Promoting Vaginal Birth Launch Call

December 14th, 2020
12:30-1:30 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

• Why PVB?
• ILPQC Structure and Supports
• Initiative overview
• Guest Speaker- Christa Sakowski CMQCC
• Getting Started with PVB
• Upcoming Events & Next Steps
  – Face-to-Face
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
- Quality Improvement Initiatives have shown results
  - CMQCC and FPQC initiatives reduced primary cesarean rates while maintaining optimal neonatal outcomes

*ACOG Safe Prevention of Primary C-Section 2014
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
Major Maternal Complications: Vaginal Births versus Primary Cesareans, Repeat Cesareans, and VBAC

- Maternal transfusion: 2-3X
- Ruptured uterus: 7-14X
- Unplanned hysterectomy: 4-12X
- Repeat cesarean: 2-4X

Source: https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_04.pdf
Illinois NTSV
C-Section Rate Data

Cesarean section rate among nulliparous, term, singleton, vertex deliveries for All Illinois Birthing Hospitals
All Illinois Birthing Hospitals
Birth Certificate Data, 2018
PVB Readiness Survey:
Current tools/responses available to staff for labor support

- Peanut Ball RN Training-
  Labor Support
- RN Training-
  Alternative Responses
- Nitrous Oxide Provider Training-
  Labor Support
- Provider Training-
  Alternative Responses
- Other

88 Teams reporting by October 2020
95% of PVB Teams

Available   Not Available
PVB Readiness Survey: Strategies currently used for cesarean delivery decisions for inductions

- Standardized Documentation when Decision is Made
- Shared Decision Making
- Care Team Huddles
- ACOG/SMFM Labor Guidelines
- Other

Use  Do Not Use
PVB Readiness Survey: Strategies currently used for cesarean delivery decisions for Labor Complications in the Second Stage

- Shared Decision Making
- Standardized Documentation when Decision is Made
- Care Team Huddles
- ACOG/SMFM Labor Guidelines
- Other
PVB Readiness Survey:
Strategies currently used for cesarean delivery decisions Fetal Heart Rate Concerns
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

>99% of IL births
ILPQC Central Team

Ann Borders
ILPQC Executive Director, OB Lead

Leslie Caldarelli & Justin Josephsen
Neonatal Leads

Patricia Lee King
State Project Director, Quality Lead

Daniel Weiss & Autumn Perrault
Project Manager, Nurse Quality Manager

Kalyan Juvvadi
Data System Developer

Ieshia Johnson & Ellie Suse
Project Coordinators
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?
Improving Postpartum Access to Care (IPAC)

INITIATIVE OVERVIEW
Promoting Vaginal Birth (PVB)

What will we focus on?

- Optimizing Labor Management and support
- Protocols and Guidelines for Induction and Labor Decision Making
- Provider, Nurse, Patient Education to support clinical culture change
**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, 2022.

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

3 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
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 2022.

**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)

**AIM**

Promoting Vaginal Birth
Key Driver Diagram

IL PQC
Illinois Perinatal Quality Collaborative
# PVB AIMs & Measures

## 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.

- Implement and integrate PVB order sets, protocols and documentation into the EMR.

- Implement cesarean decision checklist using ACOG/SMFM labor guidelines.

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

- Implement workflow process using ACOG/SMFM cesarean decision checklist through shared decision making with patient (decision huddle with provider, nurse and patient to review treatment options, risk/benefits, and ACOG/SMFM guidelines).

- Implement standardized patient education with positive messaging promoting vaginal birth strategies and techniques for women and families.

- Integrate process to review and share data that includes provider-level data with clinical team.

## Process Measures

Percentage of providers and nurses receiving standardized education regarding:

- ACOG/SMFM labor guidelines
- Labor management strategies/response for labor challenges
- 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):

- NTSV spontaneous labor arrest/labor dystocia/FTP/CPD;
- NTSV induced labor management;
- 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
- Emily White-VanGompel, MD, MPH, Family Medicine, NorthShore University Health System
THE CMQCC STORY- CHRISTA SAKOWSKI
Supporting Vaginal Birth in California: Collaborative Lessons Learned

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

• Describe the results of a large statewide collaborative for cesarean reduction in California
• Describe a team process for approaching this work
• Give examples of cesarean reduction strategies that worked in successful facilities
• Identify areas of focus for sustaining success
The CMQCC Collaborative to Support Vaginal Birth

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<th>End Date</th>
<th>Number of Hospitals</th>
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<td>Oct 2017</td>
<td>24 Hospitals</td>
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<td>Jan 2017</td>
<td>Jun 2018</td>
<td>42 Hospitals</td>
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<tr>
<td>3</td>
<td>Nov 2017</td>
<td>May 2019</td>
<td>25 Hospitals</td>
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**91 Participating Hospitals, all with starting NTSV Rates ≥24%**
California NTSV Cesarean Rate - 1/1/14 – 9/30/19

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

63% ≤23.9%
20% >26.0%
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 tertile 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).
Trendlines for NTSV Cesarean and Safety Measures (6-month blocks)

CMQCC QI Collaborative Start May 2016

Building the Team
Characteristics of a Successful Team

• Build the team before you build the plan
• Set the expectation that bedside staff is integral
• Communication
  □ Who
  □ How
  □ When
  □ Timely
• Prepare for scheduled meetings
  □ Suggest monthly to build the framework, ensure consistency of attendance and commitment to the work
Standard Team Members

• Physician Leaders – OB, MFM
• Midwifery Leaders
• Nurse Leaders – Director, Manager, CNS, Educator
• Informal Leaders
• Data Colleagues
  - Quality Staff
  - Patient Safety/Risk Management
  - Health Information Management Staff
  - Analyst
Supportive Team Members

- Administrative Leaders
- Patient Representative
- Board of Directors
- Community Leaders
- Marketing
- ILPQC!
Model Positive Culture within the Team

- Establish behavior ground rules at the first meeting. These should be generated by team members.
- Transparency, teamwork and mutual respect.
- Commit to transparent positive communication with team members, nursing staff, medical staff, quality department and administration.
- Role model the use of data to drive QI. All team members are responsible for the data, not just the Quality department. Understand what is driving your quality outcomes.
Key Activities for Meetings

• Make an agenda
• Review the data
• Present and discuss successes / challenges / concerns
• Review the implementation plan
• Review PDSA cycles in process
• Identify adjustments to plan and associated education
• Address questions and suggestions made by the staff
Plan for Success
Set Expectations - This is not an easy project

- Start with an easy win
- Identify areas of greatest impact
- No one strategy will be effective
- Involve staff in quality improvement goals
- Celebrate success!
Identify NTSV Patients

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<tr>
<th>Bed</th>
<th>Name</th>
<th>Status</th>
<th>EGA</th>
<th>RN</th>
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<td>Rachel</td>
<td>DP</td>
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<td>Name Alert</td>
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Measure Analysis: Identify “Drivers” of Rates

What Drives Our Nulliparous Term Singleton Vertex (NTSV) CS Rate?

<table>
<thead>
<tr>
<th>Category</th>
<th>Spontaneous Labor</th>
<th>Induced Labor</th>
<th>No Labor</th>
<th>Total</th>
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<tbody>
<tr>
<td>Demo Hospital</td>
<td>20.8%</td>
<td>7.3%</td>
<td>6%</td>
<td>34.1%</td>
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<tr>
<td>All Community Nurseries</td>
<td>14.1%</td>
<td>7.3%</td>
<td>4.9%</td>
<td>26.3%</td>
</tr>
<tr>
<td>CA Statewide</td>
<td>14.2%</td>
<td>7.3%</td>
<td>4.6%</td>
<td>26.1%</td>
</tr>
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NTSV CS Rate Divided into 3 Major Components

Screen Shot from the CMQCC Maternal Data Center
COMMON QI ACTIVITIES:

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)
Labor Support
Physician Badge Tag

**Prevent Her 1st Cesarean Section**

*Latent Phase Arrest (Failed Induction of Labor)*
- If <6cm dilated → 12 hrs of oxytocin after ROM?

*Active Phase Arrest (Arrest of Dilation)*
- If 6-10cm dilated + ROM → 4h with adequate uterine activity or at least 6h with inadequate uterine activity with oxytocin

*Arrest of Descent (2nd stage)*
- If completely dilated → pushing ≥3hr without epidural in Second Stage (or 4hrs with epidural)

**Elective Induction of Labor**
- Prior to 41 weeks
- Bishop score ≥ 8 (nulliparous); ≥6 (multiparous)

*Physician Documentation (tell the story)*

- Labor management
- Decision/rationale for C-section

**Laborist Contact Number**
- #(618)885-8500 ext. 5350

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Education and Adoption of ACOG/SMFM Guidelines
Share Unblinded Data

**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 primary cesarean indications. Ongoing monthly review for consistency with guidelines is also quite useful (recognizing that not every case will follow the guidelines perfectly). The Readiness Assessment and Structure Measures Checklist will assist with this baseline review. Success of the project hinges upon system improvements that support providers in reducing individual rates.

The Readiness Assessment, Structure Measures Checklist (both are found in the Implementation Guide), 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-reduce-cesareans/collaborative*

*Healthy People 2020 Target
California Hospitals: CS after IOL (nullips), 2019

All California Hospital Statistics
- Included Hospitals: 166
- Range: 13.0% – 60.0%
- Aggregate Rate: 30.3%
- Median: 30.4%

Cesareans after Labor Induction: Nullip 2019
Team Build
Celebrate Success!!!
Sustaining Success
The work is never done

- Update structure measures
- Keep up with chart audits
- Reinforce with training and resources
- Continue to share successes in a prominent place
Questions
GETTING STARTED WITH PVB
PVB Timeline

December
- Official Kick-off! 12:30-1:30pm
- Baseline Data Reporting Begins

January
- Baseline Data Reporting due January 15
- First Monthly Webinar: January 25
- Labor Culture Survey Launch
Structure Measures

Help you track your implementation of systems changes

• Provider and nurse education
• Standardized protocol processes for induction, labor support management and response to labor and fetal heart rate abnormalities
• Cesarean decision checklist for ACOG/SMFM labor guidelines
• Decision huddle and/or decision debriefs
• Workflow process for shared decision making
• Standardized patient education promoting vaginal birth strategies
• 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
Helps track 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
Baseline Data Collection

- Baseline Data Collection
  - (Oct, Nov, Dec 2020)
  - due January 15
- If you missed our PVB Data Calls
  - recordings are available at www.ilpqc.org
- REDCap
  - REDCap access has been granted by those identified when you submitted your PVB team roster
  - If you have edits to those who need access, please email ellie.suse@northwestern.edu
Data Collection
Commonly Asked Questions

• Find our PVB FAQs on ilpqc.org
• Reach out to ellie.suse@northwestern.edu if you can’t find the answer to your question here!

PVB DATA COLLECTION COMMONLY ASKED QUESTIONS

• What patient-level data are we collecting?
  o 20 total NTSV C-sections: 5 failed induction, 5 labor dystocia/failure to progress, 5 fetal heart rate concerns, and 5 miscellaneous

• Where can I find the NTSV C-section sampling instructions?
  o Sampling instructions can be found on page 3 of the Patient Level Data form

• What if our hospital does not have a large amount of NTSV deliveries (vaginal or cesarean) a month?
  o Hospitals with fewer than 20 NTSV c-sections or 10 vaginal NTSVs a month will report on what is available

• What are we collecting for baseline data?
  o Baseline data will be collected for Q4 2019 (October, November, December)
  o All baseline data is due January 15, 2021
  o If your baseline data collection yields a small amount of NTSVs, we recommend doing another quarter of data collection (Q3 2019) until you reach 10 NTSV C-sections and 5 NTSV vaginal deliveries.

• How do we decide which category our NTSV C-section falls under if two categories are documented (i.e. labor dystocia and FHR concerns)?
  o The category chosen should be the driving indication for the delivery decision.
    ▪ For example: a chart documents both a labor dystocia and FHR indication for the delivery decision. The QI team’s investigation shows a longer length of labor was not recommended due to FHR concerns. The QI team would choose the FHR category when entering data on the patient.
  o Remember, each hospital and QI team is unique and this is not a one-size-fits-all process. It is important to have a discussion with your QI team before collecting baseline data.

How do I access REDCap to enter data?

• Those with existing REDCap ID: you will receive an email confirming that ILPQC has granted you access to the PVB forms.
• Those new to REDCAP: you will receive 2 emails
  1. You should have received an email from REDCap with your username and a prompt to create a new password.
  2. You will receive an email confirming that ILPQC has granted you access to the PVB forms.

For additional questions or support, email ILPQC Project Coordinator Ellie Suse at ellie.suse@northwestern.edu
PVB Data Collection

20* NTSV C-Sections + 10 Vaginal Deliveries

Nulliparous, Term, Singleton, Vertex

- 5 Failed Inductions
- 5 Labor Dystocia/ Failure To Progress
- 5 Fetal Heart Rate Concerns
- 5 Any of the Above

*Hospitals with fewer than 20/10 cases per month will report those available
Monthly Data Collection: Patient Level Measures

C/S Failed Induction

C/S Fetal Heart Rate Concerns

C/S Labor Dystocia/ Failure to Progress

Vaginal Delivery
Data Collection tool: Process Flows

PVB Process Flow ACOG/SMFM Criteria for Review:
Induction

- Patient is <6 cm dilated
  - Yes: Was there at least 12-18 hours of rupture of membranes after induction?
  - No: Was the patient allowed a longer duration of the latest phase (up to 24 hours or longer)?

- Patient is ≥6 cm dilated
  - Yes: Was there a need for analgesia or anesthesia?
  - No: Was there any need for further action?

- Patient is completely dilated
  - Yes: Was there a need for further action?
  - No: Was there any need for further action?

PVB Process Flow ACOG/SMFM Criteria for Review:
Labor Dystocia/ Failure to Progress

- Patient is <6 cm dilated
  - Yes: Were ACOG/SMFM criteria met?
  - No: Was there any need for further action?

- Patient is ≥6 cm dilated
  - Yes: Was there a need for further action?
  - No: Was there any need for further action?

- Patient is completely dilated
  - Yes: Were ACOG/SMFM criteria met?
  - No: Was there a need for further action?

PVB Process Flow ACOG/SMFM Criteria for Review:
Fetal Heart Rate Concerns

- Antepartum testing which precedes labor
  - Yes: Was a corrective action taken on the fetal heart rate abnormalities prior to labor?
  - No: Was there any need for further action?

- Category I: Fetal heart rate tracing
  - Yes: Were ACOG/SMFM criteria met?
  - No: Was there a need for further action?

- Category II: Fetal heart rate tracing
  - Yes: Were ACOG/SMFM criteria met?
  - No: Was there a need for further action?

- Late decelerations
  - Yes: Were ACOG/SMFM criteria met?
  - No: Was there a need for further action?

- Clinically significant intrapartum events
  - Yes: Were ACOG/SMFM criteria met?
  - No: Was there a need for further action?
### Total NTSV Rate

#### Structure Measures

1. Implement provider and nurse education and other strategies to achieve buy-in.
2. Implement standardized protocol/processes for induction, labor support management, and response to labor and fetal heart rate abnormalities.
3. Implement and integrate PV/Border order sets, protocols and documentation into the EMR.
4. Implement cesarean decision checklist using ACOG/SMFM labor guidelines.
5. Implement decision huddles and/or decision briefs with appropriate care team to standardize use of ACOG/SMFM guidelines and checklist.
6. Implement workflow process to incorporate shared decision making with the patient (decision huddle with provider, nurse and patient to review treatment options, risk/benefits, and ACOG/SMFM guidelines/checklist).
7. Implement standardized patient education with positive messaging promoting vaginal birth strategies and techniques for women and families.
8. Integrate process to review and share data that includes provider-level data with labor and delivery clinical teams.

#### Process Measures

1. Percentage of providers receiving standardized education regarding ACOG/SMFM labor guidelines to date
   - 0%
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - 60%
   - 70%
   - 80%
   - 90%
   - 100%

2. Percentage of nurses receiving standardized education regarding ACOG/SMFM labor guidelines to date
   - 0%
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - 60%
   - 70%
   - 80%
   - 90%
   - 100%

3. Percentage of providers receiving standardized education regarding Labor Management strategies/response for labor challenges to date
   - 0%
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - 60%
   - 70%
   - 80%
   - 90%
   - 100%

4. Percentage of nurses receiving standardized education regarding Labor Management strategies/response for labor challenges to date
   - 0%
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - 60%
   - 70%
   - 80%
   - 90%
   - 100%

5. Percentage of providers receiving standardized education regarding Protocol for facilitating decision huddles and/or decision briefs to date
   - 0%
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - 60%
   - 70%
   - 80%
   - 90%
   - 100%

6. Percentage of nurses receiving standardized education regarding Protocol for facilitating decision huddles and/or decision briefs to date
   - 0%
   - 10%
   - 20%
   - 30%
   - 40%
   - 50%
   - 60%
   - 70%
   - 80%
   - 90%
   - 100%
Helping you use your data for PVB success

We are SO excited to introduce a new data dashboard to optimize your monthly data review

- Overall NTSV c-section rate with improved hospital comparison
- Monthly summary of NTSV c-section rate by indication
- Detailed tracking of compliance with ACOG/SMFM guidelines

Access to real time data allows your hospital to see the effects of QI strategies and drive QI efforts.
How will ILPQC help?

• PVB Toolkit available online
• Monthly team webinars starting in January 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!
PVB Toolkit: What’s Inside?

• Introduction
1. Initiative Resources *10 Steps to Getting Started with PVB*
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
   – Building a Strong QI Team
   – Provider/Nurse Education
   – Patient Education
   – Clinical Care team Debrief/Huddles and SHARED decision making
6. Labor Management
   – Algorithms for stages of labor
   – Labor management support and response to labor challenges
7. Standardization of Policy, Protocols, & Algorithms
   – Inductions
   – Labor Challenges/Dystocia
   – Fetal Intolerance
PVB Toolkit

- A member of your team should have received a toolkit binder in the mail!
  - If you did not receive a binder, extras have been sent to your PNA

- **Reminder:** The toolkit is a living document and updated often, be sure to check the online toolkit for the latest documents

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**Initiative Resources**

- 10 Steps to Getting Started with the ILPQC Promoting Vaginal Birth Initiative (Updated 11/12)
- PVB 3 Key Opportunities for Improvement
- Promoting Vaginal Birth Aims and Measures (Updated)
- Promoting Vaginal Birth Data Form (Updated 12/7)
- Promoting Vaginal Birth Hospital-Level Measures Data Form (Updated 12/7)
- PVB Data Collection Commonly Asked Questions
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)
**Example: 30-60-90 Day Plan**

### 30 Day

**Overall Goal:**
Develop Data Collection plan and schedule monthly QI Team Meetings

**Tasks to Achieve Goal**
- 1. Review RedCap data form
- 2. Assign Data Collection Tasks
- 3. Schedule monthly meetings

**Responsibility**
- QI Team
- Team Lead
- Team Lead

### 60 Day

**Overall Goal:**
Complete baseline data collection and review data with QI team

**Tasks to Achieve Goal**
- 1. Collect Baseline data
- 2. Review baseline data
- 3. Identify areas for improvement

**Responsibility**
- QI Team
- Team Lead
- Team Lead

### 90 Day

**Overall Goals:**
1. Labor culture survey launch
2. Review toolkit and Key Drivers Diagram to develop first PDSA cycle

**Tasks to Achieve Goal**
- 1. Send survey to all providers and nurses
- 2. Meet with QI team to develop PDSA cycle

**Responsibility**
- L&D Manager
- QI Team
10 Steps to Getting Started

1. Submit Roster and complete PVB Teams Readiness Survey
2. Review ILPQC Data Collection Form and Attend Data Call
3. Schedule regular, at least monthly PVB QI team meetings
4. Reference PVB Key Driver Diagram to identify possible interventions to get started
5. Review ILPQC Promoting Vaginal Birth Online Toolkit for resources to help

START HERE!
10 Steps to Getting Started

Diagram L&D process flow for delivery decisions

Plan for Labor Culture Survey Distribution

Plan PDSA cycle to address 30-60-90 day plan

Meet with QI team to create draft 30-60-90 day plan

Conduct baseline data collection and review
Next Steps

✓ Begin data collection going back to October 2019 through December 2019.

✓ Add ILPQC to your “Safe Sender List”

✓ Register for Monthly Webinars on Zoom and add to your calendar

✓ Email info@ilpqc.org or ellie.suse@northwestern.org with any questions.
# Upcoming Monthly Webinars

**4th Monday of the Month**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday, January 25</strong> 12:30-1:30</td>
<td>Labor Culture Survey and getting started</td>
</tr>
<tr>
<td><strong>Monday, February 22</strong> 12:30-1:30</td>
<td>Creating Buy-in and overcoming resistance to change</td>
</tr>
<tr>
<td><strong>Monday, March 22</strong> 12:30-1:30</td>
<td>Developing and implementing an ACOG/SMFM checklist and used a shared decision-making approach</td>
</tr>
<tr>
<td><strong>Monday, April 26</strong> 12:30-1:30</td>
<td>Labor Management Support</td>
</tr>
<tr>
<td>May 26</td>
<td>Virtual Face-to-Face</td>
</tr>
</tbody>
</table>

Zoom Registration link on ilpqc.org. Make sure to add entire series to your calendar when you register!

More information about labor management support classes coming soon!!!
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?