G1 P0 patient came in for a scheduled elective induction at 39.0 weeks gestation with a Bishop Score of 4. Cervical Ripening Balloon (CRIB) placed and 25 mcg Miso placed vaginally
- **9:00 AM**
 - CRIB comes out when patient gets up to go to the bathroom. Exam performed and SVE: 4cm, 80, -1. Pitocin started per MD order.
- **10:00 AM**
 - AROM done, clear fluid
- **2:00 PM**
 - Cervix still 4 cm dilated, irregular contractions
- **4:00 PM**
 - Nurse checks on patient and continues to increase pit per protocol and turns patient from side to side, patient comfortable and not feeling contractions
- **5:30 PM**
 - Cervix still 4 cm dilated
 - Nurse calls physician to inform them patient has not progressed, provider instructs her to try peanut ball
 - Nurse places peanut ball between patients legs while she lays on her side
- **6:15 PM**
 - Physician examines patient and determines she is still 4 cm dilated and having irregular contractions
 - Physician and nurse discuss in the hallway that it might be time for C-section for Failed Induction
 - Nurse begins to prep for C-Section while physician tells patient that a C-section is recommended because they have been trying all day and they have not been able to get her into labor. The physician shares that waiting won't likely make a difference and will just be putting off the C-section. The patient responds that she wants to do what the doctor recommends.
 - C-section performed for indication: failed induction

PVB Small Group: Scenario 2

- **9:00 AM**
 - G1 P0 patient comes into triage and is 6 cm dilated with regular contractions, after rupture of membranes at 6:00 AM
- **10:00 AM**
 - Patient gets epidural
- **1:00 PM**
 - Patient SVE 8 CM, 90% effaced, -1 Station
- **4:00 PM**
 - Patient completely dilated and starts pushing with nurse
- **5:30 PM**
 - OB comes to check on pushing progress and determines little progress has been made. Encourages nurse to try different pushing positions. Nurse calls charge nurse to help her with alternate pushing position
- **6:00 PM**
 - Physician returns and notes that different pushing position has been tried and some progress has been made but not ready to deliver. Starts discussing possibility of C-Section with patient. Patient expresses that she remains motivated for a vaginal delivery.
 - Nurse pulls out Cesarean Decision checklist and discusses with physician that ACOG/SMFM Criteria calls for 3 hours of pushing (consider 4 with epidural if progress is being made). Physician responds that the patient is getting tired, that 2 hours is usually long enough to tell if someone is going to deliver vaginally and she may need a C-section
 - Physician discusses with patient that she has already pushed for 2 hours, she is getting tired therefore additional pushing will probably not make a difference and they recommend a cesarean delivery
- **6:30 PM**
 - C-Section performed for indication: arrest in the second stage.

PVB Panel Discussion

Panelists:

- Zsakeba Henderson, MD, FACOG
- Lisa Kane Low, PhD, CNM, FACNM, FAAN
- Susan Ford, MSN, CPNC-PC

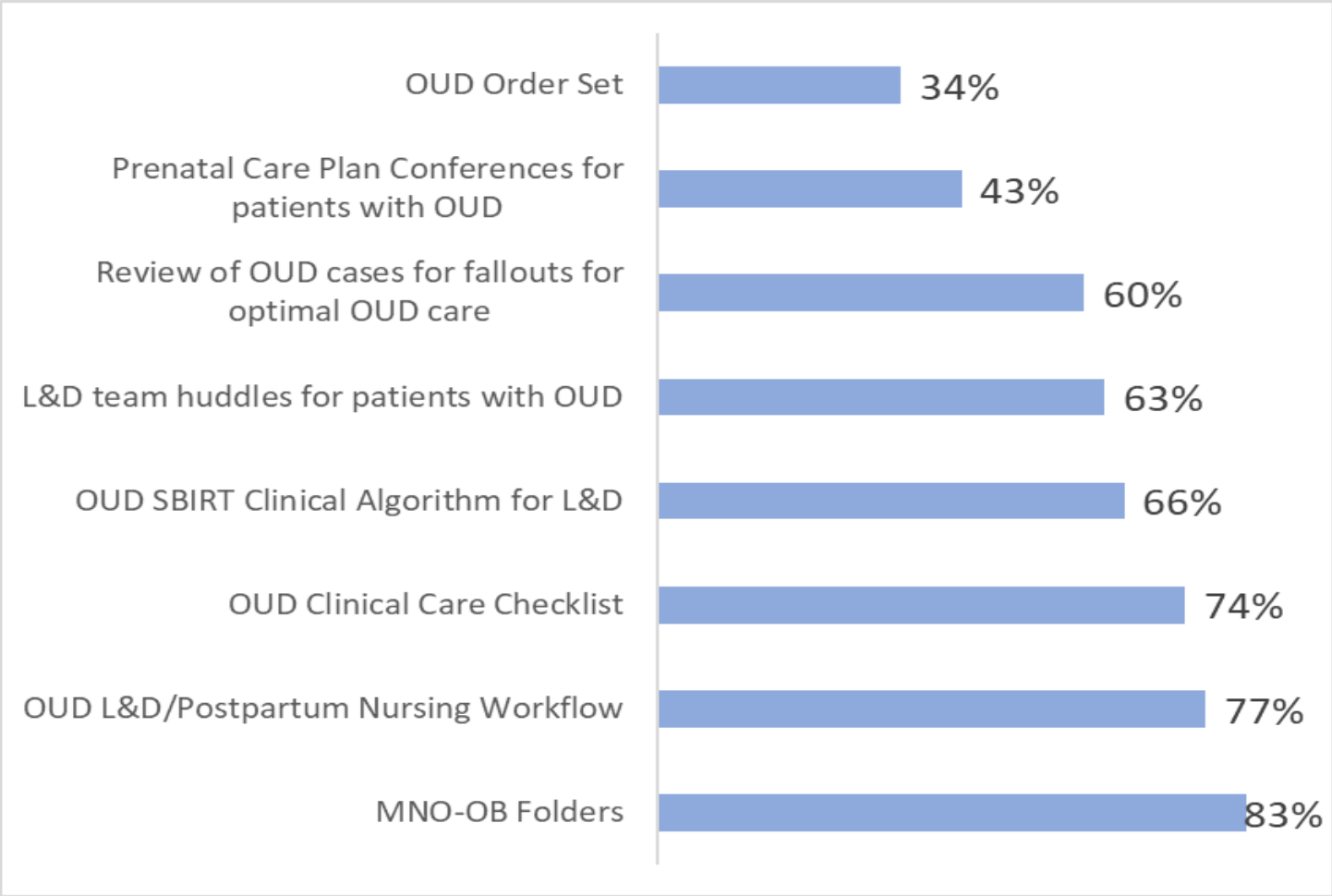
Questions:

- How do we best help teams get across the finish line to achieve initiative aims in 2023?
- What QI strategies could be most effective to drive culture change?
- Share ideas for fall out review, providing feedback or improving provider buy-in from Table Discussions?

Mothers and Newborns affected by Opioids- OB

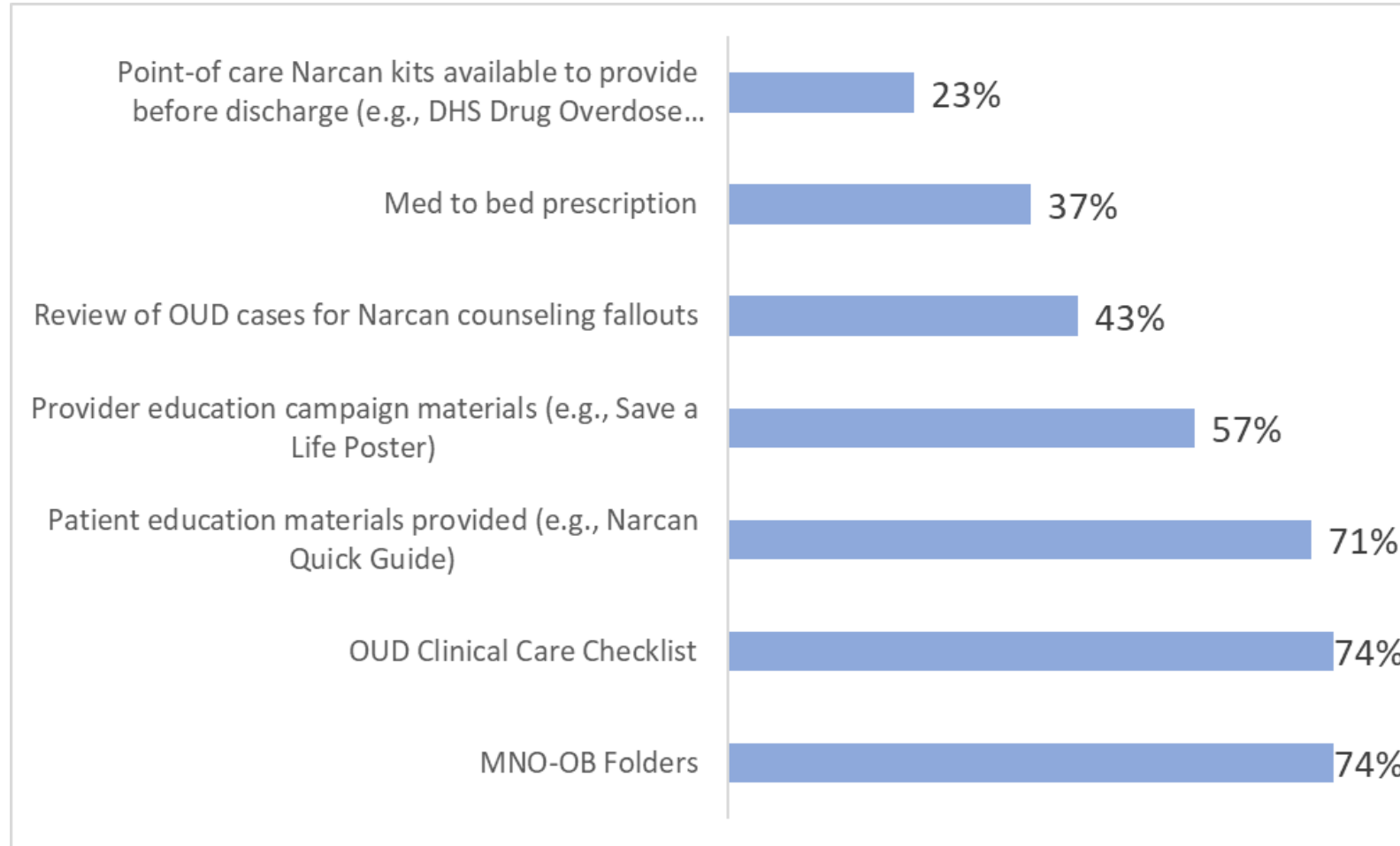
Sustainability strategies for the next year

Sustainability strategies to facilitate optimal care for all pregnant & postpartum patients with OUD

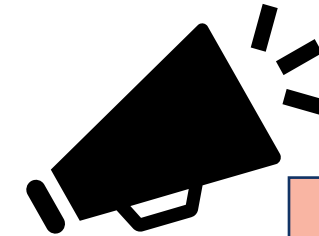


2022 Teams
Survey

Strategies implemented to assist the OB clinical team in providing Narcan counseling strategies and prescription offers



2022 Teams
Survey



Don't miss out:
Only 17% of teams have signed up to participate in DHS Drug Overdose Prevention Program!

Key resources teams are using to connect patients with OUD to MAT and RTs prenatally or by delivery discharge

2022 Teams
Survey

46%



Help navigate OUD patients to treatment and recovery services 24/7

49%

Illinois **DocAssist**

Answering primary care behavioral health questions about children, adolescents, and perinatal patients

Warmline for free perinatal substance use technical/clinical support for providers caring for OUD patients

DHS/SUPR Drug Overdose Prevention Program (DOPP):

- Your hospital can apply now to receive free Narcan kits to hand out on L&D and ERs
- Hospitals can send general inquiries, e-mail:
DHS.DOPP.Coordinator@Illinois.gov
- **NEVER** has there been an easier way to get patients Narcan kits before delivery discharge... and for free!



OUD Helpline Communication Campaign for OB & ED Units

Provider poster for OB & ED Units


Recovery is possible.

Overdose is a leading cause of death in pregnant women. And there's no better time than pregnancy for a woman to begin treatment for opioid use disorder.

Medication assisted recovery (MAR) is an evidence-based treatment proven to improve outcomes, decrease the risk of relapse, and reduce maternal death. And it's perfectly safe for a pregnant woman and her unborn child.


To help your patient find the recovery, treatment, and services that she needs, connect with the IL Helpline.



Call 833-234-6343
Text 833234
Visit [HelplineIL.org](https://helplineil.org)



ILLINOIS HELPLINE
for Opioids & Other Substances

Help is here.







Wallet Card for OB & ED Patients

Recovery is possible.

Pregnancy and post-delivery is an ideal time to connect to treatment and recovery services.

Call 833-234-6343
Text 833234
Visit [HelplineIL.org](https://helplineil.org)



ILLINOIS HELPLINE
for Opioids & Other Substances

Help is here.

Magnet for OB & ED Units

Recovery is possible.

Find treatment, recovery, and other services for pregnant and post-partum women.

Call 833-234-6343 Text 833234
Visit [HelplineIL.org](https://helplineil.org)

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Call **833-234-6343**

Text **833234**

Visit **HelplineIL.org**



Help is here.



Kelsi
in recovery (and in love) since 2019





MAR NOW launched May 9, 2022 as Chicago Pilot

Program provides low-barrier, rapid access to buprenorphine, methadone, and naltrexone to all callers regardless of insurance status, income, ability to pay, documentation status within 48 hours of first call.

Individual calls
existing 24/7 IL
Helpline

833-234-6343

6am-10pm

Connected to Care Manager & Provider

10pm-6am

Leave message, receive callback next day from Care Manager

Patient Options:

1. Buprenorphine home induction
2. Same or next-day MAR appointment at FGC (methadone, buprenorphine, naltrexone)
3. Connection to other SUD care in the community (withdrawal management, residential treatment)

Care Managers provide **free transportation**, insurance enrollment, assistance with pharmacy access, and follow up to ensure patient is connected to long-term care

Angel's Story

- NEW ILPQC provider education video
- An inspiring patient story that touches on the importance of SBIRT, reducing stigma and providing Narcan to all at-risk patients
- Find this video on our [youtube channel](#) or ilpqc.org



Discussion of Future ILPQC Initiatives

10th Annual Conference

October 27, 2022



Potential Future Initiatives for 2024-2025

Maternal Mental
Health

Cardiovascular
Health

Improving Access
to Postpartum

OB Teams Survey

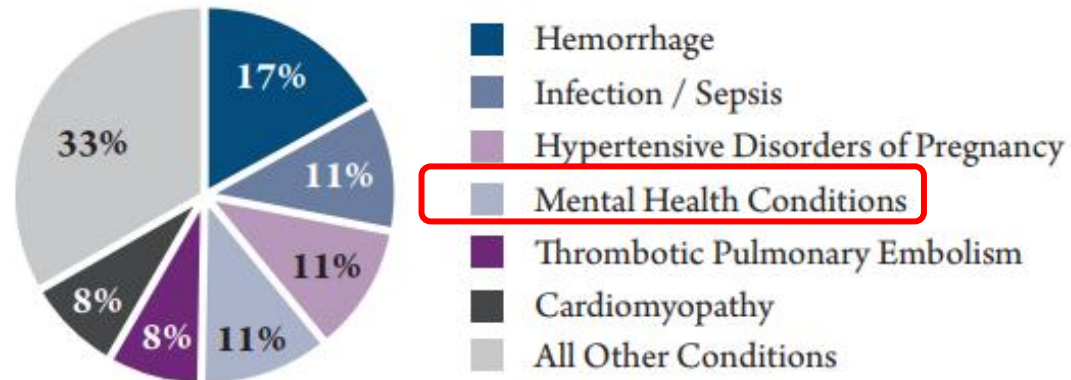
	Future Initiative	% of support from OB Teams Survey
1.	Reducing Primary C-Section	62.5%
2.	Maternal Mental Health	56.3%
3.	Postpartum Care Basics for Maternal Safety	43.8%
4.	Support after a Severe Maternal Event	40%
5.	Reducing Racial/Ethnic Disparities	31.3%
6.	Supporting/Promoting Breastfeeding	27.5%
7.	Maternal VTE	26.3%
8.	Obstetric Hemorrhage 2.0	22.5%

2018 OB Teams
Survey Results
(84 teams)

	Future Initiative	% of interest from OB Teams Survey
1.	Maternal Cardiac Conditions	65%
2.	Maternal Mental Health	59%
3.	Postpartum Discharge Transitions	41%
4.	Shared Decision-Making	29%

2022 OB Teams
Survey Results
(56 teams)

Figure 14: Underlying Cause of Death for Pregnancy-Related Deaths, Illinois 2015



2018 IDPH MMMR

Cardiomyopathy and other cardiovascular conditions included in all other causes combined (4 or less cases)

Table 1. Top Four Underlying Cause of Death Categories for Pregnancy-Related Deaths, Illinois 2016-2017

Cause of Death Category	Number of Pregnancy-Related Deaths	Percent of Pregnancy-Related Deaths
Mental Health Conditions*	24	40%
Pre-existing Chronic Medical Condition**	5	8%
Hemorrhage	5	8%
Hypertensive Disorders of Pregnancy	5	8%
All Other Causes Combined***	21	35%

Due to rounding, percentages in this figure do not add up to 100%

* Includes deaths due to depression, schizophrenia, and substance use disorder

** These deaths were related to health conditions that women were known to have prior to pregnancy, including: lupus, sickle cell disease, and end-stage renal disease. These deaths are included as "non-cardiovascular deaths" by the CDC PMSS.

*** Each of the other cause of death categories accounted for fewer than five deaths during the two-year period and are not able to be reported individually.

April 2021

2021 IDPH MMMR

Mental Health



AIM PATIENT SAFETY BUNDLES

AIM develops multidisciplinary, clinical-condition specific patient safety bundles to support best



Perinatal Mental Health
Conditions - in
development

Other states
are working
on this



Maternal Mental Health
Collaborative And
Framework



Nebraska Perinatal Quality Improvement Collaborative

Aligns well with MMRC data as
leading cause of maternal death
in Illinois and increased challenge
during pandemic

Maternal Mental Health



UWNQC
Utah Women & Newborns Quality Collaborative

Cardiovascular Health



AIM PATIENT SAFETY BUNDLES

AIM develops multidisciplinary, clinical-condition specific patient safety bundles to support best



Cardiac Conditions in
Obstetrical Care

National data on racial
disparities in maternal
cardiac conditions, an
important cause of
maternal death

Other states
have
resources

CMQCC

California Maternal
Quality Care Collaborative

Cardiovascular Disease Toolkit

Cardiac Conditions in Obstetrical Care



Timing of Future OB Initiatives



- Continue support for teams still trying to get across the finish line to complete Key Strategies for PVB/BE through 2023
- PVB and BE goal to move into sustainability with some continued support after January 2024
- Additional input from hospital teams, community advisory board, leadership team, stakeholders on options for future initiative
- Goal to launch new OB initiative in 2024



SAVE the DATES

**2023 OB & Neonatal
Face-to-Face Meetings**

**Calling ALL Perinatal Leaders, Providers,
Nurses, Advocates, and Friends!**

Join us for an interactive day of collaborative
learning with all the ILPQC initiative!

OB Teams:

May 24th 2023

Neonatal Teams:

May 25th 2023

More Information Coming Soon!

**President Abraham Lincoln
Doubletree Hotel
Springfield, IL**

**ILPQC 11th Annual Conference Thursday,
November 2, 2023**