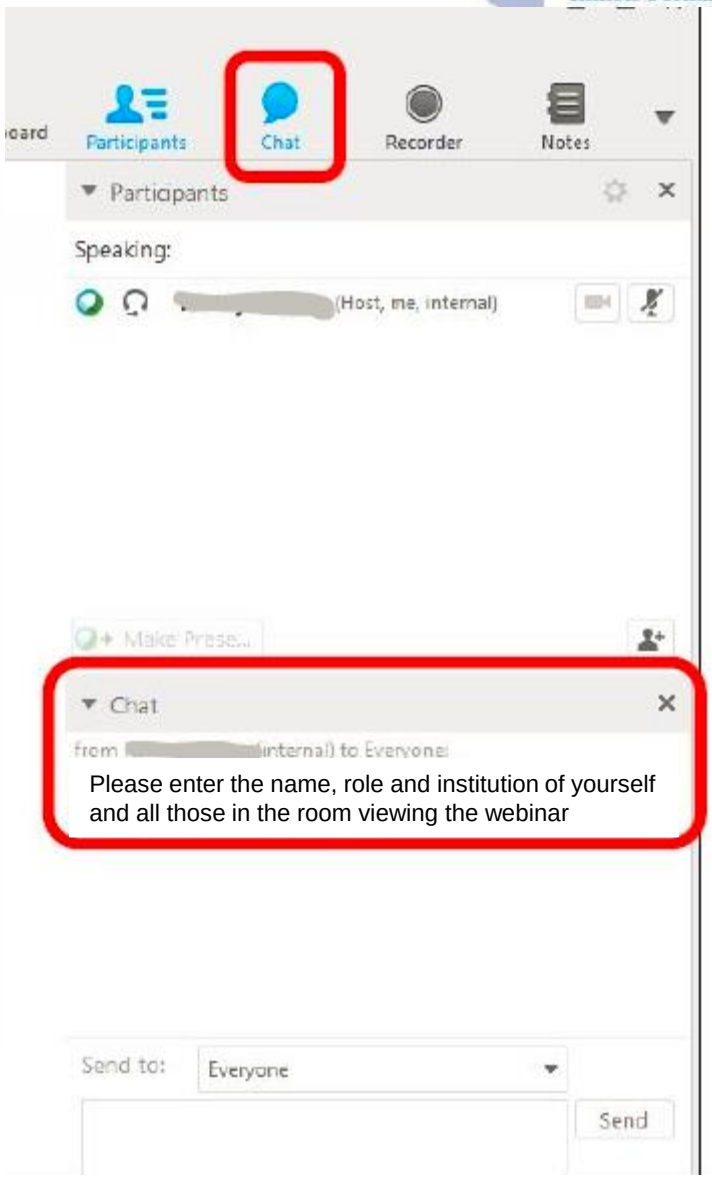
Promoting Vaginal Birth Launch Call

May 4th , 2020

11:00 – 12:30 PM

Introductions

- Please enter for yourself and all those in the room with you viewing the webinar into the chat box your:
  - Name
  - Role
  - Institution
- If you are only on the phone line, please be sure to let us know so we can note your attendance



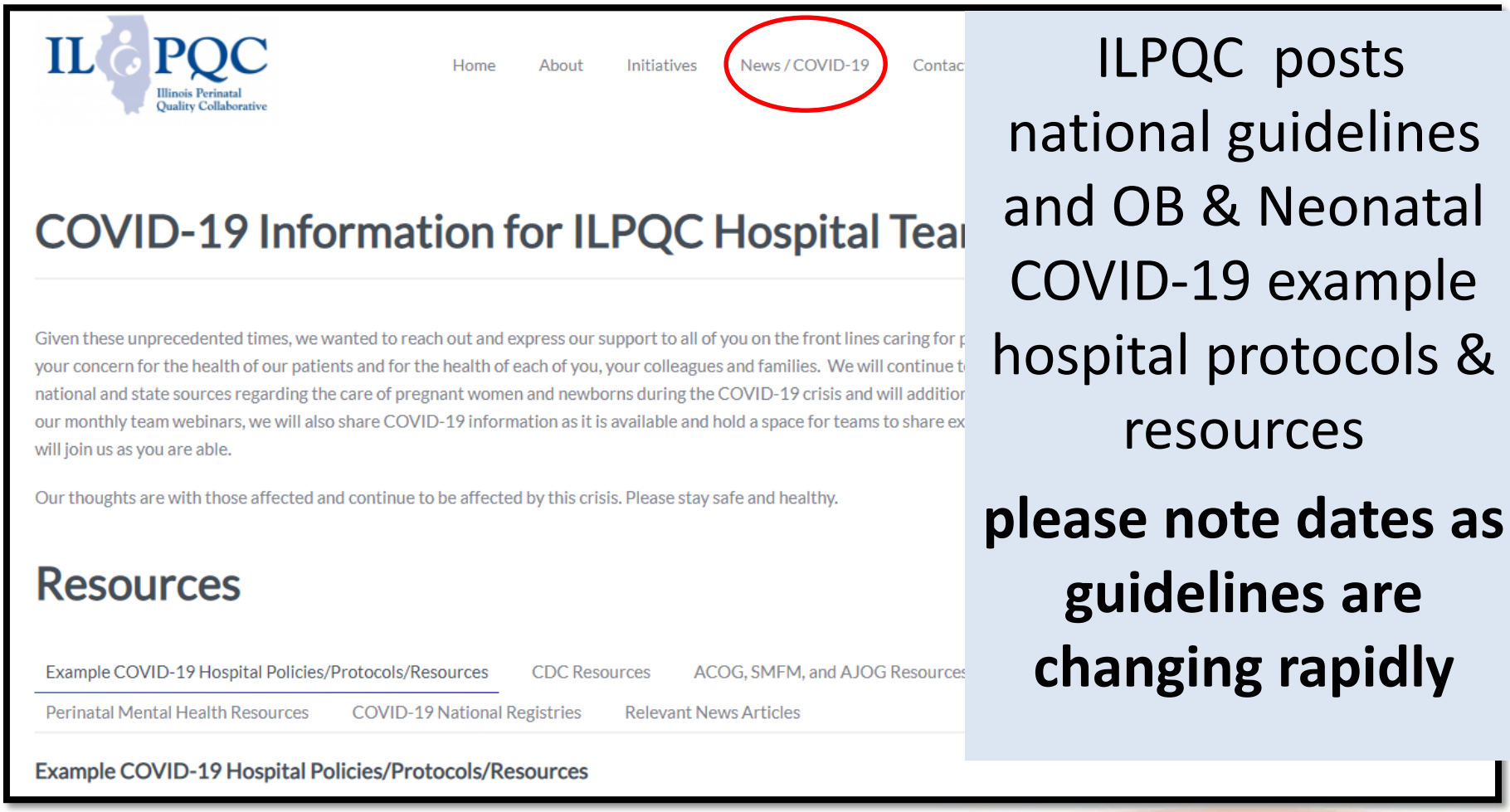
Overview

- COVID 19 Resources
- Why PVB?
- ILPQC Structure and Supports
- Initiative overview
- Guest Speaker- Christa Sakowski CMQCC
- Getting Started with PVB
- Upcoming Events & Next Steps
  - Face-to-Face

ILPQC COVID-19 Webinars

- Weekly COVID-19 OB/Neo Strategies Webinars in coordination with IDPH, Fridays 12-1pm with OB/Neo leaders sharing cases and strategies
- Please see https://ilpqc.org/covid-19-information/ for future webinar registration, and prior recorded webinars
- Questions from webinars answered by OB/Neo leaders and posted weekly
  - Q/A from 4.17.2020 webinar
  - Q/A from 4.10.2020 webinar
  - Q/A from 4.3.2020 webinar

ILPQC COVID-19 Webpage www.ilpqc.org



ILPQC posts national guidelines and OB & Neonatal COVID-19 example hospital protocols & resources

please note dates as guidelines are changing rapidly

https://ilpqc.org/covid-19-information/

ILPQC COVID-19 Webpage Resources

- Please click here for COVID-19 resource webpage

Updated OB/Neo Resources

- AAP- Initial Guidance: Management of Infants Born to Mothers with COVID-19 (4.2.2020)
- NEJM: Universal Screening for SARS-COV-2 in Women Admitted for Delivery (4.13.2020)**
- SMFM and SOAP: Labor and Delivery COVID-19 Considerations (4.14.2020)
- CDC: COVID-19 OB Care FAQs (4.16.2020)
- ACOG: COVID-19 Practice Advisory (4.23.2020)

New Patient Education Resources

- ACOG: COVID-19 Pregnancy & Breastfeeding: A Message to Patients (English & Spanish) (4.16.2020)
- Advocate Children's Hospital: Caring for Your Infant During the COVID-19 Pandemic (4.14.2020)
- "Is It Safe to Provide Milk for my Baby if I Have, or Have Been Exposed to, COVID-19" (Adapted by ILPQC with permissions 4/2020)
- "If Your Doctors Suspect You Have COVID-19" (Adapted by ILPQC with permissions 4/2020)
- March of Dimes: COVID-19: What You Need to Know About its Impact on Moms and Babies (4.8.2020)
- IL EverThrive: Protecting and Caring for Your Family During the Coronavirus Outbreak (4.3.2020)
- SMFM Information for Women & Families (4.3.2020)
- The 4th Trimester Project's patient education website on COVID-19 For New Moms (3.2020)

COVID-19 OB & Neonatal National Registries

OB Registry:

- PRIORITY: Nationwide registry established by UCSF for pregnant and postpartum women with suspected COVID-19 or confirmed diagnosis. The goal is to gather a high volume of nationwide data quickly.
- CDC is collecting surveillance data on pregnant women with COVID through a supplement to the regular case report form (CRF), which should be completed on all COVID-19 cases. The CRF can be found online.

IL Perinatal Depression & Anxiety Hotline

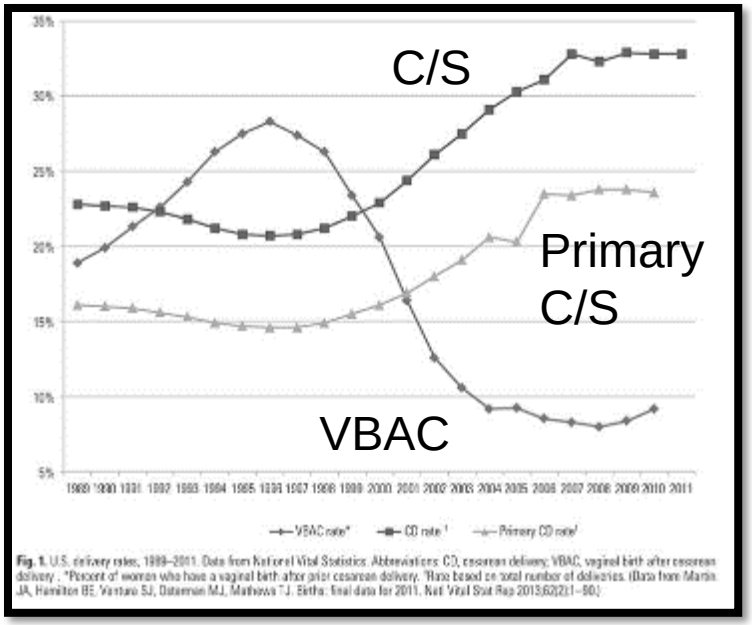
- Answered live 24/7
- Staffed by licensed mental health professionals trained in perinatal mood & anxiety disorders
- Support for moms, partners, families & providers

Promoting Vaginal Birth (PVB)

WHY-PROMOTING VAGINAL BIRTH

Promoting Vaginal Birth Initiative

- C-Sections increased 60 percent from 1996 to 2011*
- Significant social, economic & health costs, including:
  - ↑ maternal complications and longer recovery times
  - ↑ NICU admissions
  - ↑ barriers to breastfeeding
  - ↑ risk of developing life-threatening complications



*ACOG Safe Prevention of Primary C-Section 2014

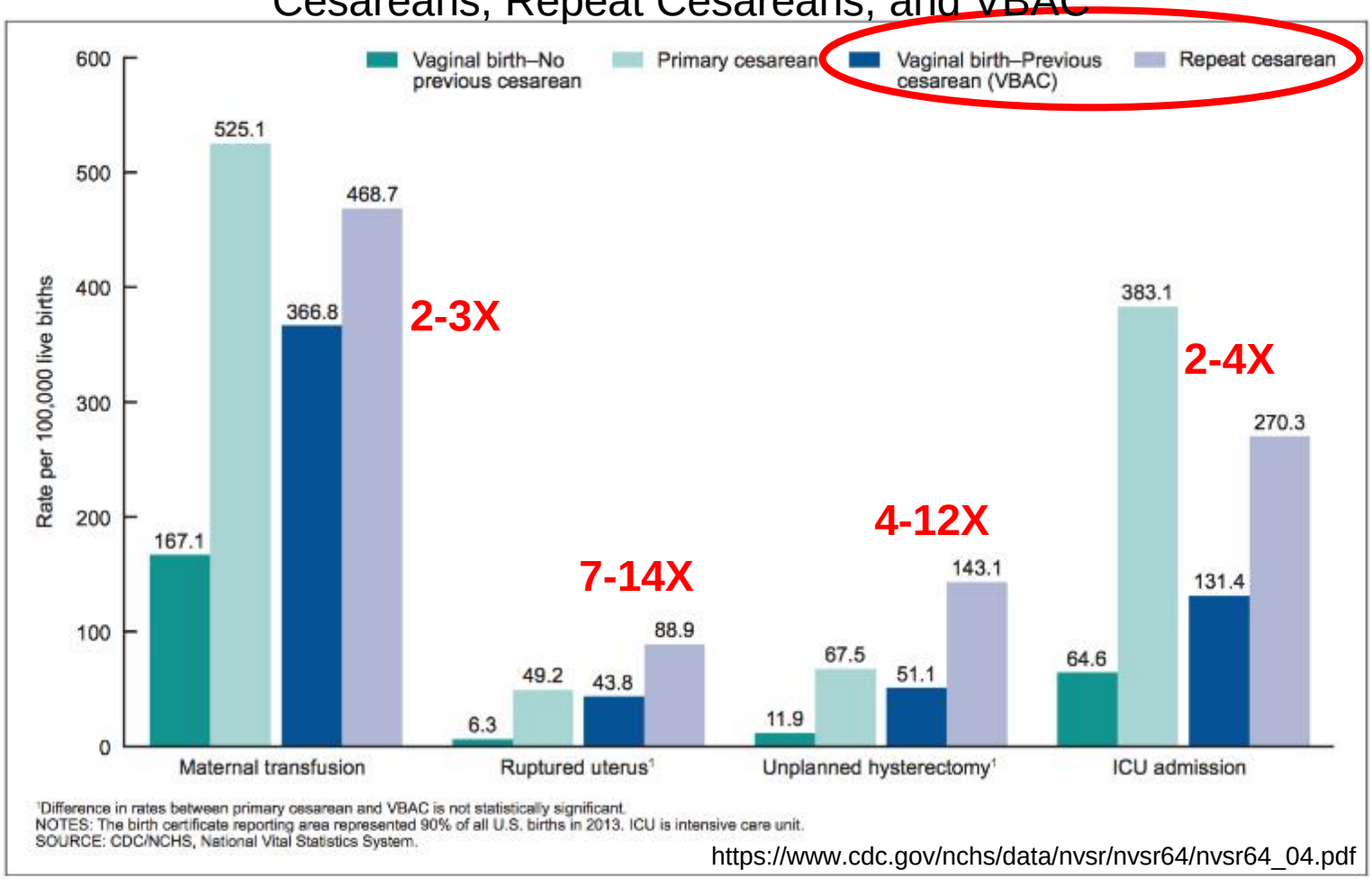
- Quality Improvement Initiatives have shown results
  - CMQCC and FPQC initiatives reduced primary cesarean rates while maintaining optimal neonatal outcomes

Why does this matter?

- Relentless Rise **without Baby or Mother benefit**
  - 6% in early 70's →20% in mid 80's→33% in 2010
  - CP rates, neonatal seizures unchanged since 1980
  - Overall, no benefit for long-term urinary continence
- **Increased maternal and neonatal morbidity**
  - Impaired neonatal respiratory function, NICU admits
  - Affects maternal-infant interaction/breast feeding
  - Increased maternal PP infections, VTE, transfusions
  - Longer recovery, 2X PP re-admissions
- Prior c/s can have **major complications**
  - Placenta previa and accrete leading to possible hysterectomy or worse uterine rupture
  - Abdominal adhesions

Adapted from CMQCC California Maternal Quality Care Collaborative

Major Maternal Complications: Vaginal Births versus Primary Cesareans, Repeat Cesareans, and VBAC



https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_04.pdf

Figure 1. Maternal morbidity, by method of delivery and previous cesarean history: 41-state and District of Columbia reporting area, 2013

QUALITY OF CARE

By Katy Backes Kozhimannil, Michael R. Law, and Beth A. Virnig

Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality And Cost Issues

DOI: 10.1377/hlthaff.2012.1030
HEALTH AFFAIRS 32,
NO. 3 (2013): 527–535

ABSTRACT **Cesarean delivery is the most commonly performed surgical procedure in the United States, and cesarean rates are increasing. Working with 2009 data from 593 US hospitals nationwide, we found that cesarean rates varied tenfold across hospitals, from 7.1 percent to 69.9 percent. Even for women with lower-risk pregnancies, in which more limited variation might be expected, cesarean rates varied fifteenfold, from 2.4 percent to 36.5 percent. Thus, vast differences in practice patterns are likely to be driving the costly overuse of cesarean delivery in many US hospitals. Because Medicaid pays for nearly half of US births, government efforts to decrease variation are warranted. We focus on four promising directions for reducing these variations, including better coordinating maternity care, collecting and measuring more data, tying Medicaid payment to quality improvement, and enhancing patient-centered decision making through public reporting.**

Katy Backes Kozhimannil (kbk@umn.edu) is an assistant professor in the Division of Health Policy and Management, School of Public Health, University of Minnesota, in Minneapolis.

Michael R. Law is an assistant professor in the Centre for Health Services and Policy Research, School of Population and Public Health, at the University of British Columbia, in Vancouver.

Beth A. Virnig is associate dean of research and a professor at the School of Public Health, University of Minnesota.

People

8/3/2017

Charles V, Charles IV and Kira Johnson

How Judge Hatchett's Son Is Coping After His Wife's Childbirth Death

(Healthy woman with complications resulting in death during "routine" repeat Cesarean)

COSMOPOLITAN

8/21/2017

I Almost Died During Childbirth. I'm Not Alone.

(Healthy woman with major complications during "routine" repeat Cesarean: "Near Miss" now with PTSD)

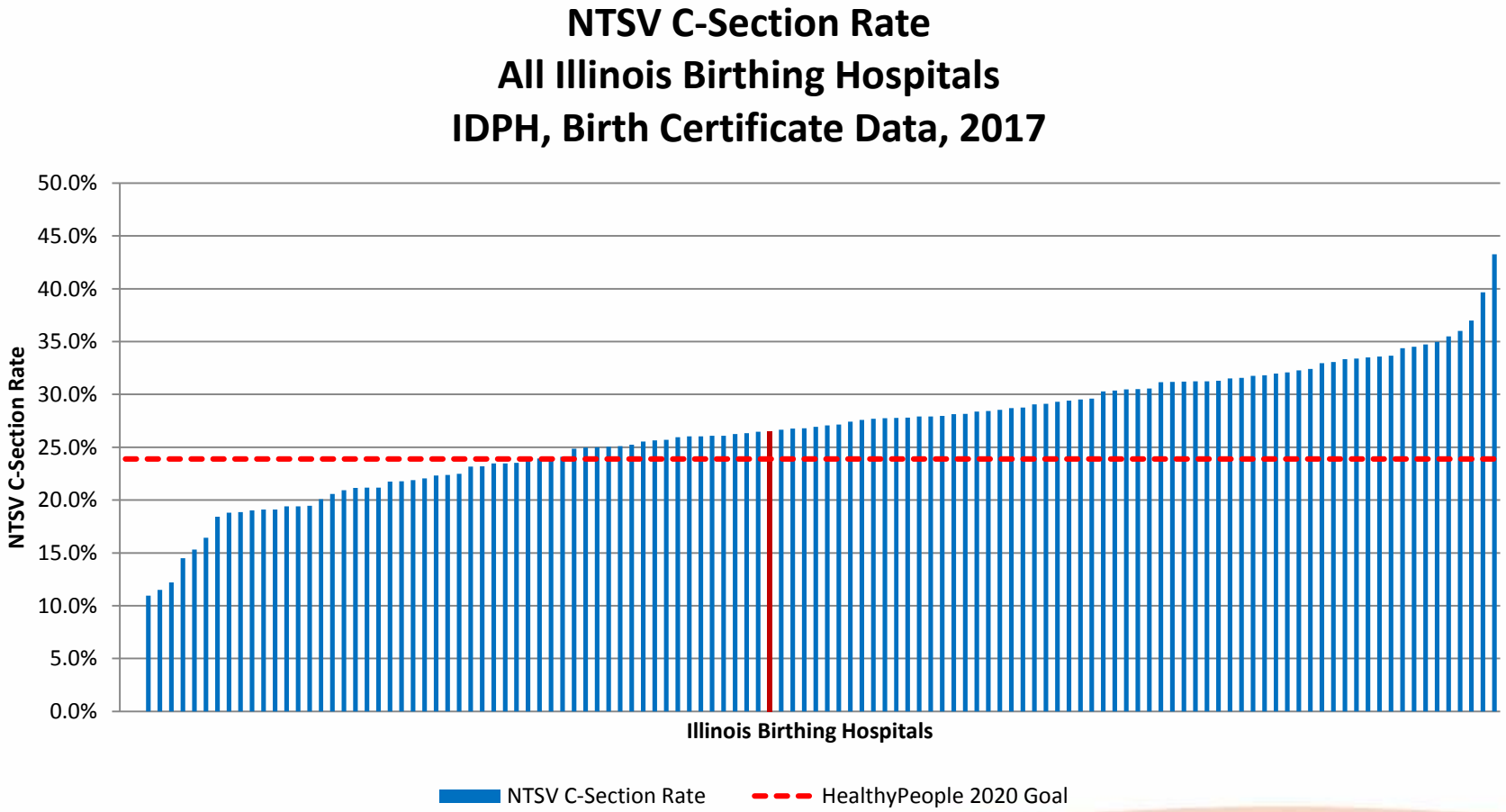
Adapted from CMQCC California Maternal Quality Care Collaborative

What Indications Have Driven the **RISE** in CS?

Cesarean Indication	Percent of the Increase in Primary Cesarean Rate Attributable to this Indication
Labor complications **(Failure to progress and Fetal concerns)**	**60%**
Breech	
Multiple Gest	
Various Obst Conditions (F Hypertensior	
"Elective" (de scheduled without "medical indication")	10%

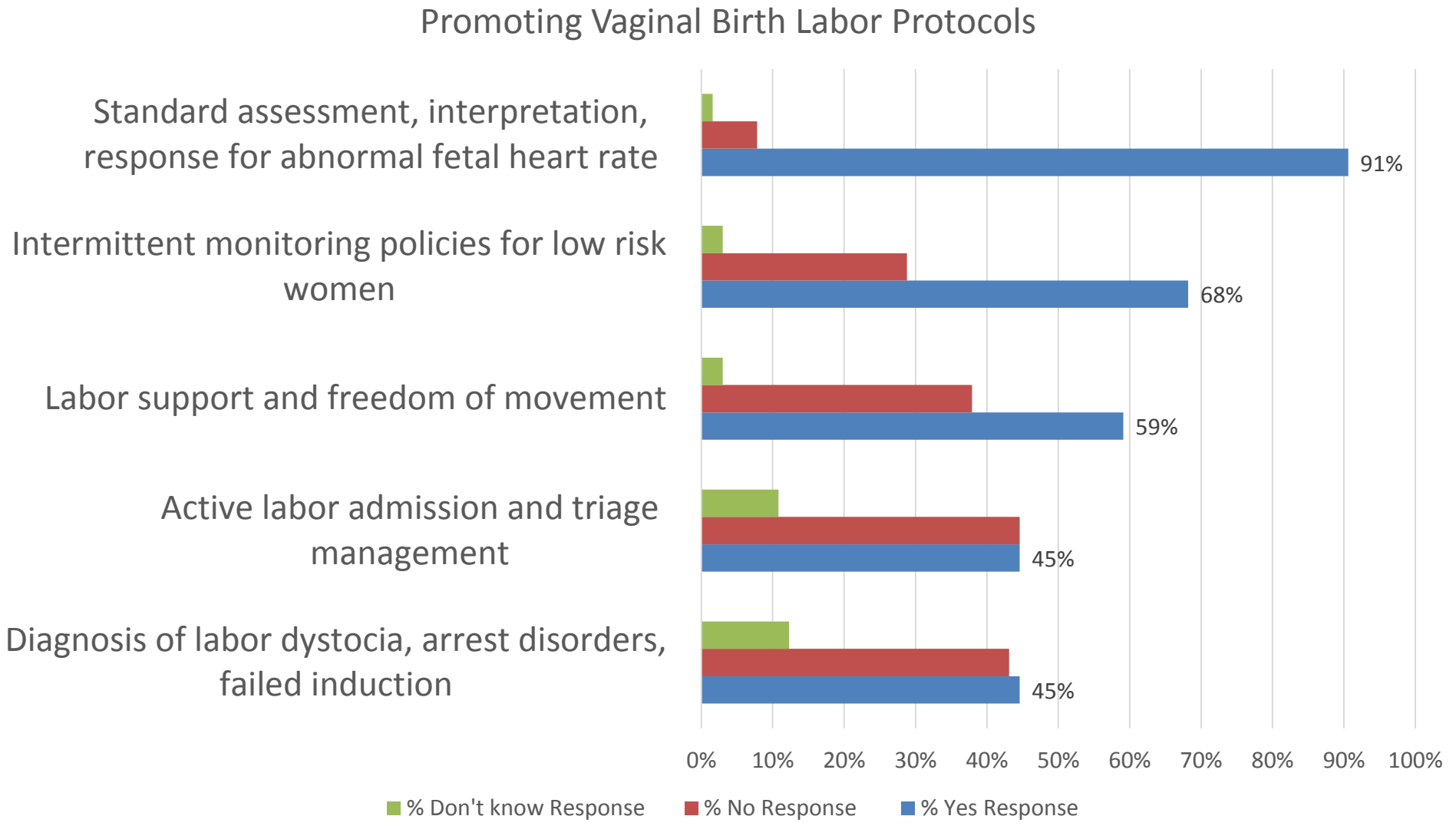
Quality Improvement Focus: How can we prevent the development of Labor Indications for Cesarean?

Illinois NTSV C-Section Rate Data



Current labor support protocols in place

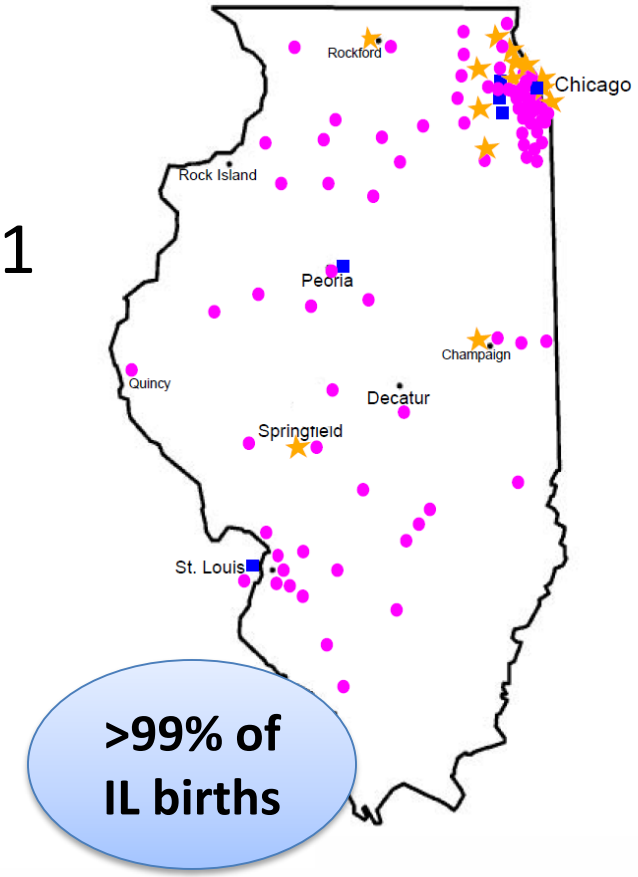
2019 OB Teams Survey Results!



ILPQC STRUCTURE AND SUPPORTS

Illinois Perinatal Quality Collaborative (ILPQC)

- Multi-disciplinary, multi-stakeholder Perinatal Quality Collaborative with 119 Illinois hospitals participating in 1 or more initiative
- Support participating hospitals' implementation of evidenced-based practices using quality improvement science, collaborative learning and rapid response data



ILPQC Central Team

Ann Borders

ILPQC Executive Director, OB Lead

Leslie Caldarelli & Justin Josephsen

Neonatal Leads

Patricia Lee King

State Project Director

Daniel Weiss

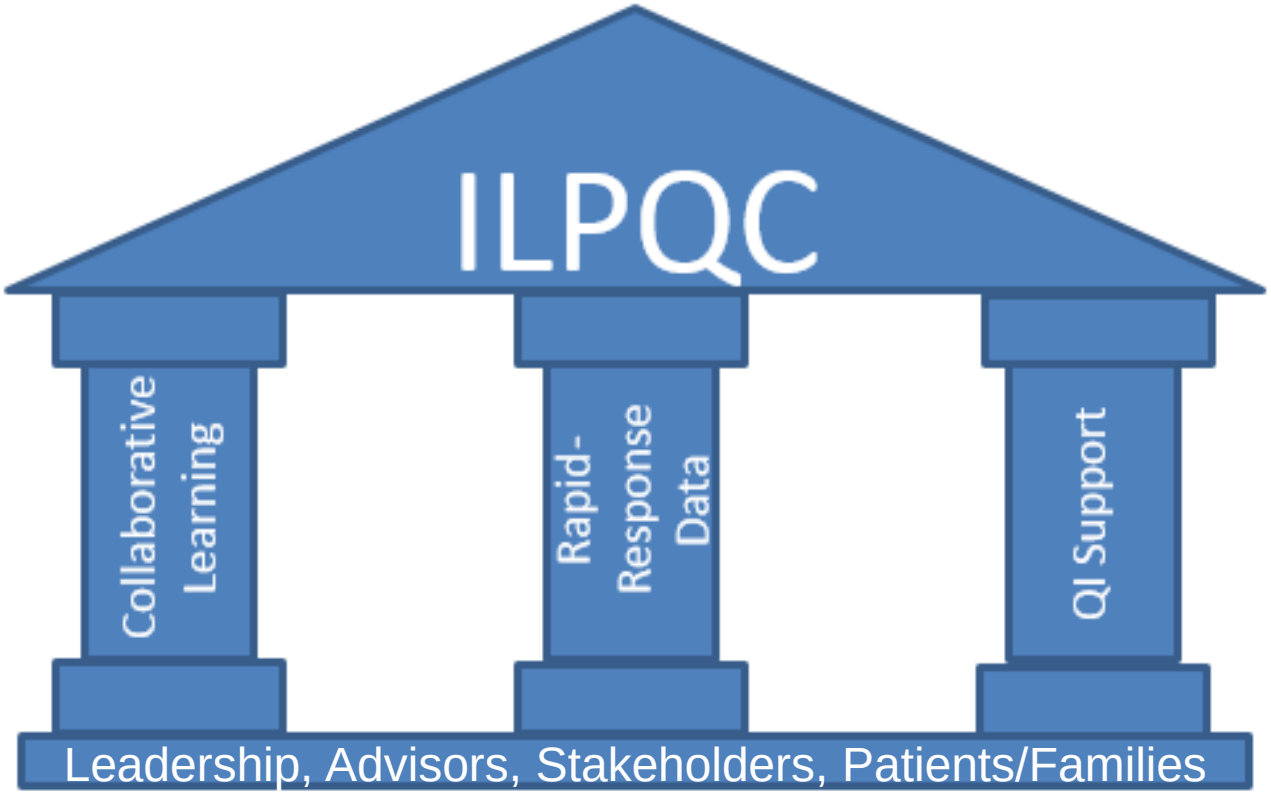
Project Manager

Autumn Perrault

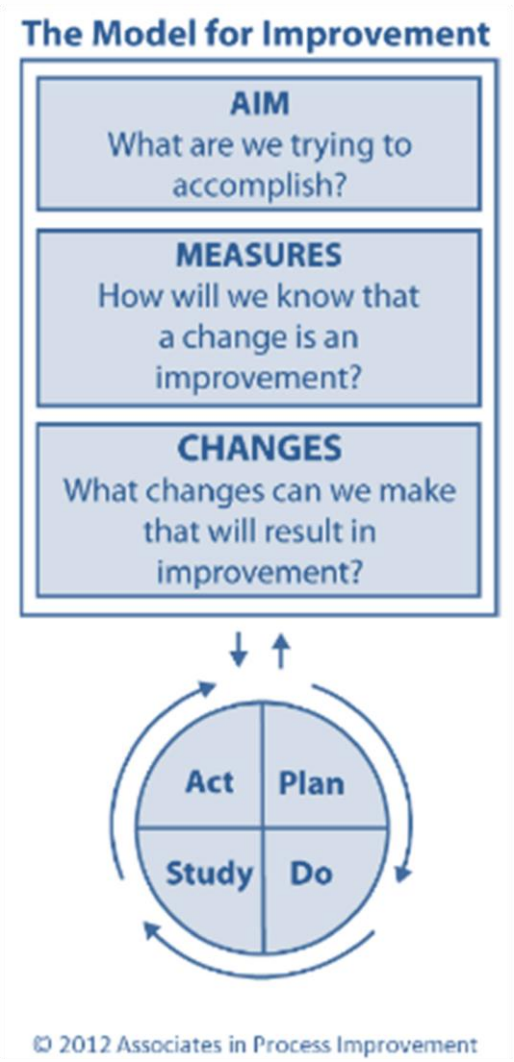
Nurse Quality Manager

info@ilpqc.org OR www.ilpqc.org

ILPQC: Three Pillars Support Quality Improvement Success



What is Quality Improvement?



Hospital QI Work:

What changes can you make to your process/system and test with a PDSA cycle to reach initiative goals?

ILPQC Provides Responsive QI Services to Hospital Teams

ILPQC
Illinois Perinatal Quality Collaborative

Webinars/ Calls

- Monthly collaborative learning calls
- Quarterly QI support calls to individual teams
- Small group QI topic calls as needed

Face to Face

- Spring Face-to-Face Meeting breakouts
- Annual Conference breakouts
- Key Player site visits
- Grand Rounds presentations

ILPQC Resources

- Paper/online QI toolkits
- Patient-education materials
- Monthly e-newsletters
- Webinar recordings

ILPQC Data

- Rapid response data system
- Real-time reports for teams to compare data across time & hospitals
- Data system training calls

Quality Improvement Support Services

Improving Postpartum Access to Care (IPAC)

INITIATIVE OVERVIEW

Promoting Vaginal Birth (PVB)
What will we focus on?

IL PQC
Illinois Perinatal Quality Collaborative

- Optimizing Labor Management and support
- Protocols and Guidelines for Induction and Labor Decision Making
- Provider, Nurse, Patient Education to support clinical culture change

ILPQC Promoting Vaginal Birth

Aim: 70% of participating hospitals will be at or below the Healthy People goal of 24.7% cesarean delivery rate among NTSV births by December 31, 2021.

To optimize the health of women by facilitating clinical culture change to optimize vaginal delivery, develop and implement standard protocols and guidelines for induction and C-section decision making, and educate providers, nurses, and patients on optimal labor management

Key Goals:

- Increase % of c/s deliveries among NTSV births that meet ACOG/SMFM criteria for cesarean
- Increase % of physicians/midwives/nurses educated on ACOG/SMFM criteria for cesarean, labor management strategies/response to labor challenges, protocol for facilitating decision huddles and/or decision debriefs

PVB Smart Aim: To support vaginal birth and reduce primary cesareans to reach the Healthy People goal for low risk cesarean section target rate of 24.7% by December 2021

Key QI Strategies

1. Facilitate clinical culture change that promotes and supports vaginal birth
2. Develop standardized processes for induction and labor support
3. Develop standardized protocols for identification and response to labor challenges / abnormalities

Promoting Vaginal Birth Key Driver Diagram

AIM

To support vaginal birth and reduce primary cesareans to reach the Healthy People goal for low risk cesarean section target rate of 24.7% by December 2021

Drivers

1. Facilitate clinical culture change that promotes, and supports vaginal birth

2. Develop standardized processes for induction and labor support

3. Develop standardized protocols for identification and response to labor challenges / abnormalities

Strategies

1. Create a QI team of providers, staff & administrators to lead the effort & cultivate buy-in

2. Educate physicians/midwives and nurses on ACOG/SMFM labor management guidelines and labor support techniques

3. Develop patient education with positive messaging to women and families about intended vaginal birth strategies/techniques that prevent cesareans through prenatal classes and patient education

4. Utilize care team huddles/debriefs to identify and review delivery decisions for consistency with process flows/protocols/checklist

5. Integrate order sets, protocols, and documentation for the safe reduction of primary cesareans into EMR

6. Share provider-level measures with department with the goal of working to transparency/open data

7. Implement policies, protocols and support tools for women who present in latent (early) labor to safely encourage early labor at home

8a. Implement policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women

8b. Implement policies and protocols for induction of labor

8c. Implement policies and protocols for pain management and labor support

9. Implement standard criteria for diagnosis and treatment of labor dystocia, arrest disorders and failed induction

10. Develop checklist for ensuring ACOG/SMFM criteria for c/s is met

11a. Implement training/procedures for identification and appropriate interventions for malpositions (e.g. OP/OT)

11b. Implement standardized assessment, and response to fetal heart rate concerns

12. Develop checklist for ensuring ACOG/SMFM criteria for c/s is met

13. Implementation of a workflow process for shared decision making (decision huddle with provider, nurse and patient to review treatment options, risk/benefits, and ACOG/SMFM guidelines)

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PVB AIMs & Measures

IL PQC
Illinois Perinatal Quality Collaborative

Overall Initiative Aim

70% of participating hospitals at or below 24.7% C/S delivery rate (Healthy People 2020) among NTSV births

Overall state C/S rate among NTSV births at or below 24.7%

Structure Measures

Implement provider and nurse education and other strategies to achieve buy-in

Implement standardized protocol/processes for induction, labor support management and response to labor and fetal heart rate abnormalities

Implementation and integration of PVB order sets, protocols and documentation into the EMR

Implementation of a cesarean decision checklist for ACOG/SMFM labor guidelines

Implementation of decision huddles and/or decision debriefs with appropriate care team to standardize use of ACOG/SMFM guidelines and checklist

Implementation of a workflow process for shared decision making (decision huddle with provider, nurse and patient to review treatment options, risk/benefits, and ACOG/SMFM guidelines)

Implementation of standardized patient education promoting vaginal birth strategies

Integration of process to review and share data including provider-level data with clinical team

Process Measures

Percentage of providers and nurses receiving standardized education regarding:

a) ACOG/SMFM labor guidelines
b) labor management strategies/response for labor challenges
c) protocol for facilitating decision huddles and/or decision debriefs

80% of cesarean deliveries among NTSV births meeting ACOG/SMFM criteria for cesarean (based on random sample of deliveries):

a) NTSV spontaneous labor arrest/labor dystocia/FTP/CPD;
b) NTSV induced labor management;
c) FHR abnormalities

Promoting Vaginal Birth Clinical Leads

- **Rob Abrams**, MD, Co-Director, IL South Central Perinatal Center
- **Roma Allen**, DNP, MSN ed., RNC-OB, Perinatal Network Administrator, Loyola University Medical Center
- **Rita Brennan**, DNP, RNC-NIC, APRN, CNS, CPHQ, Outcomes Manager, Women's & Children's Services, Northwestern Medicine Central DuPage Hospital
- **Lakieta Edwards**, DNP, CNM, WHNP-BC, Advocate South Suburban Hospital
- **Abbe Kordik**, MD, Executive Medical Director, Family Birth Center, The University of Chicago
- **Tina Stupek**, MSN, RNC-OB, C-EFM, Northwest Illinois Perinatal Center

Improving Postpartum Access to Care (IPAC)

THE CMQCC STORY- CHRISTA SAKOWSKI

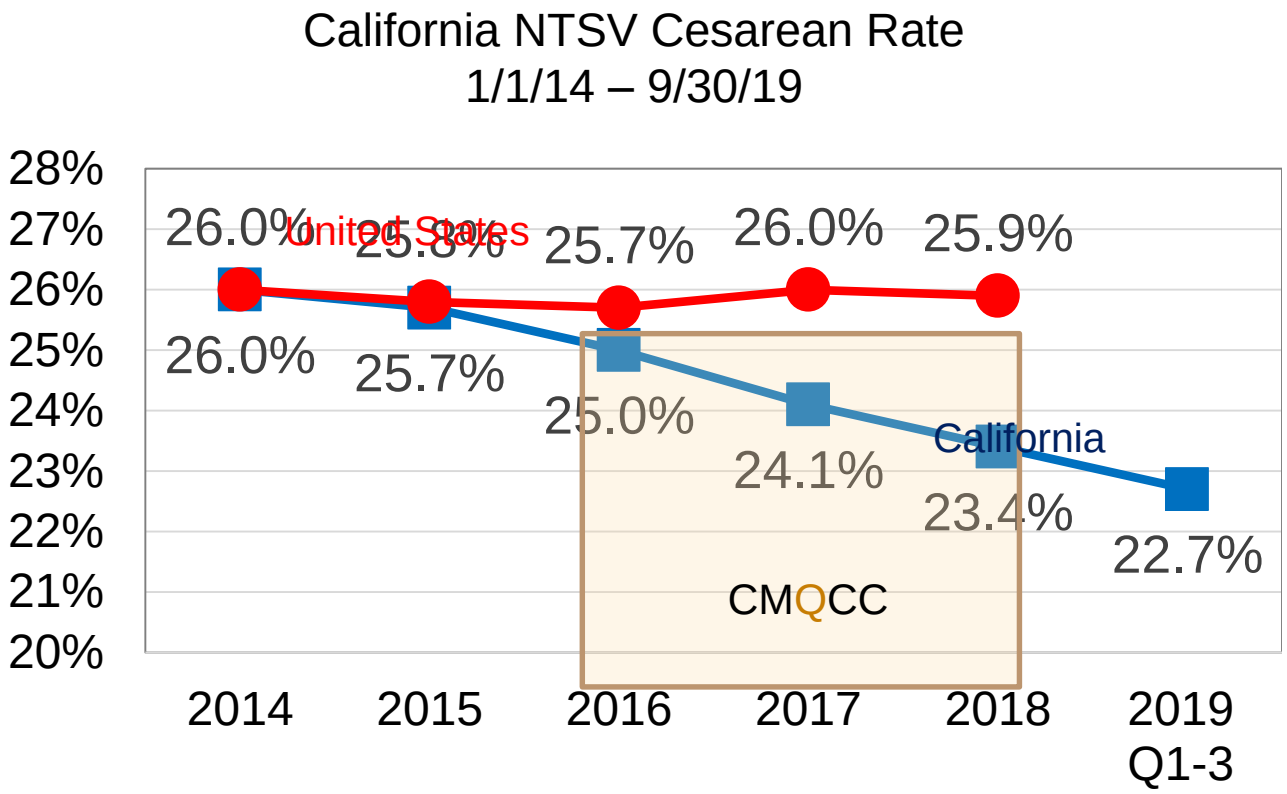
CMQCC
California Maternal Quality Care Collaborative

Moving the Dial - Supporting Vaginal Birth in California

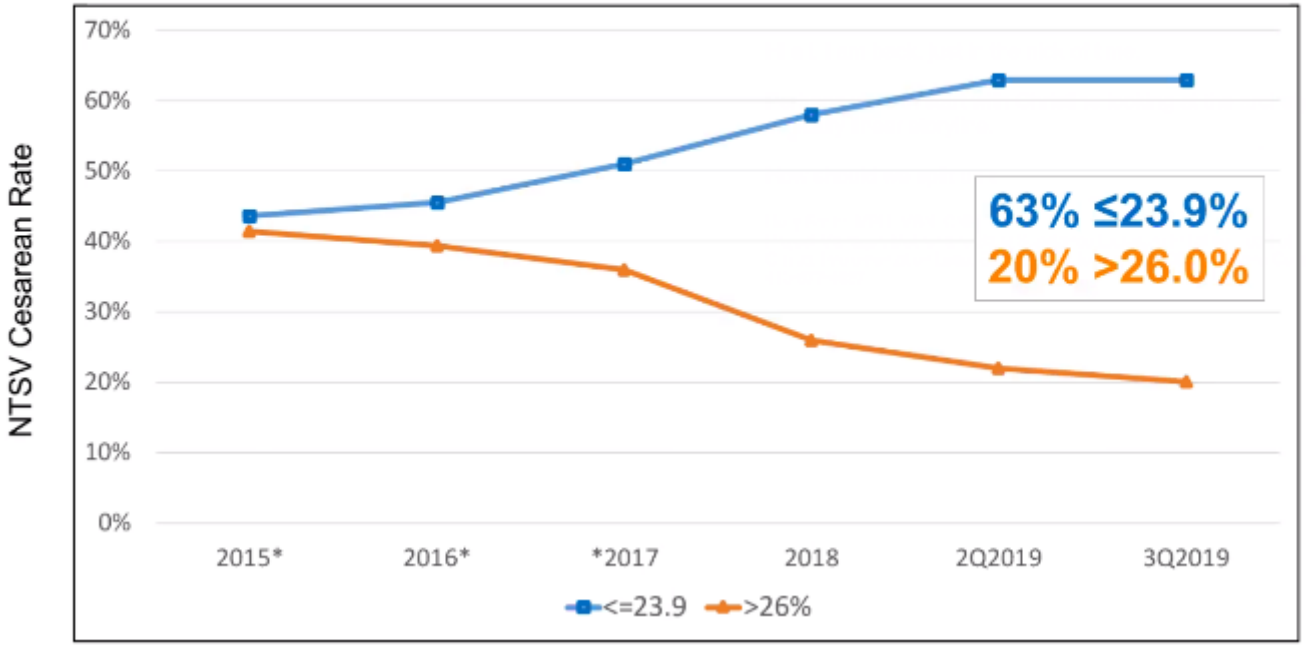
Christa Sakowski, RN, MSN, C-EFM, CLE
Clinical Lead, CMQCC
Co-lead for the Supporting Vaginal Birth Reducing Primary Cesarean Collaborative

Objectives

- Understand the landscape of cesarean in California and the results of a large statewide collaborative for cesarean reduction
- Be familiar with the cesarean reduction strategies that worked in successful facilities
- Identify areas of focus for sustaining success


California NTSV Cesarean Rate
1/1/14 – 9/30/19
28%
27%
26%
25%
24%
23%
22%
21%
20%
United States
26.0%
25.8%
25.7%
26.0%
25.9%
California
26.0%
25.7%
25.0%
24.1%
23.4%
22.7%
CMQCC
2014
2015
2016
2017
2018
2019 Q1-3

CMQCC Member Hospitals (213) with NTSV Cesarean Rates Below 23.9% or Above 26%



Safety of Cesarean Reduction

Cesarean Delivery: *Original Research*

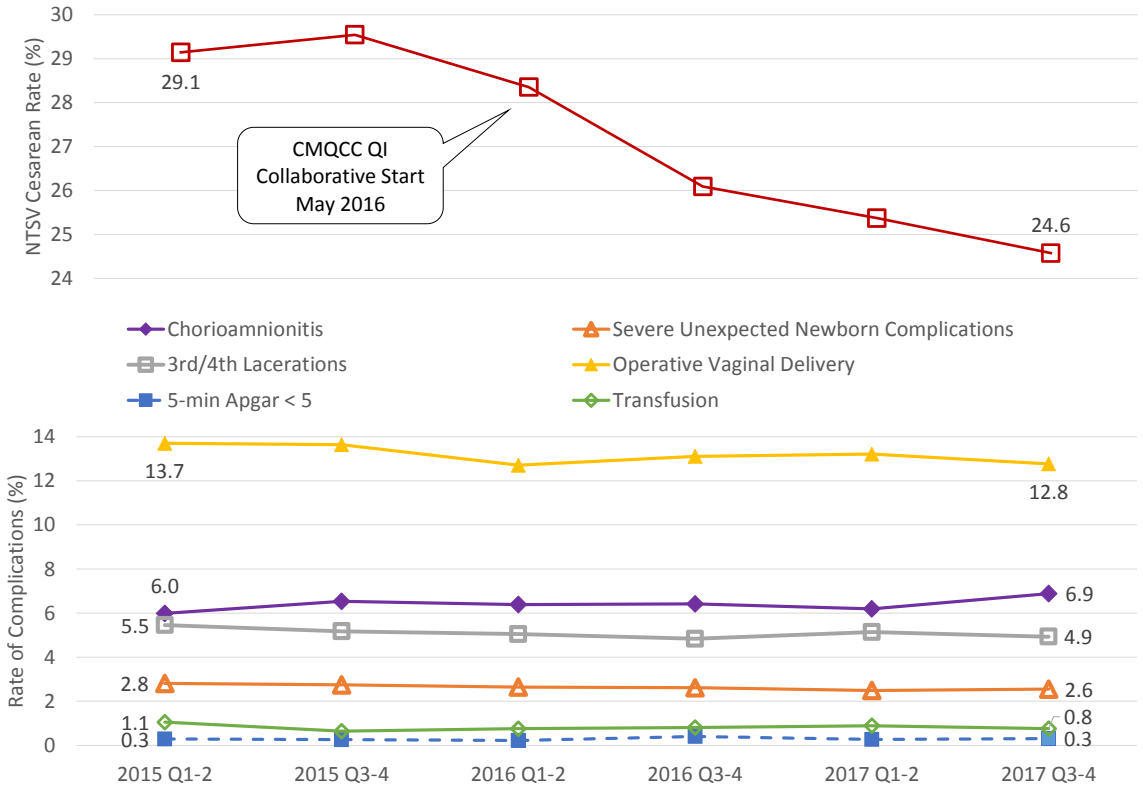
Safety Assessment of a Large-Scale Improvement Collaborative to Reduce Nulliparous Cesarean Delivery Rates

Elliott K. Main, MD, Shen-Chih Chang, MS, PhD, Valerie Cape, Christa Sakowski, MSN, RN, Holly Smith, MPH, MSN, and Julie Vasher, DNP, RNC-OB

RESULTS: Among collaborative hospitals, the nulliparous, term, singleton, vertex cesarean delivery rate fell from 29.3% in 2015 to 25.0% in 2017 (2017 vs 2015 adjusted OR [aOR] 0.76, 95% CI 0.73–0.78). None of the six safety measures showed any difference comparing 2017 to 2015. As a sensitivity analysis, we examined the tercile of hospitals with the greatest decline (31.2%–20.6%, 2017 vs 2015 aOR 0.54, 95% CI 0.50–0.58) to evaluate whether they had greater risk of poor maternal and neonatal outcomes. Again, no measure was statistically worse, and the severe unexpected newborn complications composite actually declined (3.2%–2.2%, aOR 0.71, 95% CI 0.55–0.92).

VOL. 133, NO. 4, APRIL 2019

Trendlines for NTSV Cesarean and Safety Measures (6-month blocks)



Main E. etal. Obstet Gynecol 2019;133:613-23.

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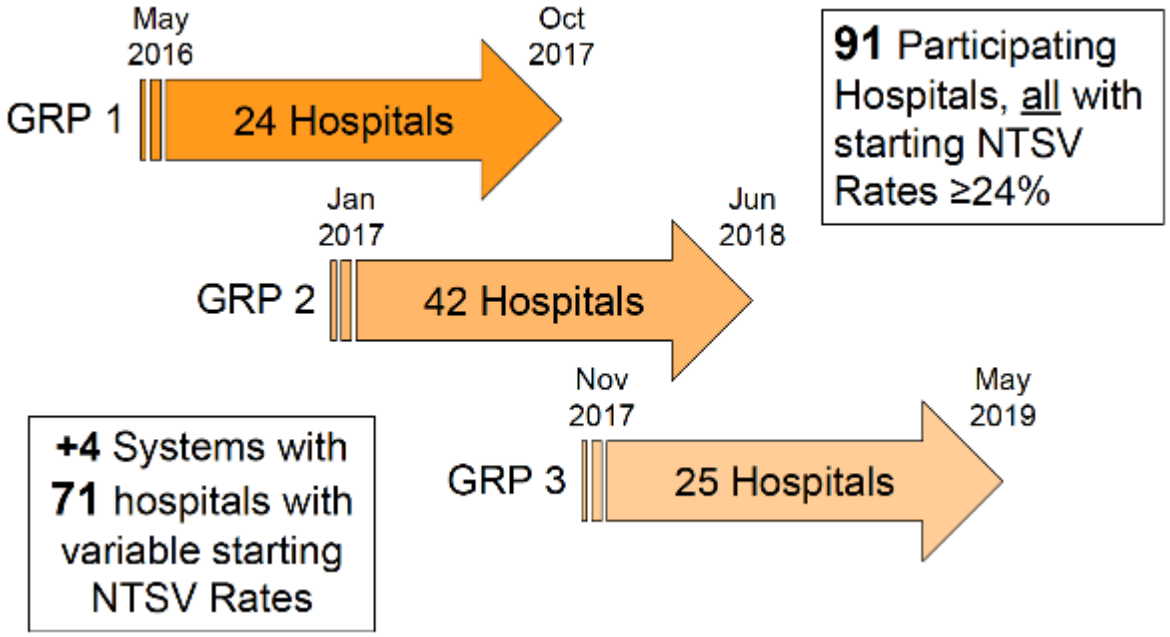
California Maternal
Quality Care Collaborative

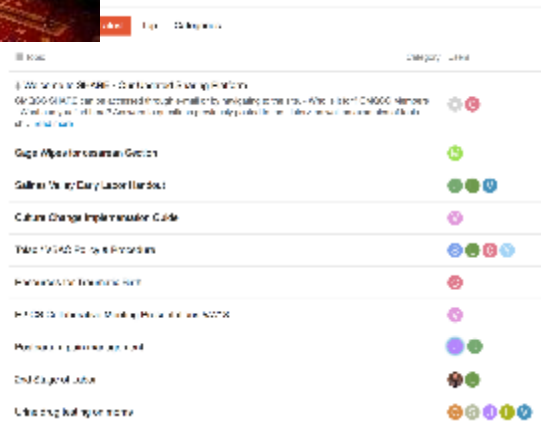
Collaborative Journey to Supporting Vaginal Birth

The CMQCC Collaborative to Support Vaginal Birth

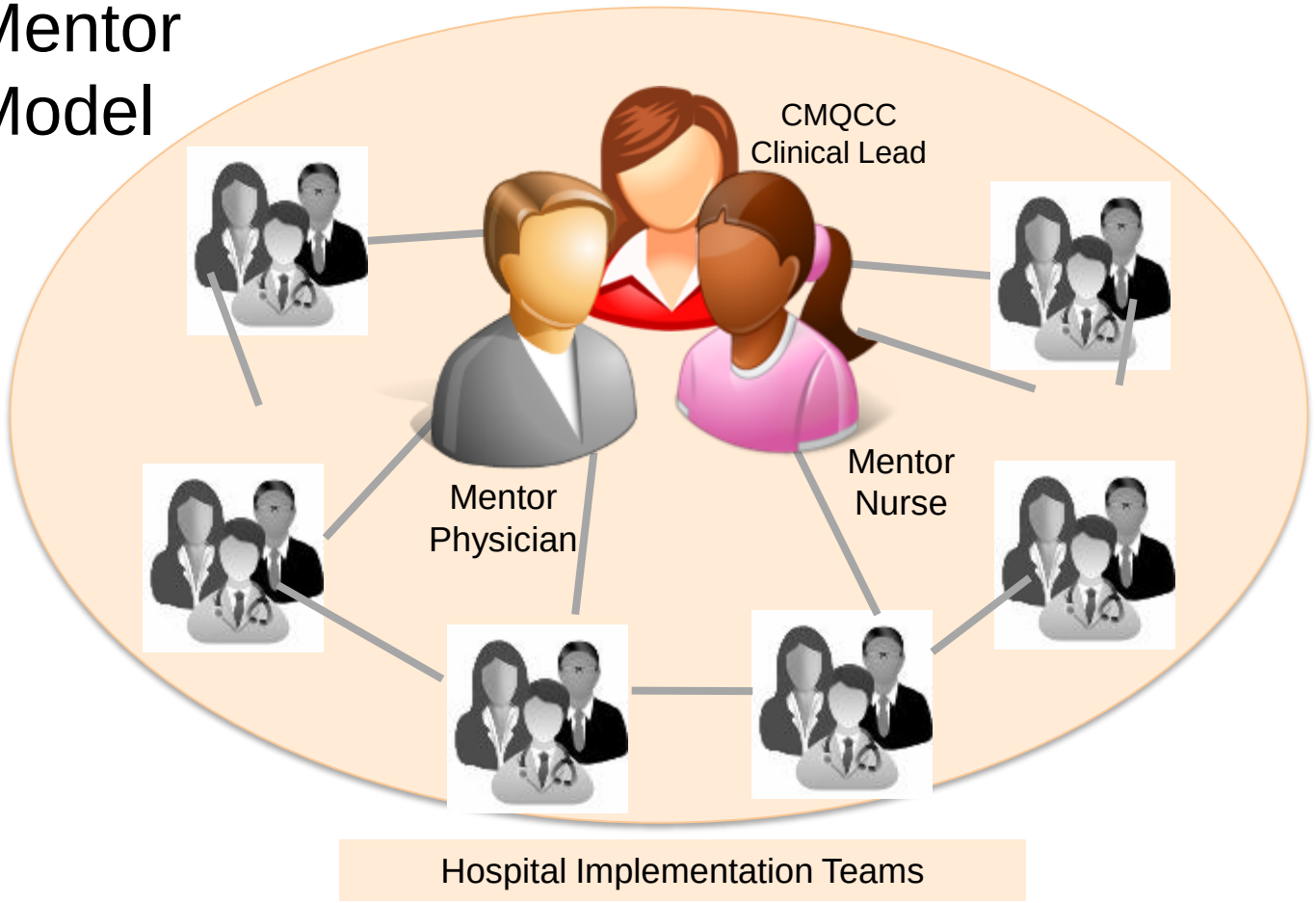


Implementation: Coaching & Sharing

- 18 months
- Mentor-lead
- Site Visits
- CMQCC team
- SHARE



Mentor Model



Features of the Mentor Model

- In-person meetings
  - Kick-off
  - Closing Celebration
- Monthly web-based meetings
- Hospital site visit within first 3-6 months
- Mentor Guidance
- CMQCC Support

40

Characteristics of a Successful Mentor Team

- Training and Resources
- Establish a relationship early
- Timely response to communication
- Prepare for monthly web meetings
- Facilitation of site visit
- Update Structure Measures
- Keep up with monthly Chart Audits in MDC
- Periodic Review of Data

Key Activities for Monthly Meetings

- Present and discuss hospital level successes/challenges/concerns
- Celebrate accomplishments
- Share resources
- Supplemental Education
- Questions/Suggestions

Usual Meeting Agenda and Minutes

Mentor Team:	Date:
Roll Call/Hospitals represented	CMQCC Representative
Review of Goals or themes from last call and any follow up that might be needed (if any)	Mentors
Team report outs	Hospital team 5-10 minutes each team
Educational topic (if your team's needs warrant)	Mentors (as time permits)
Goals for next month/Next Steps/Action Items	Mutually identified by team and mentors
Announcements: (pending webinars, site visit reminders, team contact updates, other)	CMQCC Representative

Sometimes it doesn't quite turn out the way you planned!

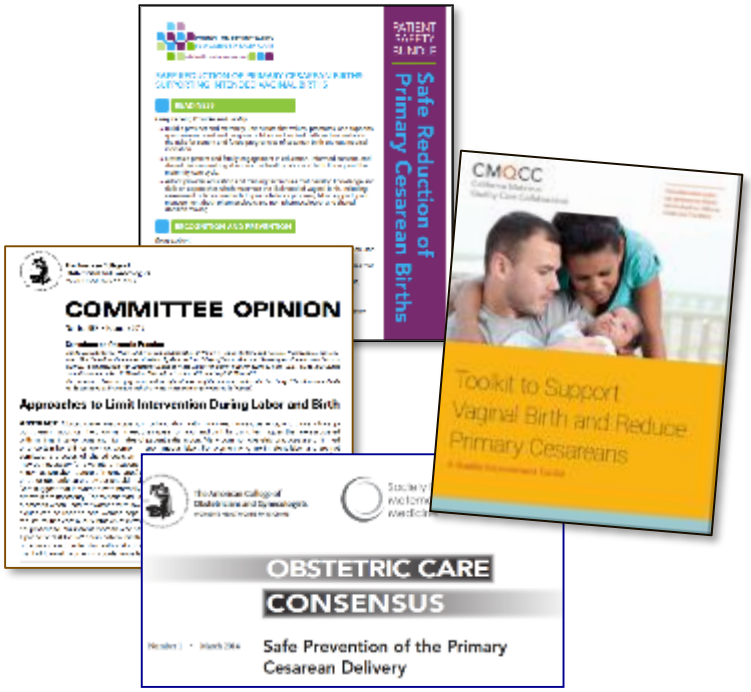
Strategies

- Regroup with your team
- Elicit a broader range of support
- Review your data
- Reach out to CMQCC

CMQCC
California Maternal
Quality Care Collaborative

Lessons Learned

- This is not an easy project
- Build a strong team
- Start with an easy win
- Identify areas of greatest impact
- No one strategy will be effective
- Celebrate success!



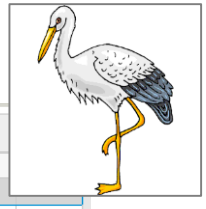
COMMON QI ACTIVITES:

1) Labor support techniques
2) Active phase guidelines - huddle
3) CS rate transparency (unit and provider)
4) Latent phase guidelines
5) Induction guidelines
6) Techniques to reduce OP
7) Patient engagement
8) Unit culture/teamwork/perinatal QI team
9) Longer 2nd Stage

(in approximate order of use)

Team Build

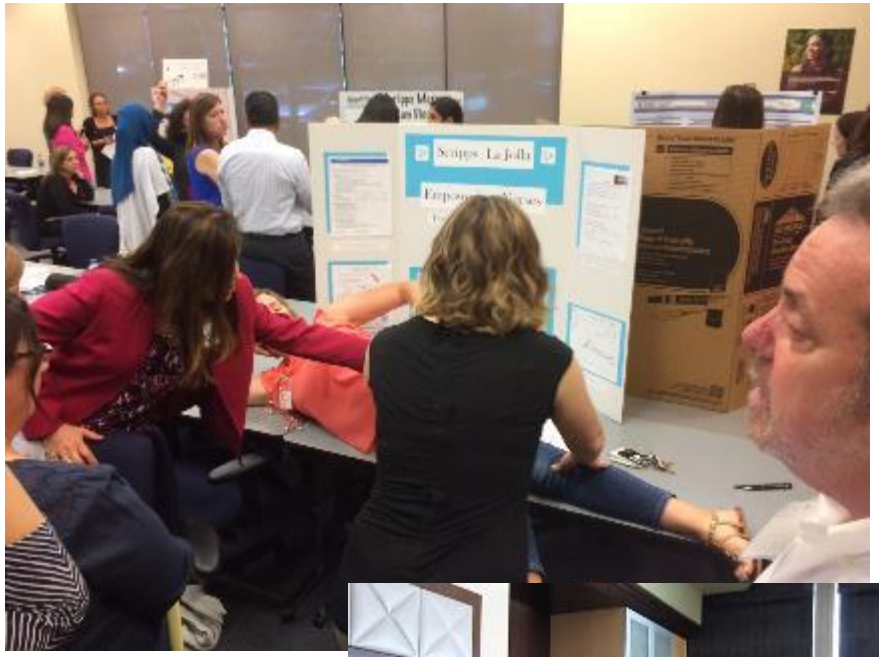
Identify NTSV Patients



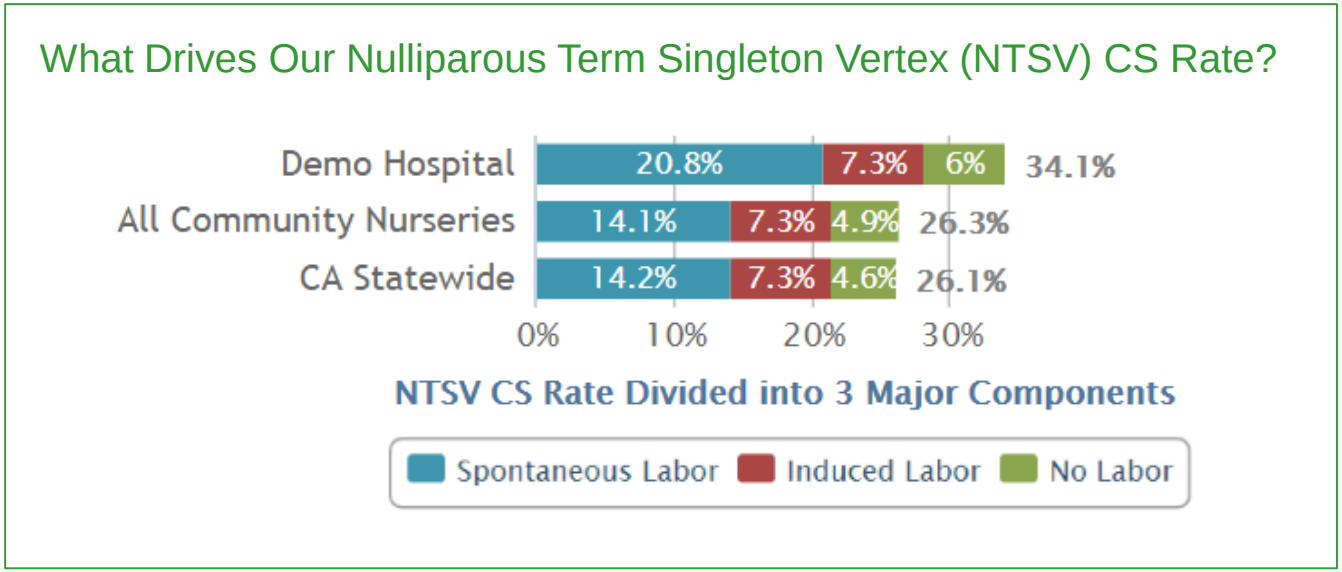
Median LOS: 23:01 Total: 15 WR: 0 Filter: OB Inpatient, OBS, OB Che

Bed	S	Name	Status	EGA	RN	Extension	Provider	Anesthesia	To Do	Notifications	NR	
2101,A	Avail											
2101,B	Avail											
2102,A	Avail											
2103,A	Avail											
2104,A	Avail											
2105,A	Assi	RC	PP Vag		Rachel	DP	SMG		B			0:6:39
2106,A	Assi	ME	Labor	35 0/7	Denise/KL	Name Alert	OBHG					0:5:58
2107,A	Assi	NS	PP Vag		Rachel/	DP	OBHG		B			0:8:30
2108,A	Assi	ME	Labor	41 1/7	Abby/LM		OBHG	Indwelling/infusin	R			1:19:59
OF 1,A	Avail											
OF 2,A	Avail											
2109,A	Assi						SMG					
2110,A	Assi						OBHG	Discontir				

Labor Support



Measure Analysis:
Identify "Drivers" of Rates



Screen Shot from the CMQCC Maternal Data Center

Share Unblinded Data

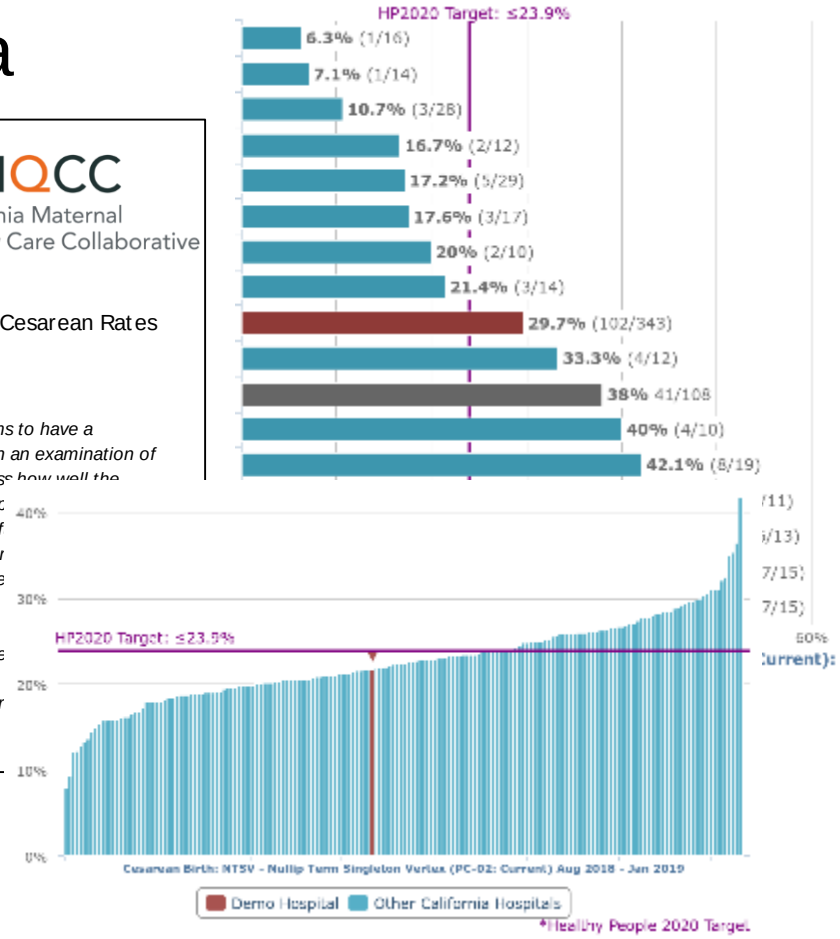
CMQCC
California Maternal
Quality Care Collaborative

Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates

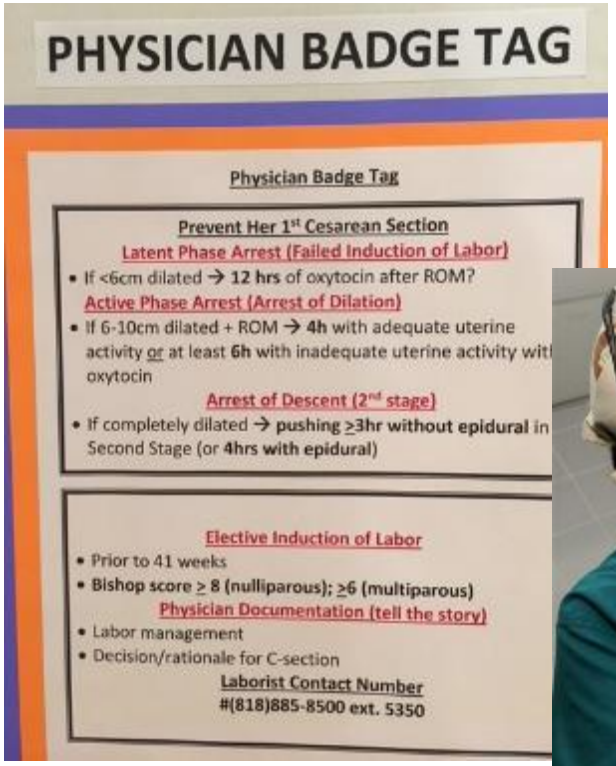
At Start of Project

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 assess how well the providers follow the national ACOG guidelines for Failure to Progress and other key p indications. Ongoing monthly review for consistency with guidelines is also quite usef not every case will follow the guidelines perfectly). The Readiness Assessment and Str Checklist will assist with this baseline review. Success of the project hinges upon syste that support providers in reducing individual rates.

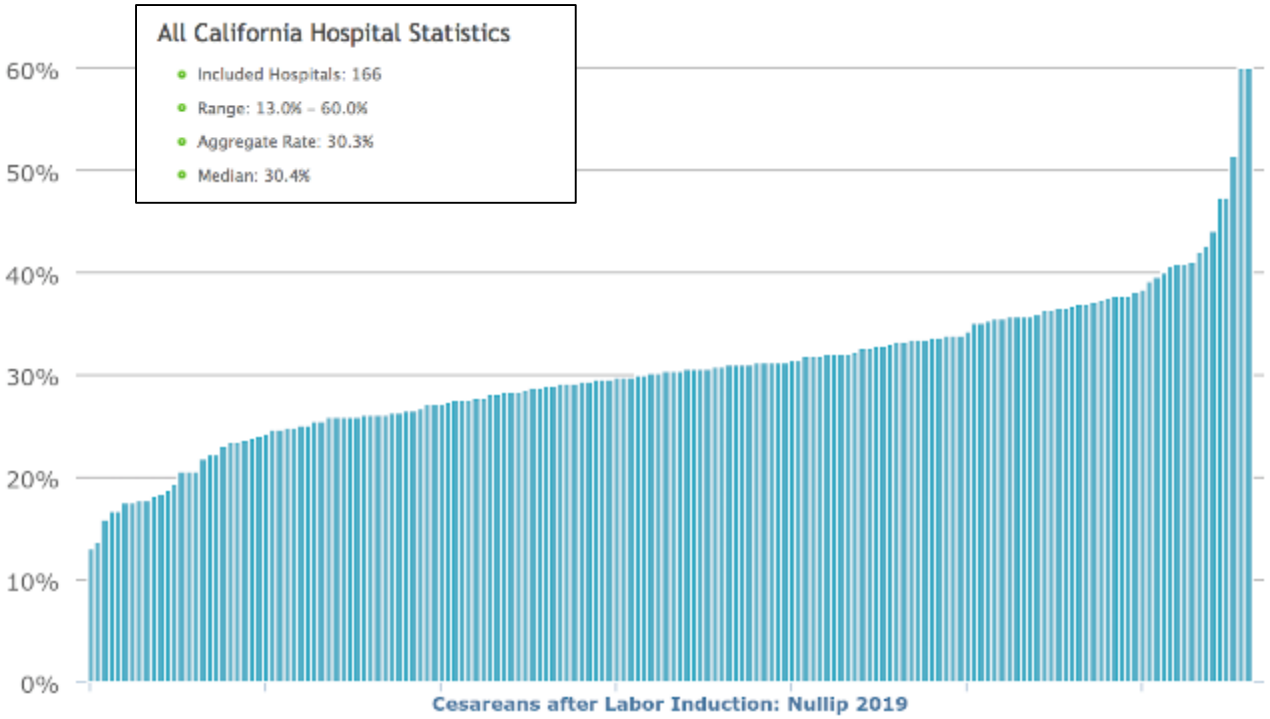
The Readiness Assessment, Structure Measures Checklist (both are found in the Imple and Chart Audit Tool are all located on the collaborative resources page at https://www.cmqcc.org/projects/toolkit-and-collaborative-support-vaginal-birth-and-r cesareans/collaborative



Education and Adoption of ACOG/SMFM Guidelines



California Hospitals: CS after IOL (nullips), 2019



ARRIVE Trial (2018)

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 AUGUST 9, 2018 VOL. 379 NO. 6

Labor Induction versus Expectant Management in Low-Risk Nulliparous Women

William A. Grobman, M.D., Madeline M. Rice, Ph.D., Uma M. Reddy, M.D., M.P.H., Alan T.N. Tita, M.D., Ph.D., Robert M. Silver, M.D., Gail Mallett, R.N., M.S., C.C.R.C., Kim Hill, R.N., B.S.N., Elizabeth A. Thom, Ph.D., Yasser Y. El-Sayed, M.D., Annette Perez-Delboy, M.D., Dwight J. Rouse, M.D., George R. Saade, M.D., Kim A. Boggess, M.D., Suneet P. Chauhan, M.D., Jay D. Iams, M.D., Edward K. Chien, M.D., Brian M. Casey, M.D., Ronald S. Gibbs, M.D., Sindhu K. Srinivas, M.D., M.S.C.E., Geeta K. Swamy, M.D., Hyagriv N. Simhan, M.D., and George A. Macones, M.D., M.S.C.E., for the Eunice Kennedy Shriver National Institute of Child Health and Human Development Maternal–Fetal Medicine Units Network*

ARRIVE Summary Results

- 3062 women were assigned to elective IOL at 39 weeks; 3044 were assigned to expectant management
- 73% Declined Participation
- Sample average age under 24
- Primary Outcome focused on reducing adverse neonatal outcomes: Results were not statistically significant (4.3% in IOL vs 5.4% in Expectant)
- Longer hospital IP stay (6 hours IOL), shorter PP stay
- Secondary Outcome noted was reduced frequency of Cesarean Delivery in the IOL group (18.6% vs 22.2%).
- Reduced incidence of PIH

Other Key Takeaways

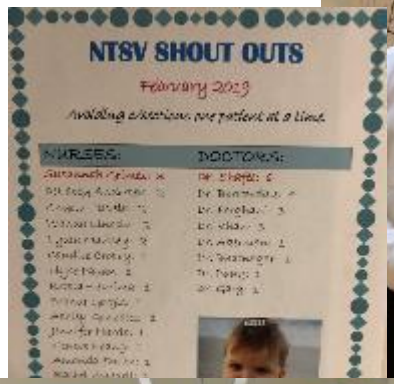
- 28 women having an IOL to reduce one CS (comparison to other “interventions” to reduce CS)
- Higher frequency CS with a lower baseline Bishop score
- Applied ACOG Guidelines for Labor Progress and Decision for CS
- IOL process was not defined
- Cervical ripening Process was not well defined

CMQCC Takeaways

- Patients in this study were very low risk.
- In California, most hospitals do not come anywhere near this rate
  - Median rate of cesarean after labor induction in low-risk nullips is 30% with rates as high as 60%.
- Hospitals in the ARRIVE trial used a common definition of failed induction
- Women with an unfavorable cervix (Bishop Score < 5) underwent cervical ripening before proceeding to oxytocin.
- California hospitals in the VBirth Collaborative achieved similar low NTSV CS rates without using labor induction as a tool.

- The preferences and values of each individual woman are extremely important to a successful vaginal birth and should be the starting point for any shared decision-making discussion about the risks and benefits of elective induction of labor at 39 weeks versus expectant management.

Celebrate Success!!!



Questions


CMQCC

GETTING STARTED WITH PVB

PVB Timeline

May	July	Sept
May 4: PVB Launch Call **May 20**: OB Face-to-Face Meeting, Springfield, IL	**Jul 27**: Statewide Initiative Webinars begin, every other month to start	Data collection begins and start monthly webinars **Sept 28**

Wave 1 Teams

Wave 1 Teams		
Advocate BroMenn	Loyola University Medical Center	St. Anthony Hospital
Advocate Christ Hospital	Memorial Hospital Belleville	St. Bernard Hospital
AMITA Alexian Brothers Medical Center	Memorial Hospital of Carbondale	SSM Health St. Mary's, St. Louis
AMITA Sts. Mary & Elizabeth	Mt. Sinai	Stroger Hospital
Elmhurst Hospital	Northwest Community Hospital	Swedish American
HSHS St. John's	Northwestern Memorial Hospital	University of Chicago Medicine
HSHS St Mary's, Decatur	OSF St. Francis	UnityPoint Trinity
Javon Bea Hospital	Rush University Medical Center	West Suburban Medical Center

PVB Team Rosters

- Developing your QI team and submitting your team roster to ILPQC are key first steps to get started
- Your team will be essential to your success, plan to meet at least monthly
- If you have not submitted a team roster yet, please do so as soon as possible
- Contact info@ilpqc.com if you need assistance developing your team or submitting your roster

Structure Measures

help you track your implementation of systems changes

- Implement provider and nurse education and other strategies to achieve buy-in
- Implement standardized protocol processes for induction, labor support management and response to labor and fetal heart rate abnormalities
- Implement a cesarean decision checklist for ACOG/SMFM labor guidelines
- Implement a decision huddle and/or decision debriefs with appropriate care team to standardize the use of ACOG/SMFM labor guidelines
- Implement a workflow process for shared decision making (decision huddle with provider, nurse and patient to review progress, patient input, risk/benefit and ACOG/SMFM labor guidelines)
- Implement standardized patient education promoting vaginal birth strategies
- Integrate process to review and share data including provider-level data with clinical team

Process Measures

Help you track your implementation of clinical practices towards culture change

- % of Providers and nurses receiving standardized education on ACOG/SMFM labor guidelines, labor management strategies/response for labor challenges, protocols for facilitating decision huddles and/or debriefs

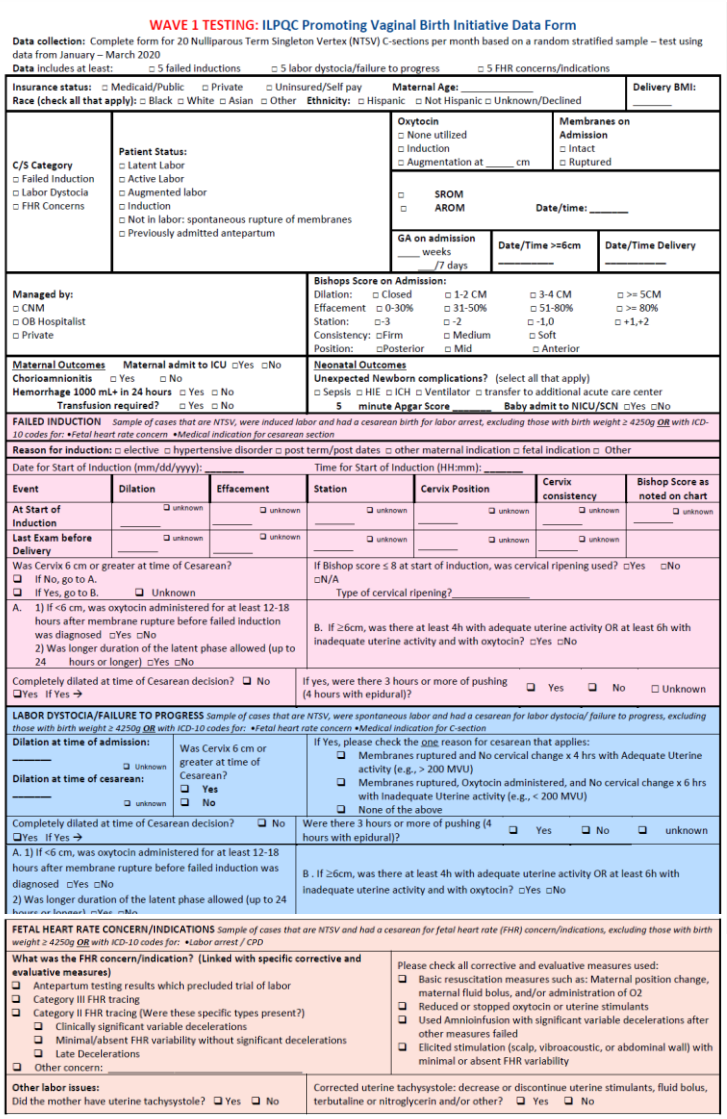
Outcome Measures

Help you track your progress towards changing the health status of patients

- % of participating hospitals at or below the Healthy People Target Rate of 24.7 C/S delivery rate among NTSV births
  - Goal: 70% or greater
- Overall state C/S delivery rate among NTSV births
  - Goal: 24.7% or lower

PVB Data Collection: Monthly Random Sample of NTSV and Vaginal Births

- 20 Nulliparous Term Singleton Vertex (NTSV) C-sections per month based on a random stratified sample. Data includes at least:
  - 5 failed inductions
  - 5 labor dystocia/failure to progress
  - 5 FHR concerns/indications
- 10 NTSV Vaginal births per month



WAVE 1 TESTING: ILPQC Promoting Vaginal Birth Initiative Data Form

Data collection: Complete form for 20 Nulliparous Term Singleton Vertex (NTSV) C-sections per month based on a random stratified sample – test using data from January – March 2020

Data includes at least: ☐ 5 failed inductions ☐ 5 labor dystocia/failure to progress ☐ 5 FHR concerns/indications

Insurance status: ☐ Medicaid/Public ☐ Private ☐ Uninsured/Self pay **Maternal Age:** _____ **Delivery BMI:** _____
Race (check all that apply): ☐ Black ☐ White ☐ Asian ☐ Other **Ethnicity:** ☐ Hispanic ☐ Not Hispanic ☐ Unknown/Declined

C/S Category
☐ Failed Induction
☐ Labor Dystocia
☐ FHR Concerns

Patient Status:
☐ Latent Labor
☐ Active Labor
☐ Augmented labor
☐ Induction
☐ Not in labor: spontaneous rupture of membranes
☐ Previously admitted antepartum

Oxytocin
☐ None utilized
☐ Induction
☐ Augmentation at _____ cm

Membranes on Admission
☐ Intact
☐ Ruptured

☐ **SROM**
☐ **AROM**
Date/time: _____

GA on admission ____ weeks ____/7 days
Date/Time >=6cm _____
Date/Time Delivery _____

Managed by:
☐ CNM
☐ OB Hospitalist
☐ Private

Bishops Score on Admission:
Dilation: ☐ Closed ☐ 1-2 CM ☐ 3-4 CM ☐ >= 5CM
Effacement ☐ 0-30% ☐ 31-50% ☐ 51-80% ☐ >= 80%
Station: ☐-3 ☐ -2 ☐ -1,0 ☐ +1,+2
Consistency: ☐Firm ☐ Medium ☐ Soft
Position: ☐Posterior ☐ Mid ☐ Anterior

Maternal Outcomes **Maternal admit to ICU** ☐Yes ☐No
Chorioamnionitis ☐ Yes ☐ No
Hemorrhage 1000 mL+ in 24 hours ☐ Yes ☐ No
Transfusion required? ☐ Yes ☐ No

Neonatal Outcomes
Unexpected Newborn complications? (select all that apply)
☐ Sepsis ☐ HIE ☐ ICH ☐ Ventilator ☐ transfer to additional acute care center
5 minute Apgar Score _____ **Baby admit to NICU/SCN** ☐Yes ☐No

FAILED INDUCTION *Sample of cases that are NTSV, were induced labor and had a cesarean birth for labor arrest, excluding those with birth weight ≥ 4250g **OR** with ICD-10 codes for: •Fetal heart rate concern •Medical indication for cesarean section*

Reason for induction: ☐ elective ☐ hypertensive disorder ☐ post term/post dates ☐ other maternal indication ☐ fetal indication ☐ Other

Date for Start of Induction (mm/dd/yyyy): _____ Time for Start of Induction (HH:mm): _____

Event	Dilation	Effacement	Station	Cervix Position	Cervix consistency	Bishop Score as noted on chart
At Start of Induction	☐ unknown _____	☐ unknown _____	☐ unknown _____	☐ unknown _____	☐ unknown _____	☐ unknown _____
Last Exam before Delivery	☐ unknown _____	☐ unknown _____	☐ unknown _____	☐ unknown _____	☐ unknown _____	

Was Cervix 6 cm or greater at time of Cesarean?
☐ If No, go to A.
☐ If Yes, go to B. ☐ Unknown

If Bishop score ≤ 8 at start of induction, was cervical ripening used? ☐Yes ☐No ☐N/A
Type of cervical ripening?_____

A. 1) If <6 cm, was oxytocin administered for at least 12-18 hours after membrane rupture before failed induction was diagnosed ☐Yes ☐No
2) Was longer duration of the latent phase allowed (up to 24 hours or longer) ☐Yes ☐No

B. If ≥6cm, was there at least 4h with adequate uterine activity OR at least 6h with inadequate uterine activity and with oxytocin? ☐Yes ☐No

Completely dilated at time of Cesarean decision? ☐ No ☐Yes If Yes →

If yes, were there 3 hours or more of pushing (4 hours with epidural)? ☐ Yes ☐ No ☐ Unknown

LABOR DYSTOCIA/FAILURE TO PROGRESS *Sample of cases that are NTSV, were spontaneous labor and had a cesarean for labor dystocia/ failure to progress, excluding those with birth weight ≥ 4250g **OR** with ICD-10 codes for: •Fetal heart rate concern •Medical indication for C-section*

Dilation at time of admission: _____ ☐ Unknown
Dilation at time of cesarean: _____ ☐ unknown

Was Cervix 6 cm or greater at time of Cesarean?
☐ **Yes**
☐ **No**

If Yes, please check the one reason for cesarean that applies:
☐ Membranes ruptured and No cervical change x 4 hrs with Adequate Uterine activity (e.g., > 200 MVU)
☐ Membranes ruptured, Oxytocin administered, and No cervical change x 6 hrs with Inadequate Uterine activity (e.g., < 200 MVU)
☐ None of the above

Completely dilated at time of Cesarean decision? ☐ No ☐Yes If Yes →

Were there 3 hours or more of pushing (4 hours with epidural)? ☐ Yes ☐ No ☐ unknown

A. 1) If <6 cm, was oxytocin administered for at least 12-18 hours after membrane rupture before failed induction was diagnosed ☐Yes ☐No
2) Was longer duration of the latent phase allowed (up to 24 hours or longer) ☐Yes ☐No

B . If ≥6cm, was there at least 4h with adequate uterine activity OR at least 6h with inadequate uterine activity and with oxytocin? ☐Yes ☐No

FETAL HEART RATE CONCERN/INDICATIONS *Sample of cases that are NTSV and had a cesarean for fetal heart rate (FHR) concern/indications, excluding those with birth weight ≥ 4250g **OR** with ICD-10 codes for: •Labor arrest / CPD*

What was the FHR concern/indication? (Linked with specific corrective and evaluative measures)
☐ Antepartum testing results which precluded trial of labor
☐ Category III FHR tracing
☐ Category II FHR tracing (Were these specific types present?)
  ☐ Clinically significant variable decelerations
  ☐ Minimal/absent FHR variability without significant decelerations
  ☐ Late Decelerations
☐ Other concern: _____

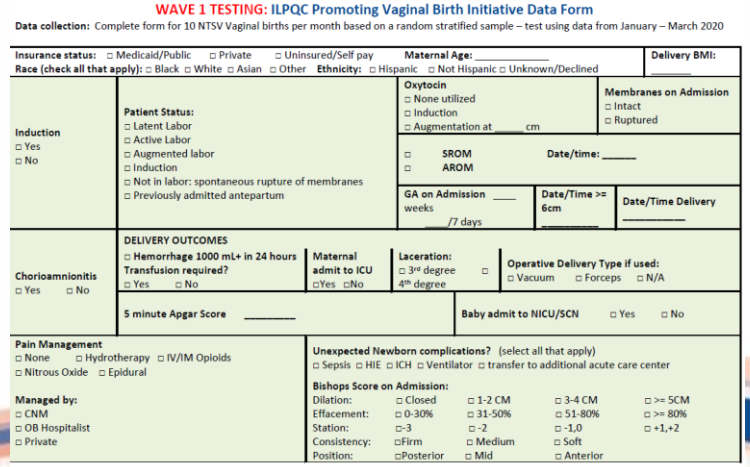
Please check all corrective and evaluative measures used:
☐ Basic resuscitation measures such as: Maternal position change, maternal fluid bolus, and/or administration of O2
☐ Reduced or stopped oxytocin or uterine stimulants
☐ Used Amnioinfusion with significant variable decelerations after other measures failed
☐ Elicited stimulation (scalp, vibroacoustic, or abdominal wall) with minimal or absent FHR variability

Other labor issues:
Did the mother have uterine tachysystole? ☐ Yes ☐ No

Corrected uterine tachysystole: decrease or discontinue uterine stimulants, fluid bolus, terbutaline or nitroglycerin and/or other? ☐ Yes ☐ No

Short Monthly Data Form to drive QI change at your hospital

- complete section based on type of delivery



WAVE 1 TESTING: ILPQC Promoting Vaginal Birth Initiative Data Form

Data collection: Complete form for 10 NTSV Vaginal births per month based on a random stratified sample – test using data from January – March 2020

Insurance status: ☐ Medicaid/Public ☐ Private ☐ Uninsured/Self pay **Maternal Age:** _____ **Delivery BMI:** _____
Race (check all that apply): ☐ Black ☐ White ☐ Asian ☐ Other **Ethnicity:** ☐ Hispanic ☐ Not Hispanic ☐ Unknown/Declined

Induction
☐ Yes
☐ No

Patient Status:
☐ Latent Labor
☐ Active Labor
☐ Augmented labor
☐ Induction
☐ Not in labor: spontaneous rupture of membranes
☐ Previously admitted antepartum

Oxytocin
☐ None utilized
☐ Induction
☐ Augmentation at _____ cm

Membranes on Admission
☐ Intact
☐ Ruptured

☐ **SROM**
☐ **AROM**
Date/time: _____

GA on Admission ____ weeks ____/7 days
Date/Time >= 6cm _____
Date/Time Delivery _____

Chorioamnionitis
☐ Yes ☐ No

DELIVERY OUTCOMES
☐ Hemorrhage 1000 mL+ in 24 hours
Transfusion required?
☐ Yes ☐ No

Maternal admit to ICU
☐Yes ☐No

Laceration:
☐ 3rd degree ☐ 4th degree

Operative Delivery Type if used:
☐ Vacuum ☐ Forceps ☐ N/A

5 minute Apgar Score _____

Baby admit to NICU/SCN ☐ Yes ☐ No

Pain Management
☐ None ☐ Hydrotherapy ☐ IV/IM Opioids
☐ Nitrous Oxide ☐ Epidural

Managed by:
☐ CNM
☐ OB Hospitalist
☐ Private

Unexpected Newborn complications? (select all that apply)
☐ Sepsis ☐ HIE ☐ ICH ☐ Ventilator ☐ transfer to additional acute care center

Bishops Score on Admission:
Dilation: ☐ Closed ☐ 1-2 CM ☐ 3-4 CM ☐ >= 5CM
Effacement: ☐ 0-30% ☐ 31-50% ☐ 51-80% ☐ >= 80%
Station: ☐-3 ☐ -2 ☐ -1,0 ☐ +1,+2
Consistency: ☐Firm ☐ Medium ☐ Soft
Position: ☐Posterior ☐ Mid ☐ Anterior

Data Form – ILPQC – C-Section Deliveries part 1/3

WAVE 1 TESTING: ILPQC Promoting Vaginal Birth Initiative Data Form

Data collection: Complete form for 20 Nulliparous Term Singleton Vertex (NTSV) C-sections per month based on a random stratified sample – test using data from January – March 2020

Data includes at least: ◻ 5 failed inductions ◻ 5 labor dystocia/failure to progress ◻ 5 FHR concerns/indications

Insurance status: ◻ Medicaid/Public ◻ Private ◻ Uninsured/Self pay **Maternal Age:** _____

Race (check all that apply): ◻ Black ◻ White ◻ Asian ◻ Other **Ethnicity:** ◻ Hispanic ◻ Not Hispanic

Delivery BMI: _____

C/S Category
- ◻ Failed Induction
- ◻ Labor Dystocia
- ◻ FHR Concerns

Patient Status:
- ◻ Admitted already in labor
- ◻ Induced
- ◻ Indicated augmented labor
- ◻ Not in labor: spontaneous rupture of membranes
- ◻ Previously admitted antepartum

Oxytocin
- ◻ None utilized
- ◻ Induction
- ◻ Augmentation at _____ cm

Membranes on Admission
- ◻ Intact
- ◻ Ruptured

GA ____ weeks ___/7 days

Date/Time 6cm _____

Date/Time Delivery _____

Maternal Outcomes **Maternal admit to ICU** ◻Yes ◻No

Chorioamnionitis ◻ Yes ◻ No

Hemorrhage 1000 mL+ in 24 hours ◻ Yes ◻ No

Transfusion required? ◻ Yes ◻ No

Neonatal Outcomes

Unexpected Newborn complications? (select all that apply)

◻ Sepsis ◻ HIE ◻ ICH ◻ Ventilator ◻ transfer to additional acute care center

5 minute Apgar Score _____ **Baby admit to NICU/SCN** ◻Yes ◻No

Data Form – ILPQC – C-Section Deliveries part 2/3

FAILED INDUCTION *Sample of cases that are NTSV, were induced labor and had a cesarean birth for labor arrest, excluding those with birth weight ≥ 4250g **OR** with ICD-10 codes for: •Fetal heart rate concern •Medical indication for cesarean section*

Reason for induction: ◻ elective ◻ hypertensive disorder ◻ post term/post dates ◻ other maternal indication ◻ fetal indication ◻ Other

Event	Dilation	Effacement	Station	Cervix Position	Cervix consistency	Bishop Score as noted on chart
At Start of Induction	❑ unknown _____	❑ unknown _____	❑ unknown _____	❑ unknown _____	❑ unknown _____	❑ unknown _____
Last Exam before Delivery	❑ unknown _____	❑ unknown _____	❑ unknown _____	❑ unknown _____	❑ unknown _____	

Was Cervix 6 cm or greater at time of Cesarean?
❑ If No, go to A.
❑ If Yes, go to B. ❑ Unknown

If Bishop score ≤ 8 at start of induction, was cervical ripening used? ◻Yes ◻No ◻N/A
Type of cervical ripening?_____

A. 1) If <6 cm, was oxytocin administered for at least 12-18 hours after membrane rupture before failed induction was diagnosed ◻Yes ◻No
2) Was longer duration of the latent phase allowed (up to 24 hours or longer)

B. If ≥6cm, was there at least 4h with adequate uterine activity OR at least 6h with inadequate uterine activity and with oxytocin? ◻Yes ◻No

Completely dilated at time of Cesarean decision? ❑ No ❑Yes If Yes → If yes, were there 3 hours or more of pushing (4 hours with epidural)? ❑ Yes ❑ No ❑ Unknown

Data Form – ILPQC – C-Section Deliveries section 3/3

LABOR DYSTOCIA/FAILURE TO PROGRESS *Sample of cases that are NTSV, were spontaneous labor and had a cesarean for labor dystocia/ failure to progress, excluding those with birth weight ≥ 4250g **OR** with ICD-10 codes for: •Fetal heart rate concern •Medical indication for C-section*

Dilation at time of admission: _____ ❑ Unknown **Dilation at time of cesarean:** _____ ❑ unknown	Was Cervix 6 cm or greater at time of Cesarean? ❑ **Yes** ❑ **No**	If Yes, please check the one reason for cesarean that applies: ❑ Membranes ruptured and No cervical change x 4 hrs with Adequate Uterine activity (e.g., > 200 MVU) ❑ Membranes ruptured, Oxytocin administered, and No cervical change x 6 hrs with Inadequate Uterine activity (e.g., < 200 MVU) ❑ None of the above

Completely dilated at time of Cesarean decision? ❑ No ❑Yes If Yes →	Were there 3 hours or more of pushing (4 hours with epidural)? ❑ Yes ❑ No ❑ unknown

FETAL HEART RATE CONCERN/INDICATIONS *Sample of cases that are NTSV and had a cesarean for fetal heart rate (FHR) concern/indications, excluding those with birth weight ≥ 4250g **OR** with ICD-10 codes for: •Labor arrest / CPD*

What was the FHR concern/indication? (Linked with specific corrective and evaluative measures) ❑ Antepartum testing results which precluded trial of labor ❑ Category III FHR tracing ❑ Category II FHR tracing (Were these specific types present?) ❑ Clinically significant variable decelerations ❑ Minimal/absent FHR variability without significant decelerations ❑ Other concern: _____	Please check all corrective and evaluative measures used: ❑ Basic resuscitation measures such as: Maternal position change, maternal fluid bolus, and/or administration of O2 ❑ Reduced or stopped oxytocin or uterine stimulants ❑ Used Amnioinfusion with significant variable decelerations after other measures failed ❑ Elicited stimulation (scalp, vibroacoustic, or abdominal wall) with minimal or absent FHR variability

Other labor issues: Did the mother have uterine tachysystole? ❑ Yes ❑ No	Corrected uterine tachysystole: decrease or discontinue uterine stimulants, fluid bolus, terbutaline or nitroglycerin and/or other? ❑ Yes ❑ No

Data Form – ILPQC – Vaginal deliveries part 1/1

WAVE 1 TESTING: ILPQC Promoting Vaginal Birth Initiative Data Form

Data collection: Complete form for 10 NTSV Vaginal births per month based on a random stratified sample – test using data from January – March 2020

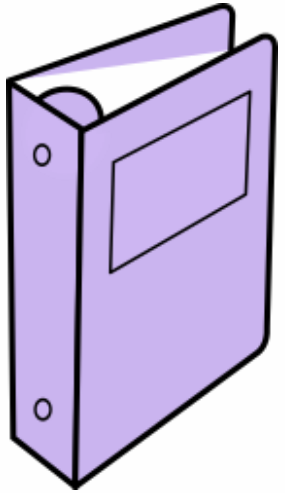
<table>
<tr><td colspan="3">Insurance status: ☐ Medicaid/Public ☐ Private ☐ Uninsured/Self pay Maternal Age: _____
Race (check all that apply): ☐ Black ☐ White ☐ Asian ☐ Other Ethnicity: ☐ Hispanic ☐ Not Hispanic</td><td>Delivery BMI:
_____</td></tr>
<tr><td rowspan="2">Induction
☐ Yes
☐ No</td><td rowspan="2">Patient Status:
☐ Admitted already in labor
☐ Indicated augmented labor
☐ Not in labor: spontaneous rupture of membranes
☐ Previously admitted antepartum</td><td>Oxytocin
☐ None utilized
☐ Induction
☐ Augmentation at _____ cm</td><td>Membranes on Admission
☐ Intact
☐ Ruptured</td></tr>
<tr><td>GA ____ weeks
____/7 days
Date/Time 6cm
_____</td><td>Date/Time Delivery
_____</td></tr>
<tr><td rowspan="2">Chorioamnionitis
☐ Yes ☐ No</td><td colspan="3">DELIVERY OUTCOMES
☐ Hemorrhage 1000 mL+ in 24 hours
Transfusion required?
☐ Yes ☐ No
Maternal admit to ICU
☐Yes ☐No
Laceration:
☐ 3rd degree
☐ 4th degree
Operative Delivery Type if used:
☐ Vacuum ☐ Forceps ☐ N/A</td></tr>
<tr><td colspan="2">5 minute Apgar Score _____</td><td>Baby admit to NICU/SCN ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Bishop score as noted on chart
_____ ❑ unknown</td><td colspan="2">Unexpected Newborn complications? (select all that apply)
☐ Sepsis ☐ HIE ☐ ICH ☐ Ventilator ☐ transfer to additional acute care center</td></tr>
</table>

How will ILPQC help?

- PVB Toolkit available online at Face-to-Face meeting on 5/20
- Monthly team webinars starting this fall with education, data review and Team Talks on strategies for improvement
- Provider and Nurse Education under development
- Labor Support /Response to Labor Challenges Trainings
- ILPQC Data System will provide each team a secure access to the REDCap portal and live reports that can be reviewed monthly and shared at your hospital to support your teams efforts
- QI support coaching calls to teams to problem solve

Submit PVB Roster today!

Promoting Vaginal Birth Toolkit Outline

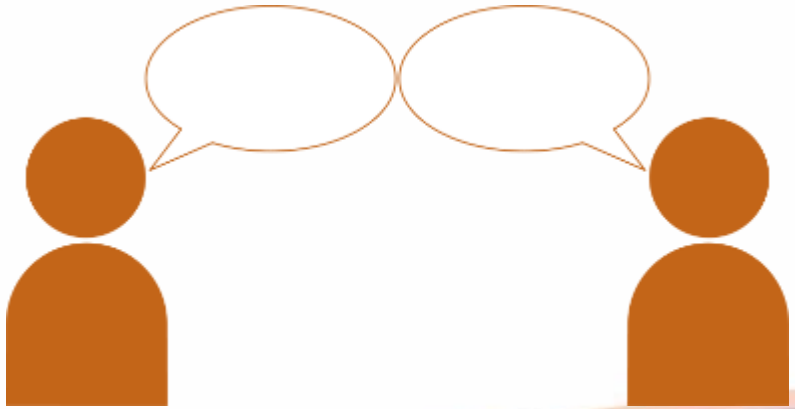


- Introduction

1. Initiative Resources
2. Promoting Vaginal Birth Slide Set
3. National Guidance: AIM Bundle
4. National Guidance: ACOG Committee Opinions/Practice Advisories and AWOHNN Statements
5. Creating Clinical Culture Change
6. Labor Management
7. Standardization of Policy, Protocols, & Algorithms

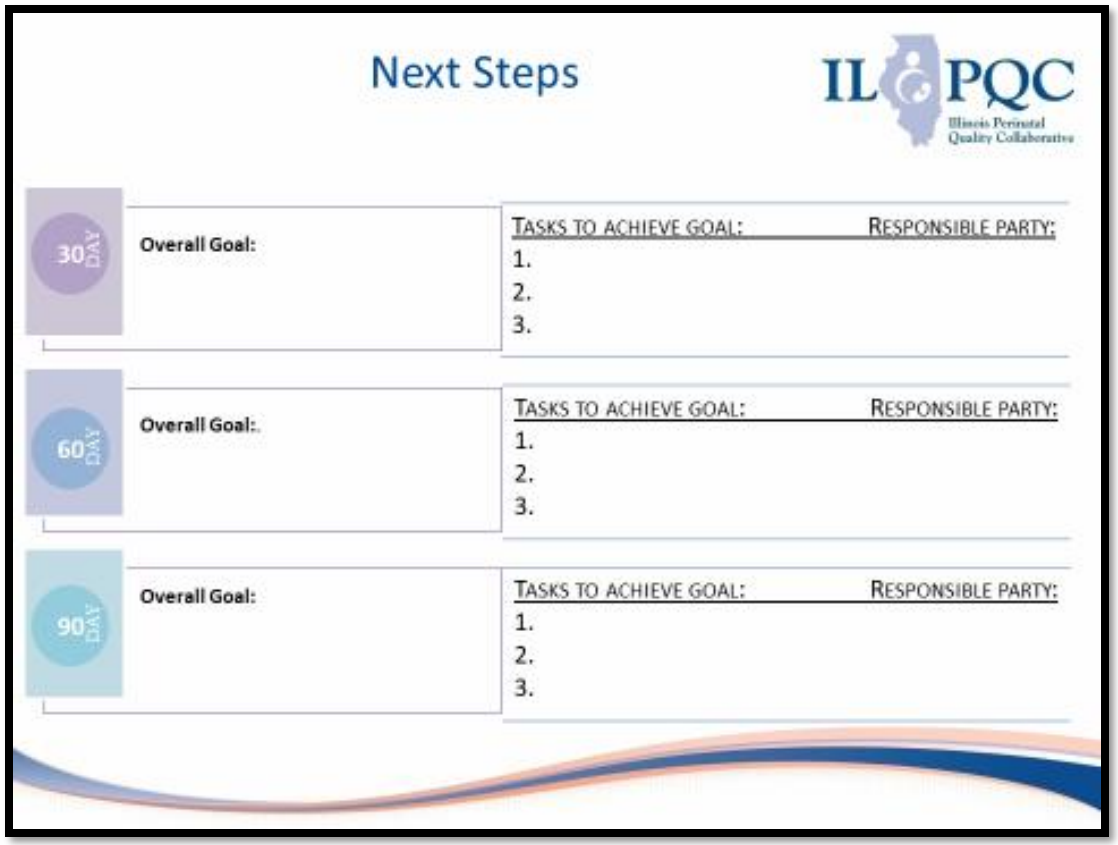
Key questions to discuss with your team before getting started:

- Where can your team begin to build buy-in from providers? Nurses? to get ready for this work.
- What is the current education provided to your MDs/CNMs/RNs to assist with labor management support and response to labor challenges?



30-60-90 Day Plans or "Where should we start" Plan

- What are your **goals**?
- Where do you want to **start**?
- What would you like to accomplish in first 3 months of this initiative?
- Include plan for **1st small test of change** (PDSA cycle)



Getting started with PVB

- Form your QI team and find a monthly meeting time
- Submit team roster for team members if not completed
- Complete PVB readiness survey and identify team goals-**DUE MAY 15th**
- Create a draft 30-60-90 day plan (ideas for QI plan for first 3 months) – what are your ideas for how you want to get started?
- Incorporate this work into Virtual Storyboard for Face-to-Face meeting on May 20 (goal share your team story and plan)- **DUE MAY 15th**

Register team for Face-to-Face Meeting

All teams have opportunities for quality improvement to achieve PVB AIM regardless of where you are in implementation process

Q&A

- Unmute your line (*6) to ask a question!
- We want to hear from you
  - How do you think your team will collect data for this initiative?
  - Is your team already collecting this data? What do you need to add to your EMR documentation?
  - What can ILPQC do to support your team?

2020
FACE- TO- FACE MEETING

ILPQC
Illinois Perinatal Quality Collaborative

You're Invited!

2020 OB & Neonatal Face-to-Face Meetings

Nurses, Providers, & Staff
join us for an interactive day of collaborative learning for current & upcoming ILPQC initiatives!

OB Teams: May 20, 2020

~~Check-in: 8:00a-9:00a~~
Meeting: 9:00a-3:30p

Mothers & Newborns affected by Opioids - OB (MNO-OB)
Immediate Postpartum LARC (IPLARC)
Improving Postparutm Acess to Care (IPAC)
Promoting Vaginal Birth (PVB)

Neonatal Teams: May 21, 2020

~~Check-in: 8:00a-9:00a~~
Meeting: 9:00a- 3:00p

Mothers & Newborns affected by Opioids - Neonatal (MNO-Neonatal)
Babies Antibiotic Stewardship Improvement Collborative (BASIC)

Register now! https://ilpqc.eventbrite.com

This activity has been submitted to the Ohio Nurses Association for approval to award contact hours. The Ohio Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91)

NEW VIRTUAL MEETING

Illinois Perinatal Quality Collaborative
633 N. St. Clair, 20th Floor
Chicago, IL 60611

2020 Face-to-Face Speakers and Panels

Jessica Brumley, CNM, PhD

"Promoting Vaginal Birth: Lessons Learned from FPQC"

Helena Girouard

"A Mom's Recovery Story: Helena Girouard"

"OB Teams Panel: Sharing Strategies for Success for Obstetric QI Initiatives"

MNO X2

IPLARC

IPAC

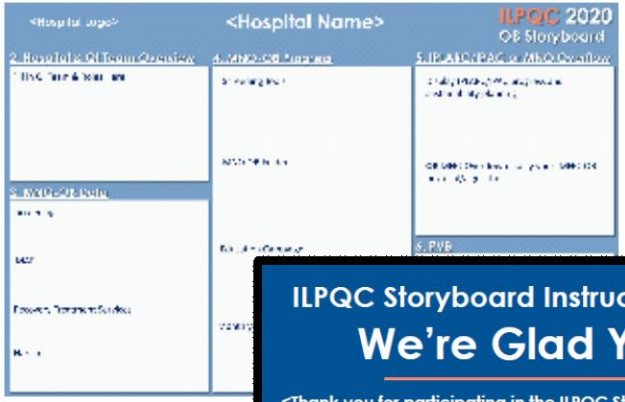
Breakout Facilitators

- We will have nurse/provider pair from each network to facilitate breakout sessions

OB Breakout Sessions	Neonatal Breakout Sessions
MNO-OB: Finishing Strong / Key Strategies for Success	MNO-Neonatal: Finishing Strong
MNO-OB: Preparing for Sustainability	MNO-Neonatal: Preparing for Sustainability
MNO-OB: Optimize Narcan Counseling & Access	MNO-Neo: Engaging Pediatricians
Immediate Postpartum LARC (IPLARC): Sustainability & Billing	QI: Using QI Data to Drive Change
Improving Postpartum Access to Care (IPAC): Sustainability & Billing	QI: Building a Strong Interdisciplinary QI Team
PVB: Data Collection Strategies	BASIC: Preparing your QI Team for BASIC
PVB: Unpacking the Toolkit / Getting Started	State & Community Partner Breakout
Obstetrics Chair / Obstetrics Leadership Breakout	
State & Community Partner Breakout	

F2F Storyboard Session

- All teams will bring a storyboard to the Face to Face
- ILPQC will provide a template and an instruction sheet to use
- For MNO-OB, share your progress toward crossing the finish line including implementation of the 4 key strategies
- For IPLARC/IPAC teams, share your Go Live success and sustainability plans
- For PVB teams, share your PVB QI Team, and can include if you have ideas for getting started.
- See the diagram for examples of how to lay out your storyboard



F2F Storyboard Session

Due May 15, 2020
More information to come in your inbox today!

<Hospital Logo>

<Hospital Name>

ILPQC 2020
OB Storyboard

2. Hospital & QI Team Overview

4. MNO-OB Progress

5. IPLARC/IPAC or MNO Overflow

3. MNO-OB Da

We will be having voting & awards for top storyboards.

Attendees will enter a raffle for participating and reviewing the virtual storyboard

NEXT STEPS

- **Save the date** and register for the ILPQC virtual OB Face-to-Face webinar **May 20, 2020, 9am-3pm.**
- Work to complete your hospitals **virtual storyboard** - easy to complete just share bullets on your QI work this year, add data and pics if want

  -- will have voting & awards for top storyboards
- **Spread the word** about PVB & share the roster link
- Reach out to ILPQC with additional feedback
- Mark your calendars for our next PVB call **July 27 at 12pm**

THANKS TO OUR

FUNDERS

IDPH
Illinois Department of Public Health

CDC
Centers for Disease Control and Prevention

DHS
Illinois Department of Human Services

JB & MK PRITZKER
Family Foundation

Email info@ilpqc.org or visit us at www.ilpqc.org

Additional Info

1) Facilitate clinical culture change that promotes, and supports vaginal birth

- Create a QI team of providers, staff & administrators to lead the effort & cultivate buy-in
- Educate physicians/midwives and nurses on ACOG/SMFM labor management guidelines and labor support techniques
- Develop patient education with positive messaging to women and families about intended vaginal birth strategies/techniques that prevent cesareans through prenatal classes and patient education
- Utilize care team huddles/debriefs to identify and review delivery decisions for consistency with process flows/protocols/checklist
- Integrate order sets, protocols, and documentation for the safe reduction of primary cesareans into EMR
- Share provider-level measures with providers with the goal of working to transparency/open data

2) Develop 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
- Implement policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women
- Implement policies and protocols for induction of labor
- Implement policies and protocols for pain management and labor support

3) Develop standardized protocols for identification and response to labor challenges/abnormalities

- Implement standard criteria for diagnosis and treatment of labor dystocia, arrest disorders and failed induction
- Develop checklist for ensuring ACOG/SMFM criteria for c/s is met
- Implement training/procedures for identification and appropriate interventions for malpositions (e.g. OP/OT)
- Implement standardized assessment, and response to fetal heart rate concerns
- Develop checklist for ensuring ACOG/SMFM criteria for c/s is met
- Implementation of a workflow process for shared decision making (decision huddle with provider, nurse and patient to review progress, patient input, treatment options, risk/benefits, and ACOG/SMFM guidelines)