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

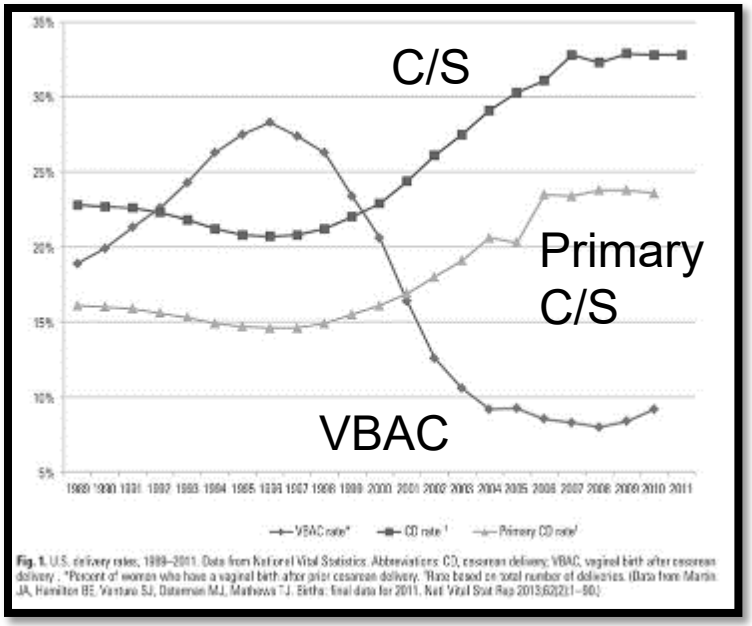
- Why PVB?
- ILPQC Structure and Supports
- Initiative overview
- Guest Speaker- Christa Sakowski CMQCC
- Getting Started with PVB
- Upcoming Events & Next Steps
  - Face-to-Face

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



*ACOG Safe Prevention of Primary C-Section 2014

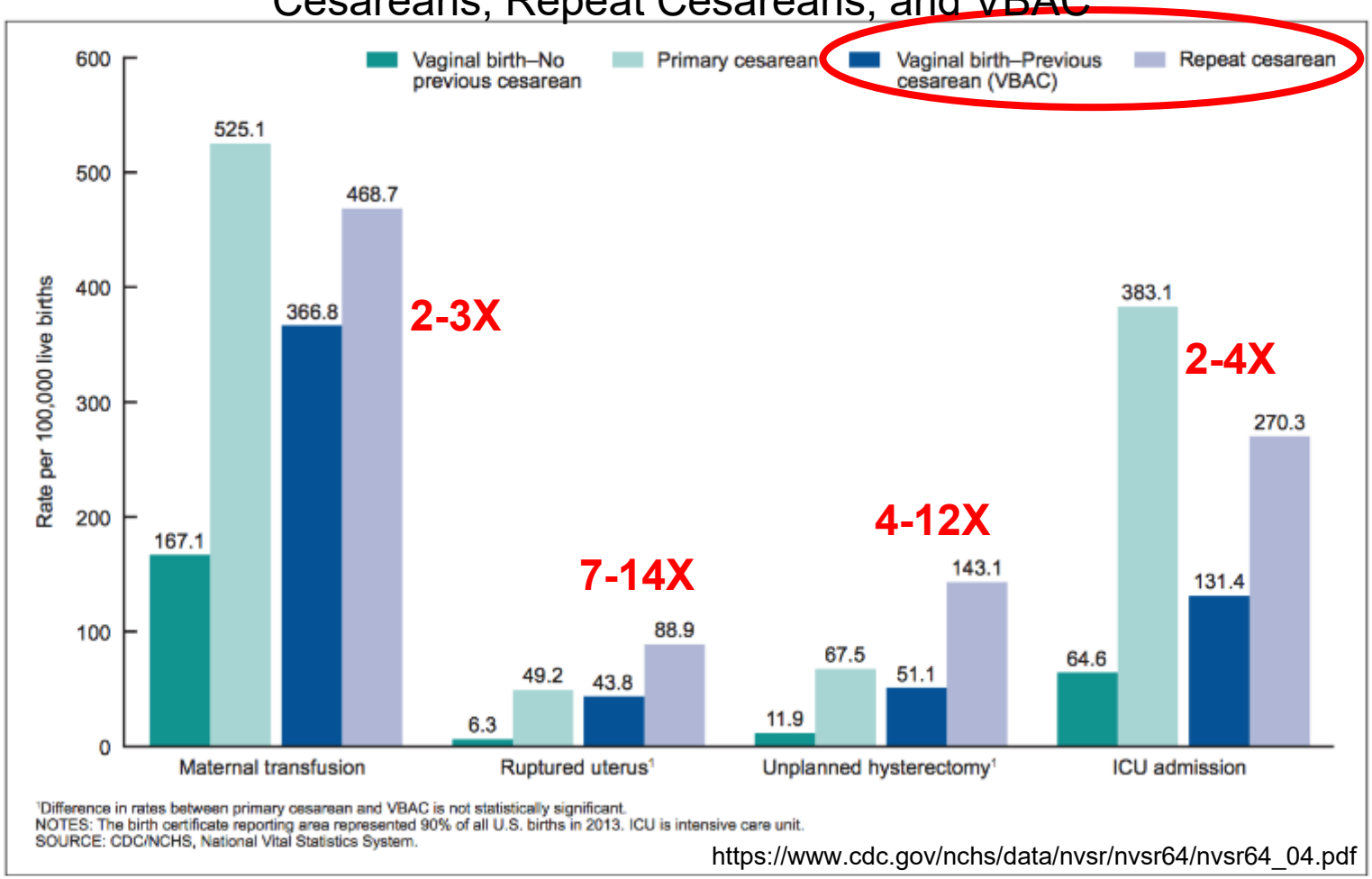
- Quality Improvement Initiatives have shown results
  - CMQCC and FPQC initiatives reduced primary cesarean rates while maintaining optimal neonatal outcomes

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

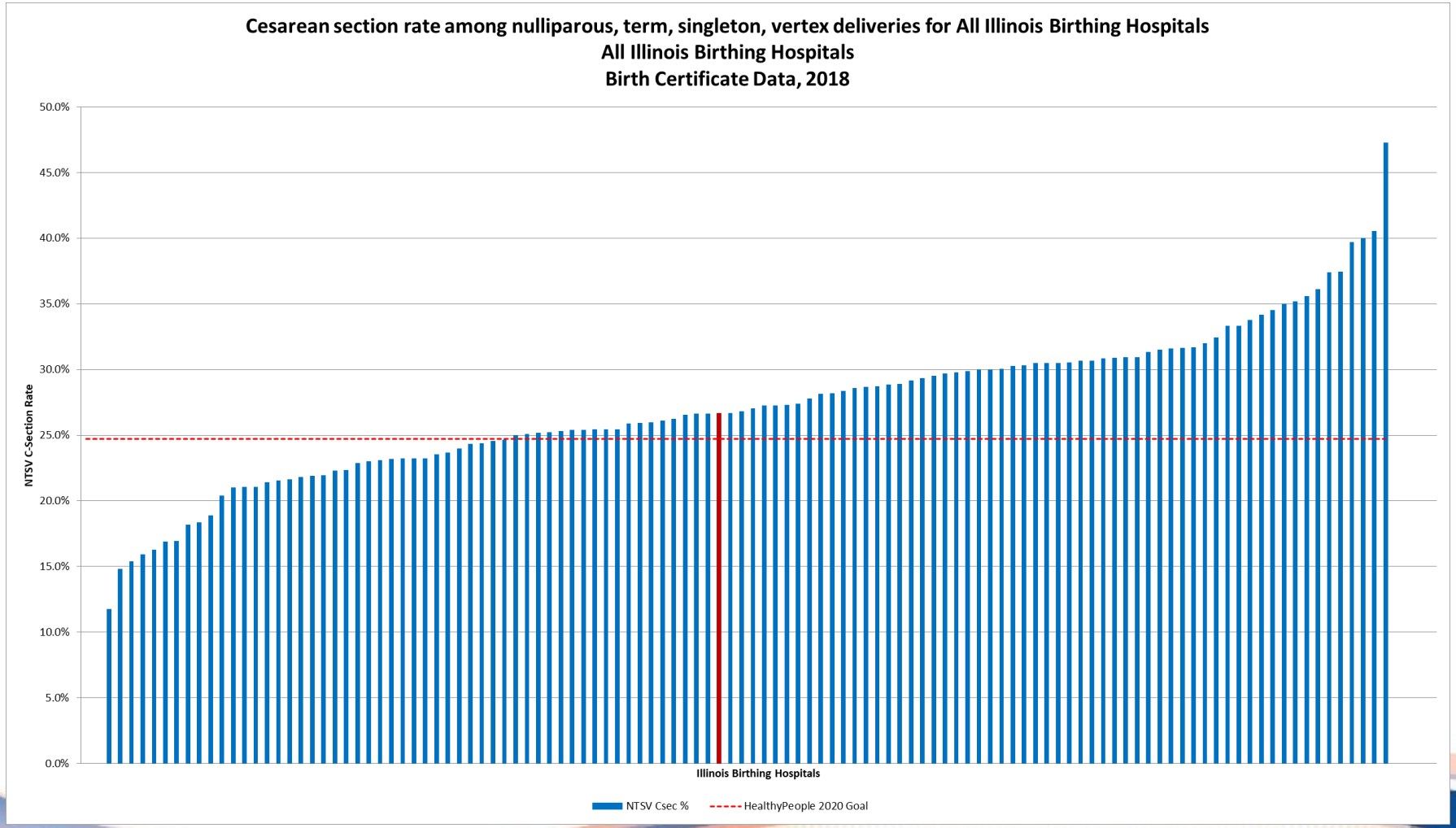
Major Maternal Complications: Vaginal Births versus Primary Cesareans, Repeat Cesareans, and VBAC



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

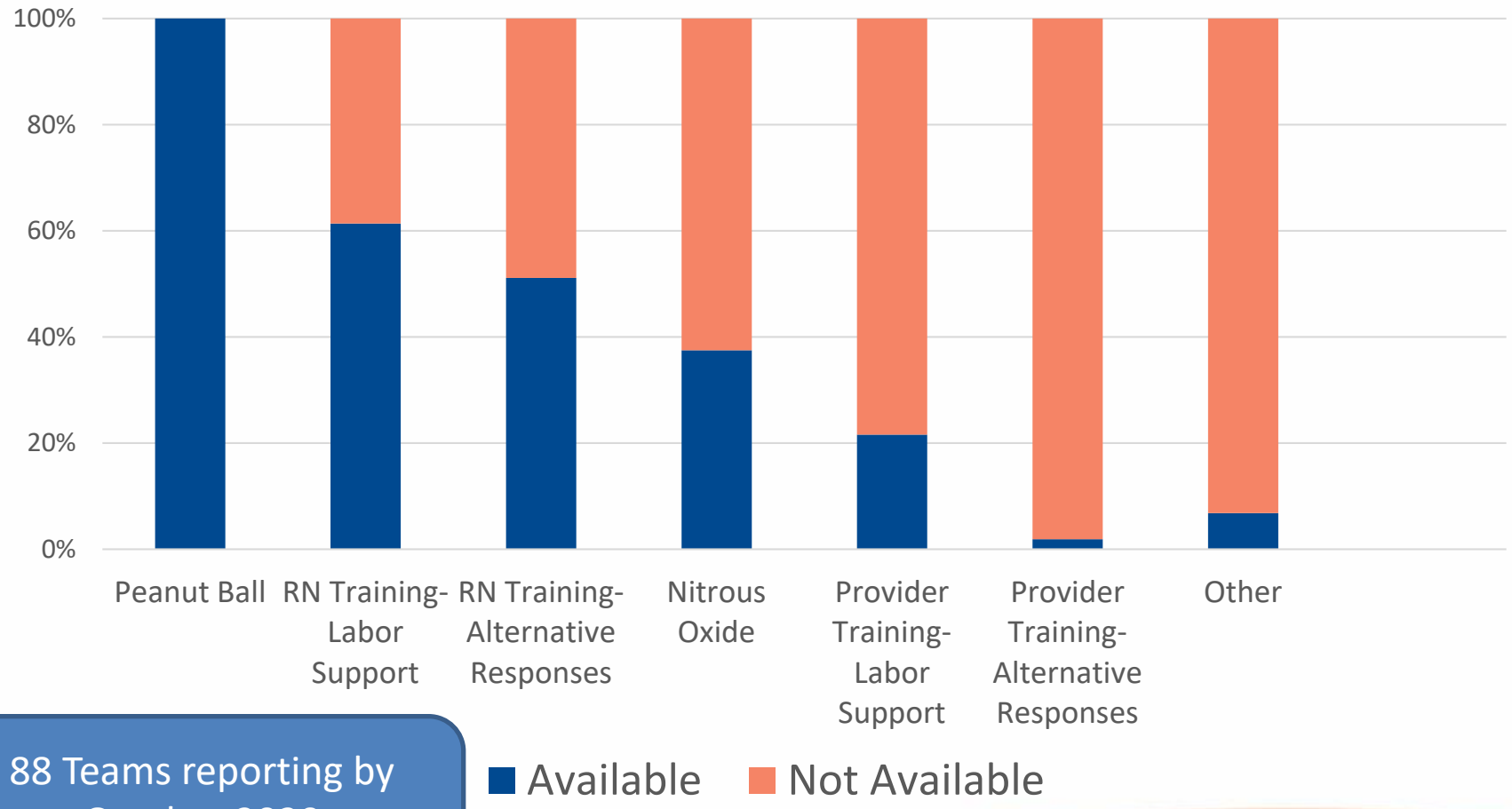
Figure 1. Maternal morbidity, by method of delivery and previous cesarean history: 41-state and District of Columbia reporting area, 2013

Illinois NTSV C-Section Rate Data



PVB Readiness Survey:

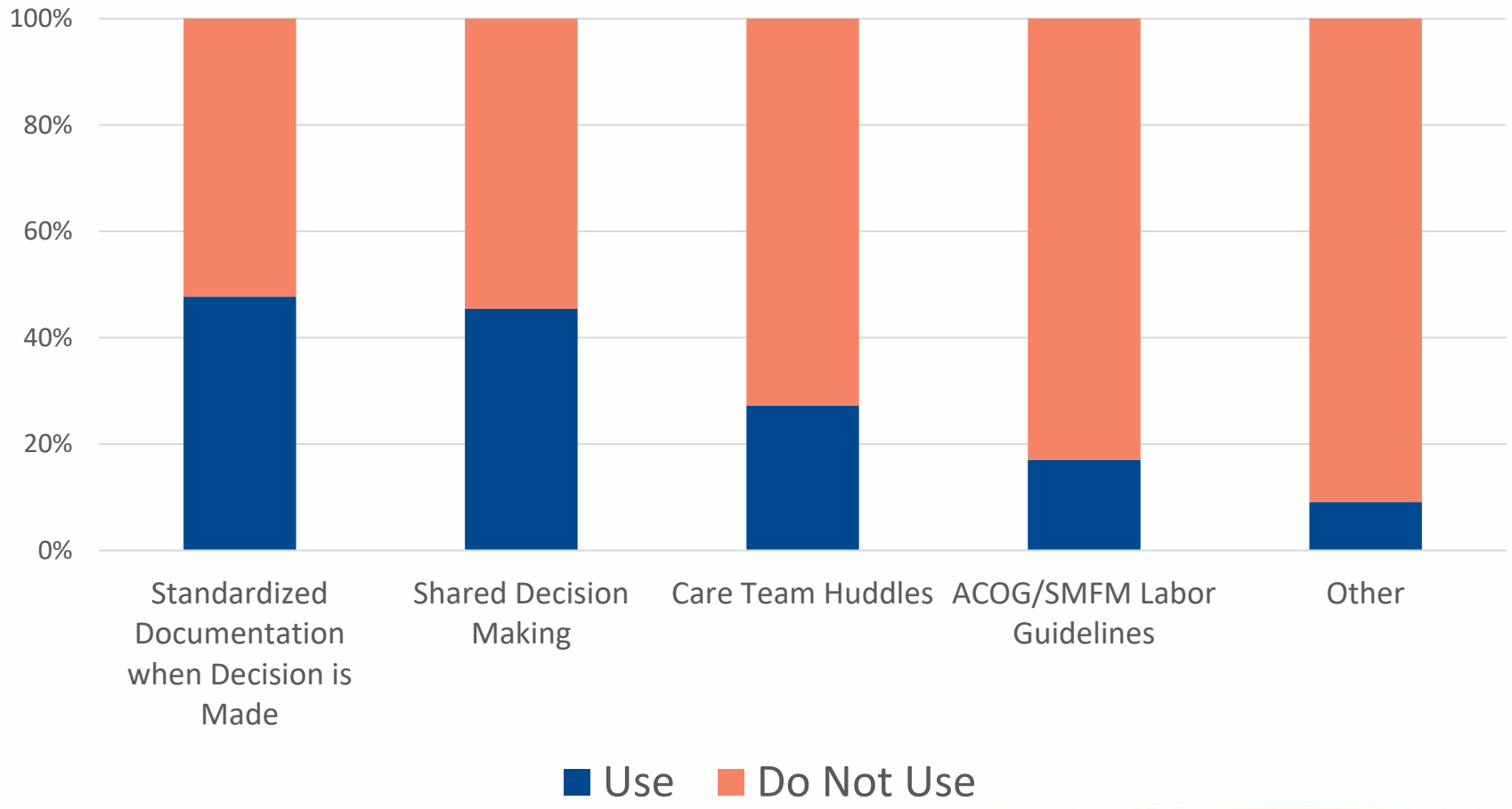
Current tools/responses available to staff for labor support



88 Teams reporting by October 2020
95% of PVB Teams

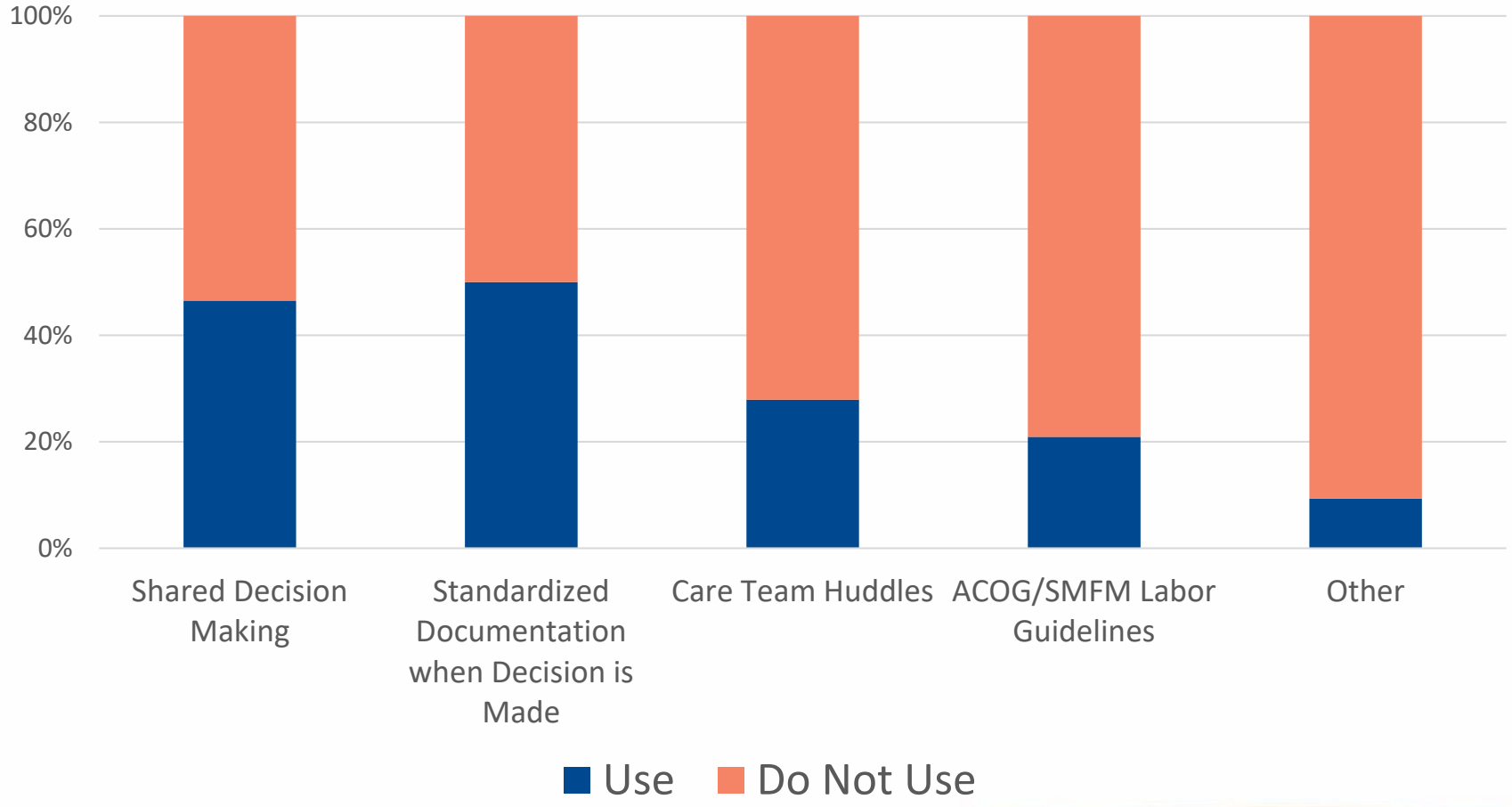
PVB Readiness Survey:

Strategies currently used for cesarean delivery decisions for inductions



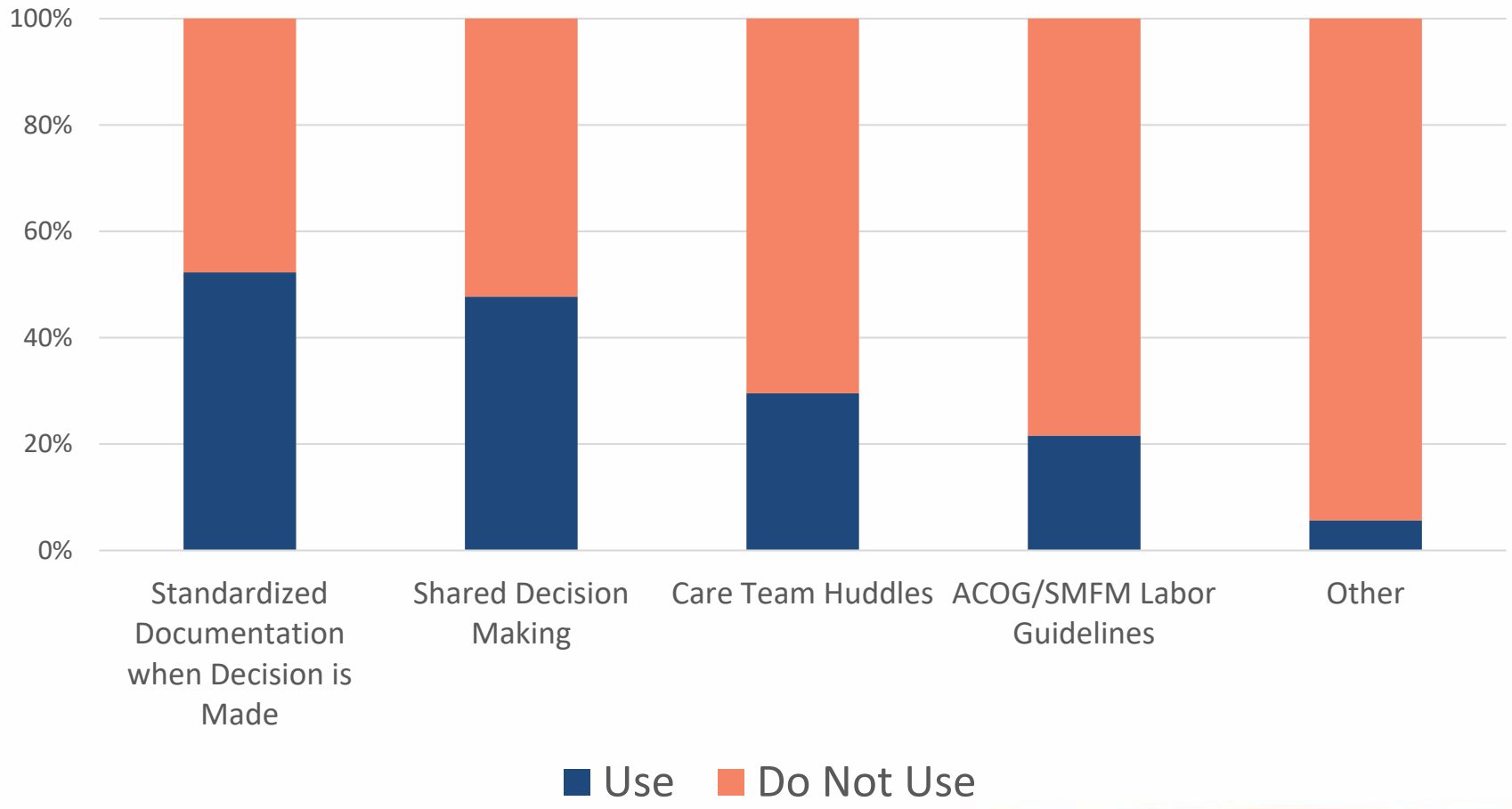
PVB Readiness Survey:

Strategies currently used for cesarean delivery decisions for Labor Complications in the Second Stage



PVB Readiness Survey:

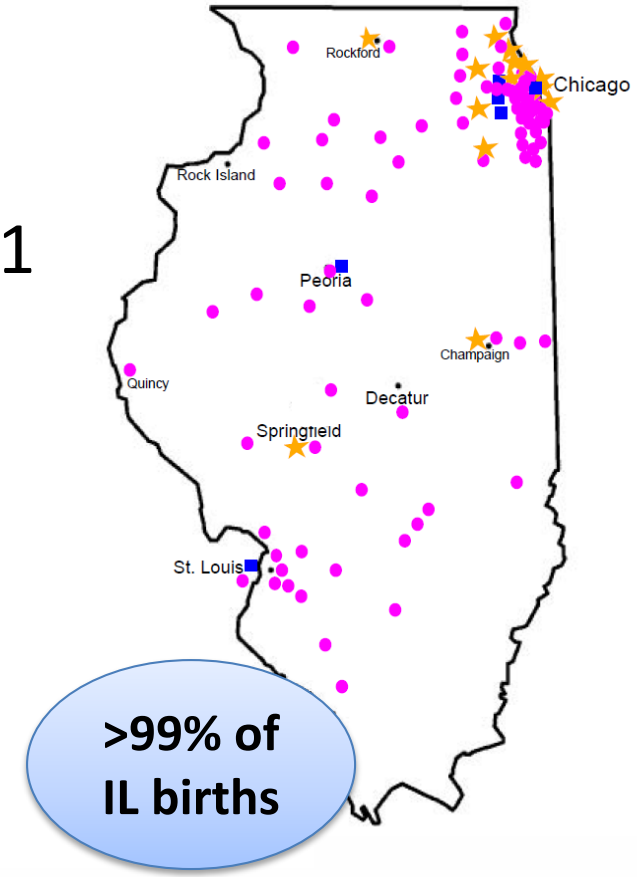
Strategies currently used for cesarean delivery decisions Fetal Heart Rate Concerns



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



ILPQC Central Team

Ann Borders
ILPQC Executive Director, OB Lead

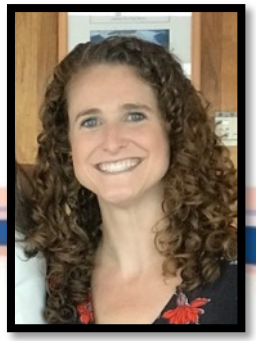
Leslie Caldarelli & Justin Josephsen
Neonatal Leads

Patricia Lee King
State Project Director, Quality Lead

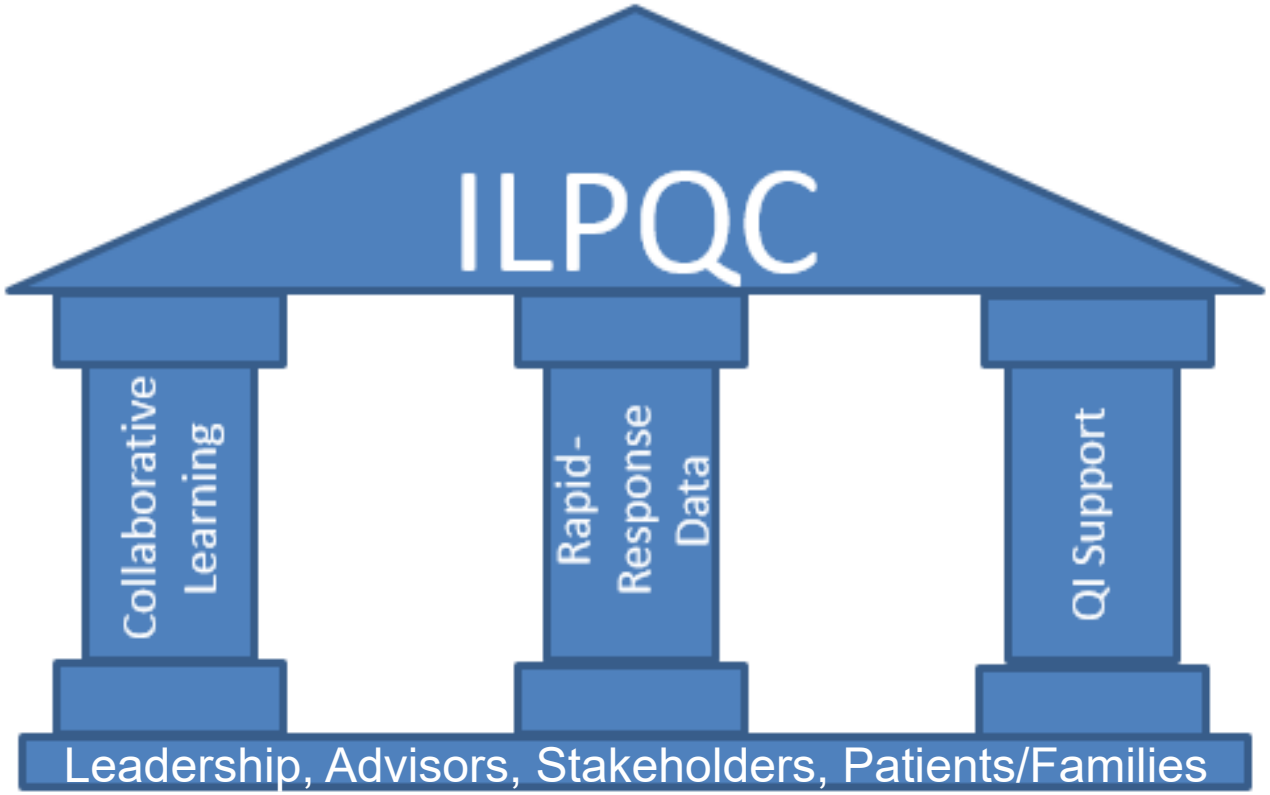
Daniel Weiss & Autumn Perrault
Project Manager, Nurse Quality Manager

Kalyan Juvvadi
Data System Developer

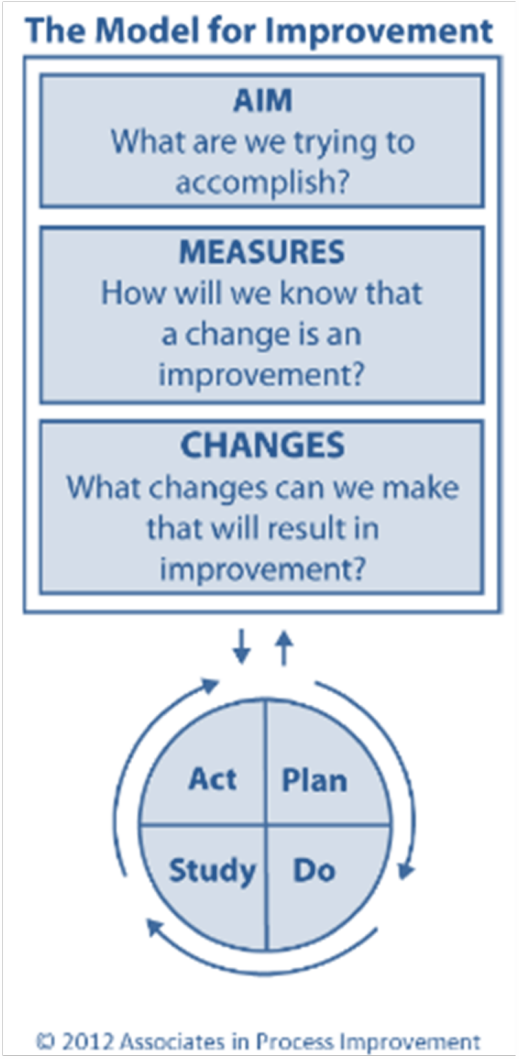
Ieshia Johnson & Ellie Suse
Project Coordinators



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?

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, 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

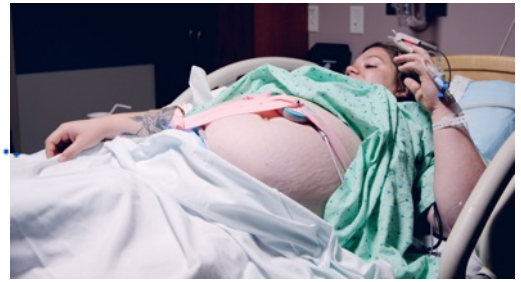
TO SUPPORT VAGINAL BIRTH AND REDUCE PRIMARY CESAREANS TO REACH THE HEALTHY PEOPLE GOAL FOR LOW RISK CESAREAN SECTION TARGET RATE OF 24.7% BY DECEMBER 2021

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



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 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)

ILPQC
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: 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
- **Emily White-VanGompel**, MD, MPH, Family Medicine, NorthShore University Health System

THE CMQCC STORY- CHRISTA SAKOWSKI

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California Maternal
Quality Care Collaborative

Supporting Vaginal Birth in California: Collaborative Lessons Learned

Christa Sakowski, RN, MSN, C-EFM, CLE

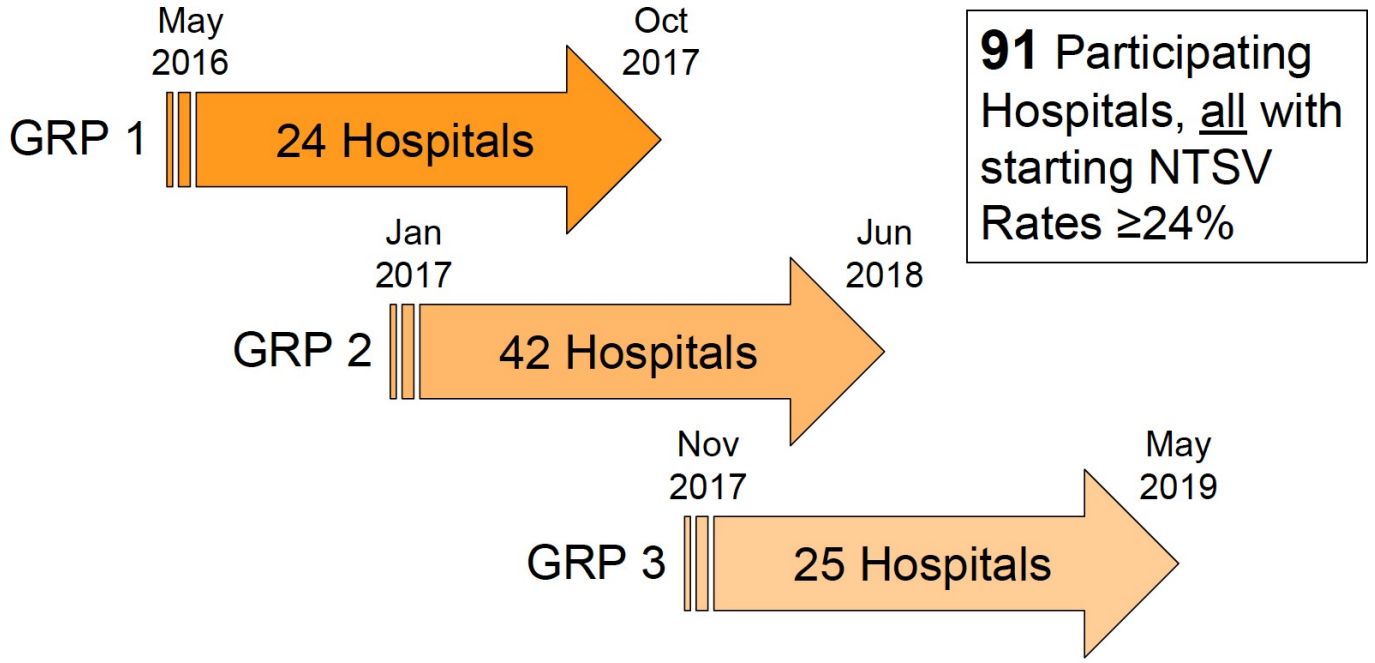
Clinical Lead, CMQCC

Co-lead for the Supporting Vaginal Birth Reducing Primary Cesarean Collaborative

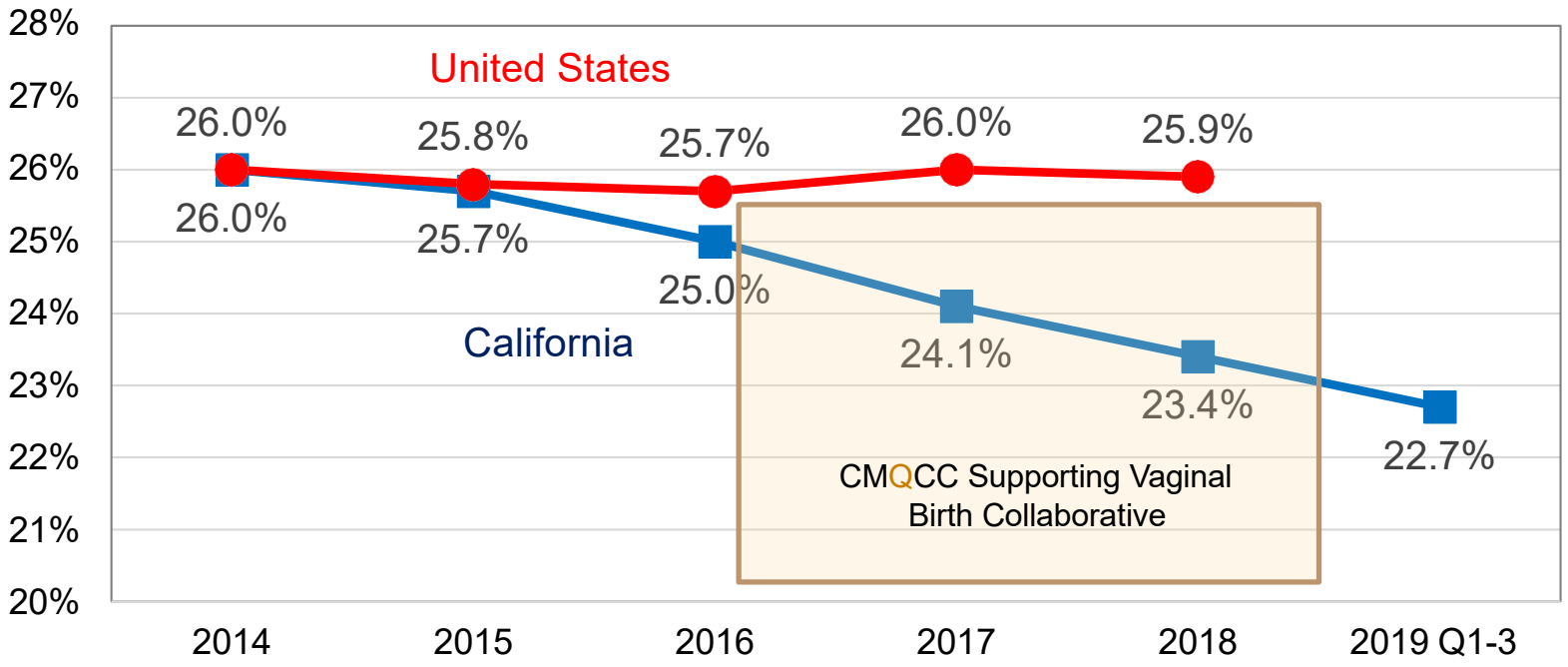
Objectives

- 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

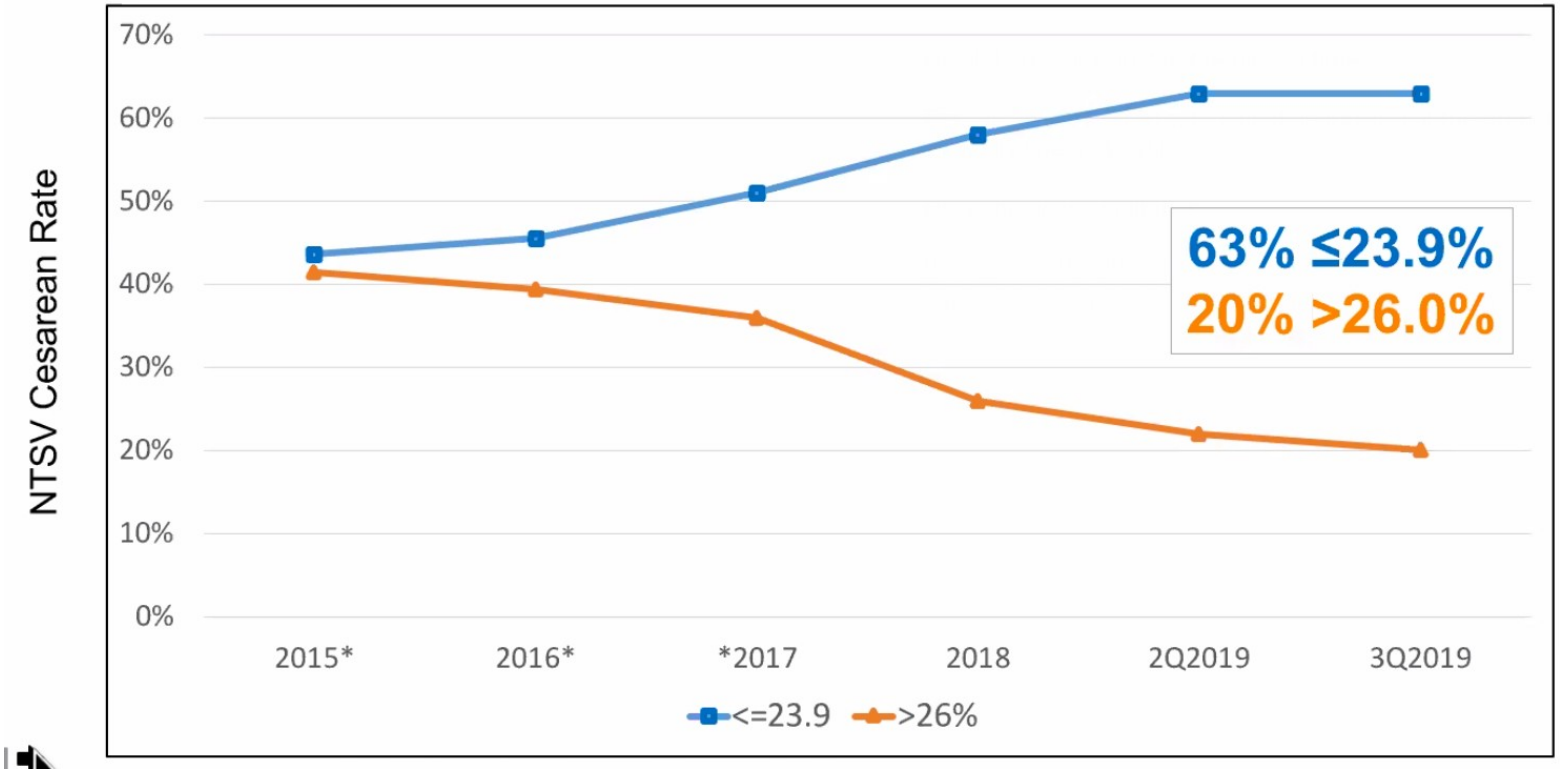
The CMQCC Collaborative to Support Vaginal Birth



California NTSV Cesarean Rate - 1/1/14 – 9/30/19



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



Safety of Cesarean Reduction

Cesarean Delivery: *Original Research*

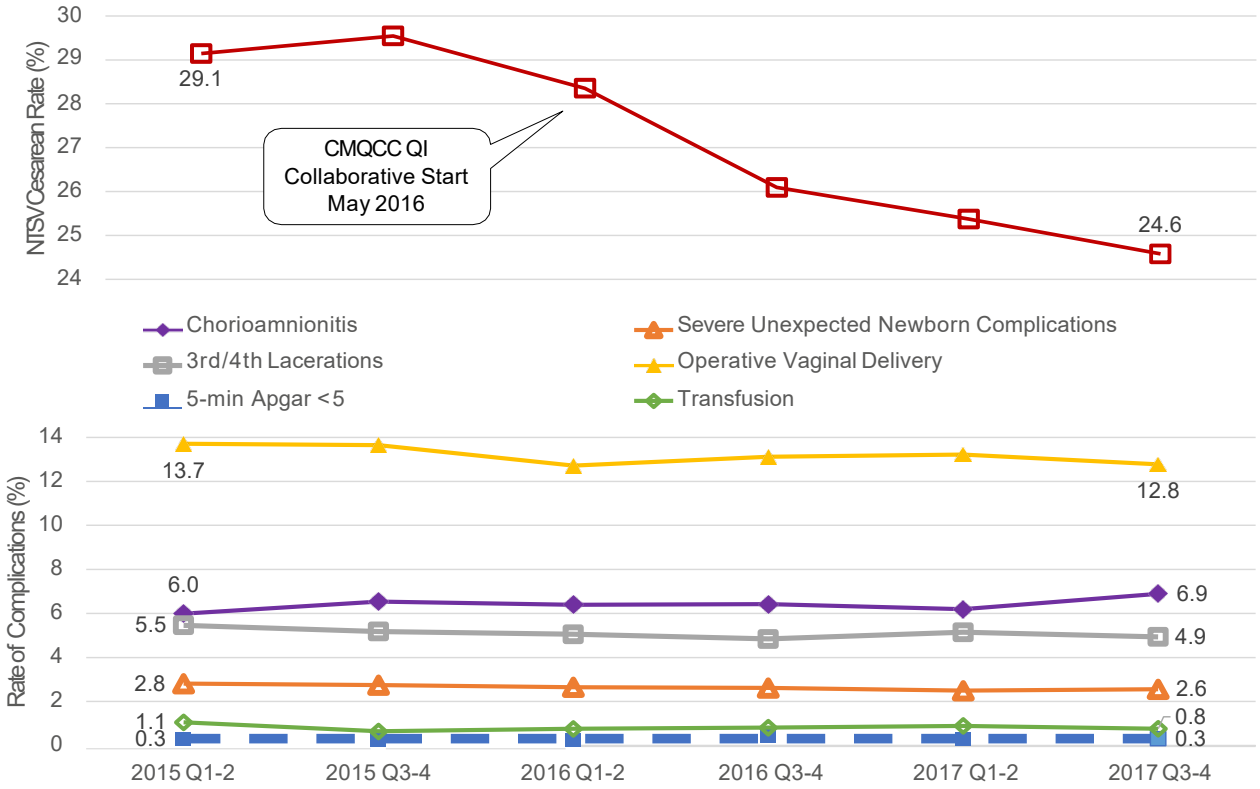
Safety Assessment of a Large-Scale Improvement Collaborative to Reduce Nulliparous Cesarean Delivery Rates

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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Quality Care Collaborative

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

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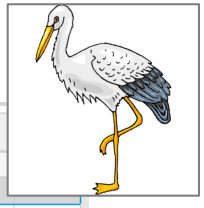
Plan for Success

Set Expectations - This is not an easy project

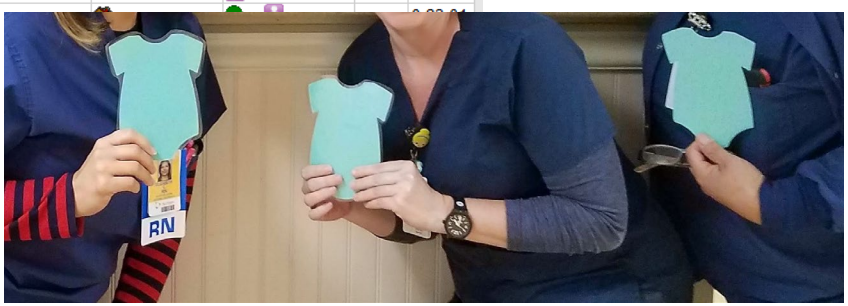
- Start with an easy win
- Identify areas of greatest impact
- No one strategy will be effective
- Involve staff in quality improvement goals
- Celebrate success!

Identify NTSV Patients



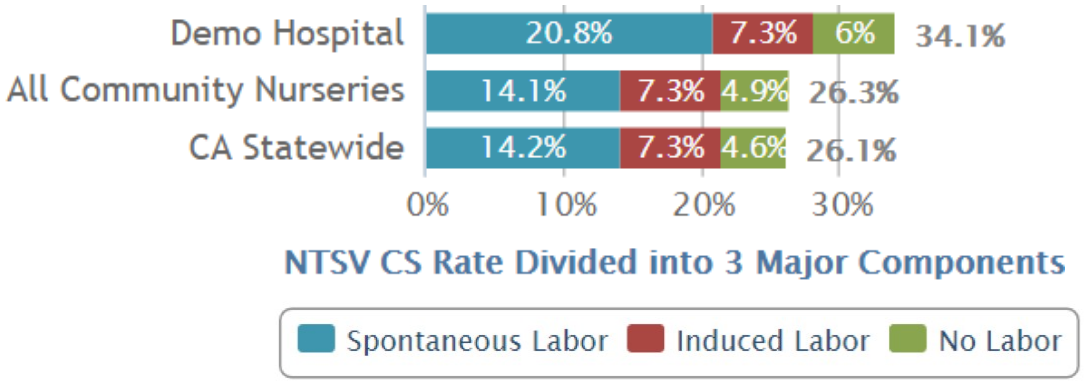
Median LOS: 23:01 Total: 15 WR: 0 Filter: OB Inpatient, OBS, OB Che

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		B			0:2:17
2110,A	Assi						OBHG	Discontinued		V		4:2:51

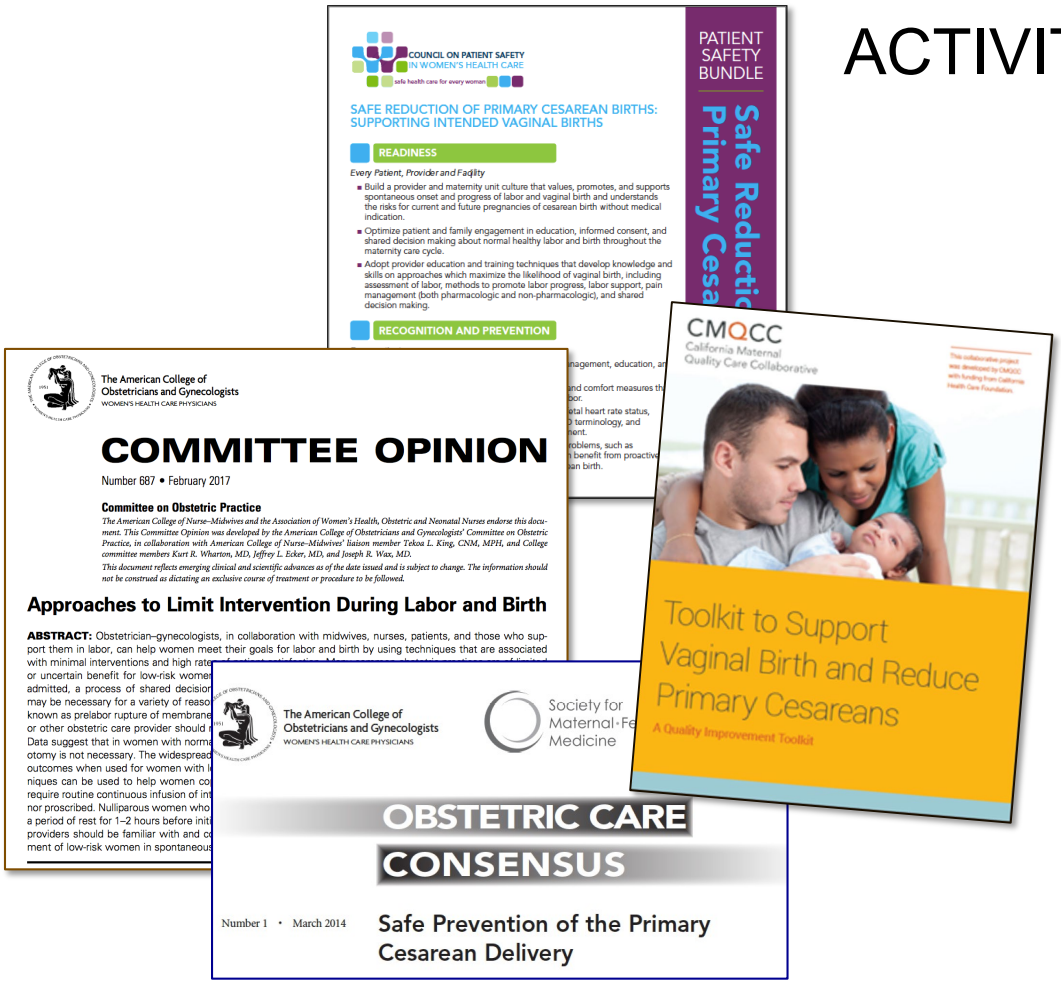


Measure Analysis: Identify "Drivers" of Rates

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



Screen Shot from the CMQCC Maternal Data Center

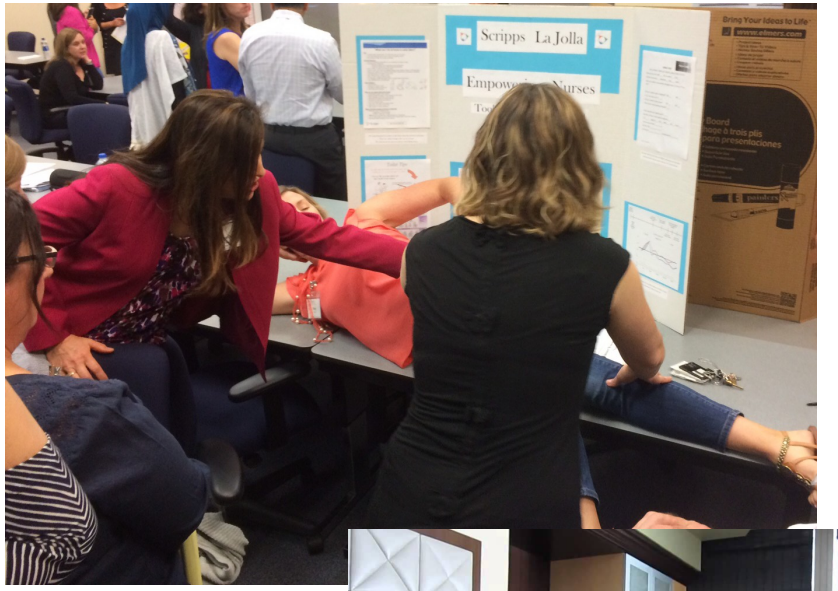


COMMON QI ACTIVITES:

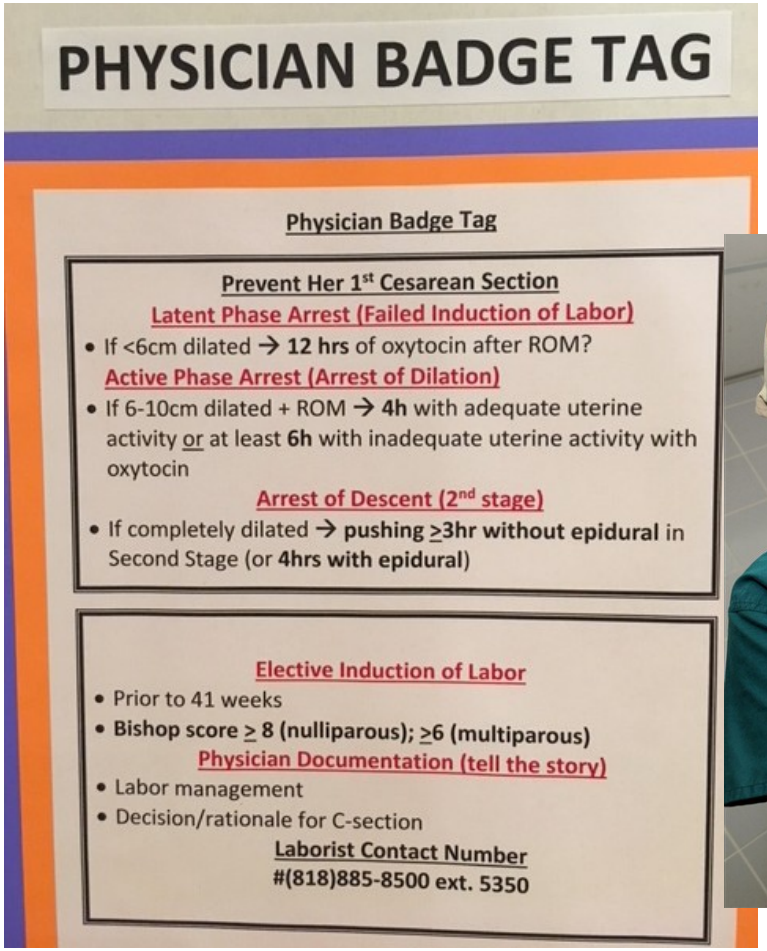
1) Labor support techniques
2) Active phase guidelines - huddle
3) CS rate transparency (unit and provider)
4) Latent phase guidelines
5) Induction guidelines
6) Techniques to reduce OP
7) Patient engagement
8) Unit culture/teamwork/perinatal QI team
9) Longer 2nd Stage

(in approximate order of use)

Labor Support



Education and Adoption of ACOG/SMFM Guidelines



PHYSICIAN BADGE TAG

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

#(818)885-8500 ext. 5350

Share Unblinded Data

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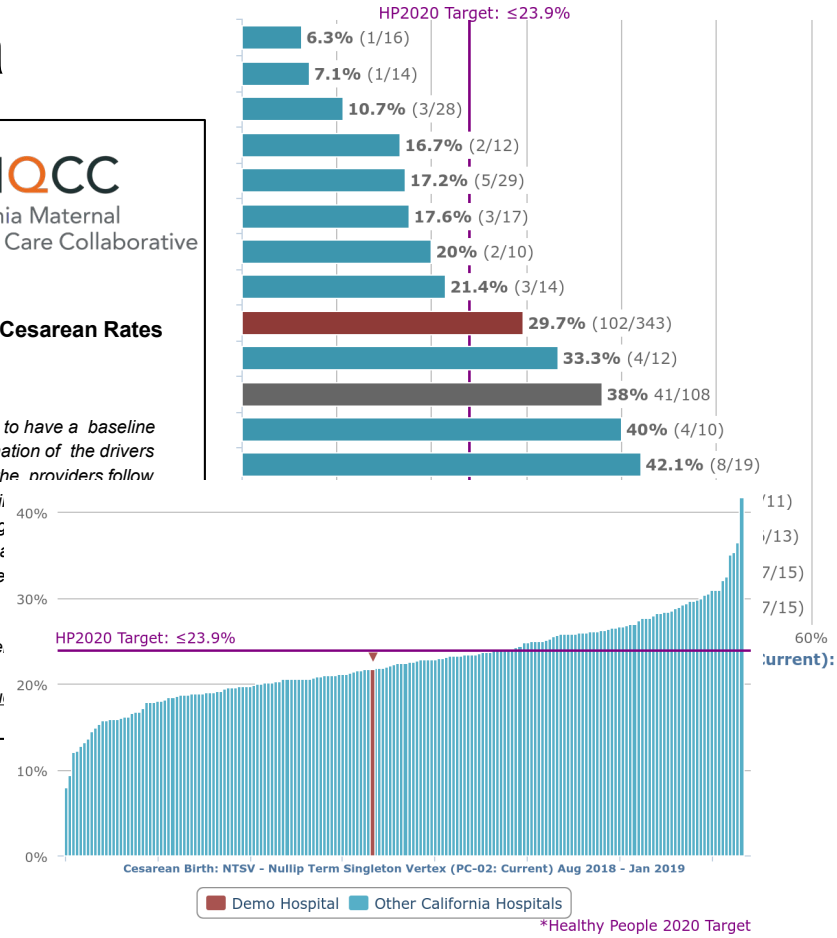
Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates

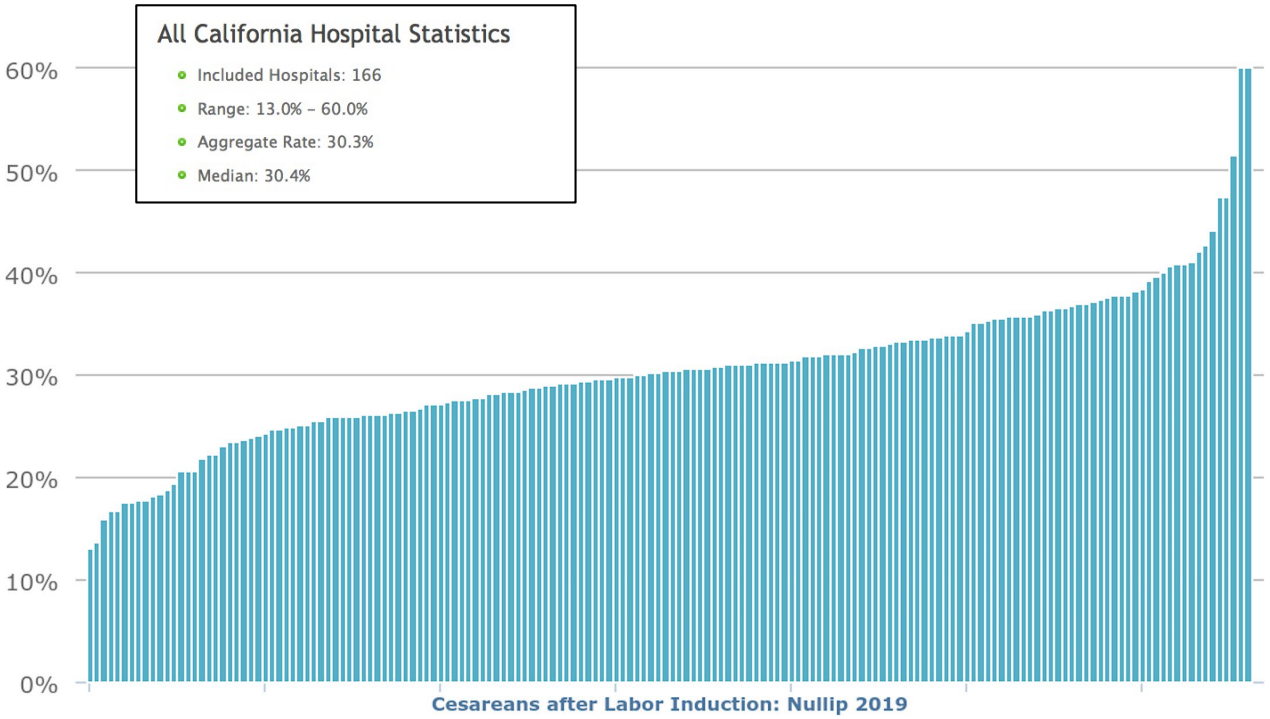
At Start of Project

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 i Ongoing monthly review for consistency with guidelines is also quite useful (recognizing case will follow the guidelines perfectly). The Readiness Assessment and Structure Mea will assist with this baseline review. Success of the project hinges upon system improve support providers in reducing individual rates.

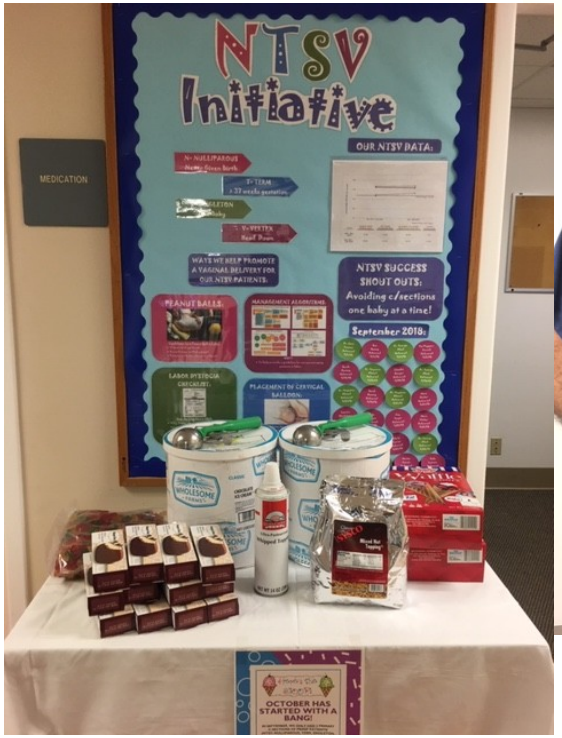
The Readiness Assessment, Structure Measures Checklist (both are found in the Imple and Chart Audit Tool are all located on the collaborative resources page at https://www.cmqcc.org/projects/toolkit-and-collaborative-support-vaginal-birth-and-redu cesareans/collaborative



California Hospitals: CS after IOL (nullips), 2019

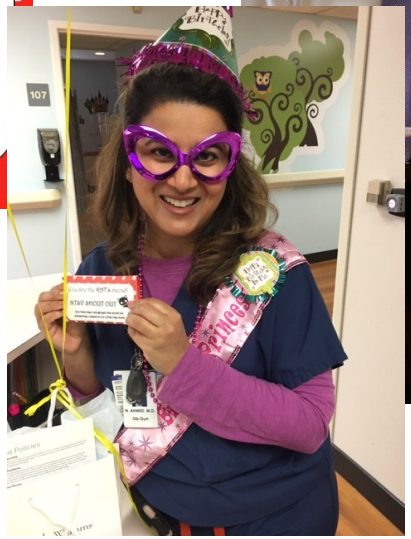


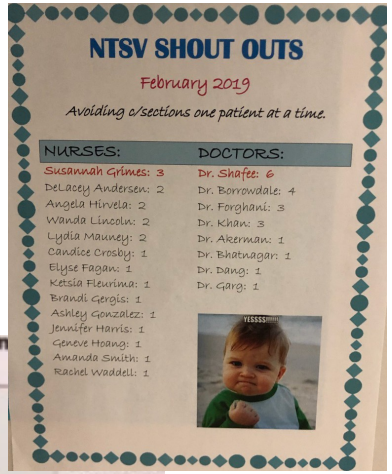
Team Build


NTSV
Initiative
OUR NTSV DATA:
NTSV SUCCESS SHOUT OUTS:
Avoiding c/sections one baby at a time!
September 2018:
MEDICATION
OCTOBER HAS STARTED WITH A BANG!


EXIT

Celebrate Success!!!





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Sustaining Success

The work is never done

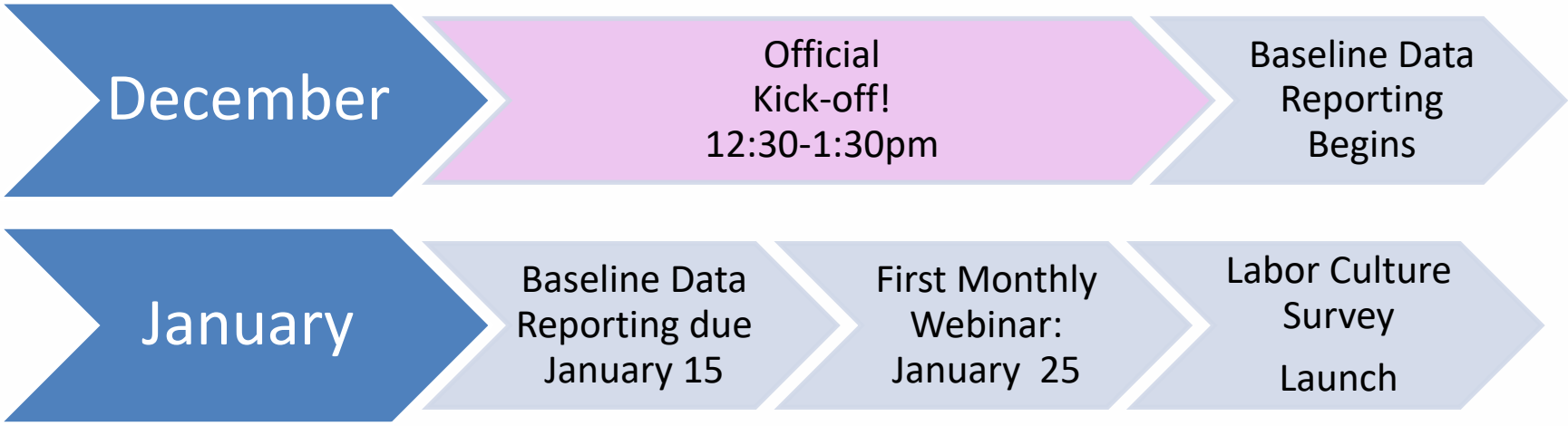
- Update structure measures
- Keep up with chart audits
- Reinforce with training and resources
- Continue to share successes in a prominent place

Questions


CMOCC

GETTING STARTED WITH PVB

PVB Timeline



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@norhtwestern.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?**
  - 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?**
  - 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?**
  - 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?**
  - Baseline data will be collected for Q4 2019 (October, November, December)
  - All baseline data is due January 15, 2021
  - 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)?
  - 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.
  - 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

ILPQC Illinois Perinatal Quality Collaborative

20* NTSV C-Sections + 10 Vaginal Deliveries

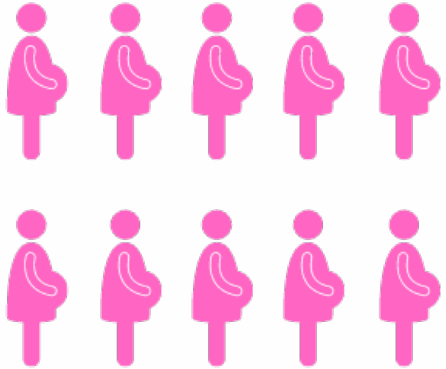
Nulliparous, **T**erm, **S**ingleton, **V**ertex

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

Illinois Perinatal Quality Collaborative

C/S Failed Induction

…V, were induced labor and had a cesarean birth for labor arrest, …h ICD-10 codes for: •Fetal heart rate concern •Medical indication for cesarean section)

Reason for induction
* must provide value
- Elective
- Hypertensive disorder
- Post-term/post-dates
- Other maternal indication
- Fetal indica…
- Other

Date for Start of Induction (M-D-Y):

Time for start of induction in military time (HH:MM):

Other
other indication for induction

Dilation at last exam before delivery
* must provide value
(enter -90 if unknown)

Effacement at last exam before delivery
(enter -90 if unknown)

Station at last exam before delivery
(enter -90 if unknown)

Cervix position at last exam before delivery
(enter -90 if unknown)

Cervix consistency at last exam before delivery
(enter -90 if unknown)

Was cervix 6cm or greater at time of Cesarean?
* must provide value
- If No, go to A
- If Yes, go to B
- Unknown

A1) If < 6 cm, was oxytocin administered for at least 12-18 hours after membrane rupture before failed induction was diagnosed
- Yes
- No

A2) 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

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

reset

Type of cervical ripening?
(enter -90 if unknown)

Completely dilated at time of Cesarean decision?
* must provide value
- Yes
- No

reset

C/S Fetal Heart Rate Concerns

…s that are NTSV and had a cesarean for fetal heart rate (FHR) …250g OR with ICD-10 codes for: •Labor arrest / CPD

What was the FHR concern/indication? (Linked with specific corrective and evaluative measures)
* must provide value
- Antepartum testing results which precluded trial of labor
- Category III FHR tracing
- Category II FHR tracing (Were these specific types present?)
- Other concern

reset

Specific category II FHR tracing type present that led to cesarean delivery
* must provide value
- Clinically significant variable decelerations
- Minimal/absent FHR variability WITHOUT significant decelerations
- Late Decelerations

reset

Other concern

Please check all corrective and evaluative measures use…
* must provide value

Other Labor Issues:
Did the mother have uterine tachysystole?

Corrected uterine tachysystole: decrease or discontinue uterine stimulants, fluid bolus, terbutaline or nitroglycerin and/or other?

Vaginal Delivery

- Yes
- No

reset

Chorioamnionitis
* must provide value
- Yes
- No

reset

Hemorrhage 1000 mL+ in 24 hours
* must provide value
- Yes
- No

reset

Transfusion required?
* must provide value
- Yes
- No

reset

Laceration
- 3rd Degree
- 4th Degree

reset

Operative Delivery Type (if used)
- Vacuum
- Forceps
- N/A

Neonatal Outcomes

…apply)
- Sepsis
- HIE
- ICH
- Ventilator
- transfer to additional acute care center
- None

- Yes
- No

reset

C/S Labor Dystocia/ Failure to Progress

…s that are NTSV, were spontaneous labor and had a cesarean for …birth weight ≥ 4250g OR with ICD-10 codes for: •Fetal heart rate

Dilation at time of admission
(enter -90 if unknown)

Dilation at time of Cesarean
(enter -90 if unknown)

Was cervix ≥ to 6cm at time of Cesarean?
* must provide value
- Yes
- No

reset

If Yes, please check the ONE reason for the Cesarean that applies:
* must provide value
- 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

reset

Completely dilated at time of Cesarean decision?
* must provide value
- Yes
- No

reset

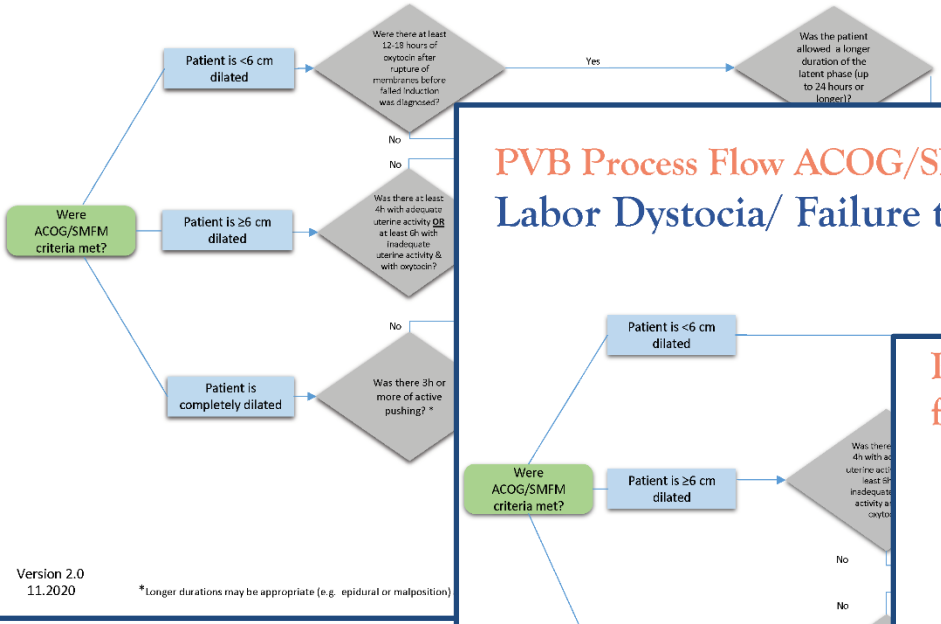
Were there 3 hours or more of pushing (4 hours with epidural)?
* must provide value
- Yes
- No
- Unknown

reset

Data Collection tool: Process Flows

Illinois Perinatal Quality Collaborative

PVB Process Flow ACOG/SMFM Criteria for Review: Induction



Version 2.0
11.2020

*Longer durations may be appropriate (e.g. epidural or malposition)

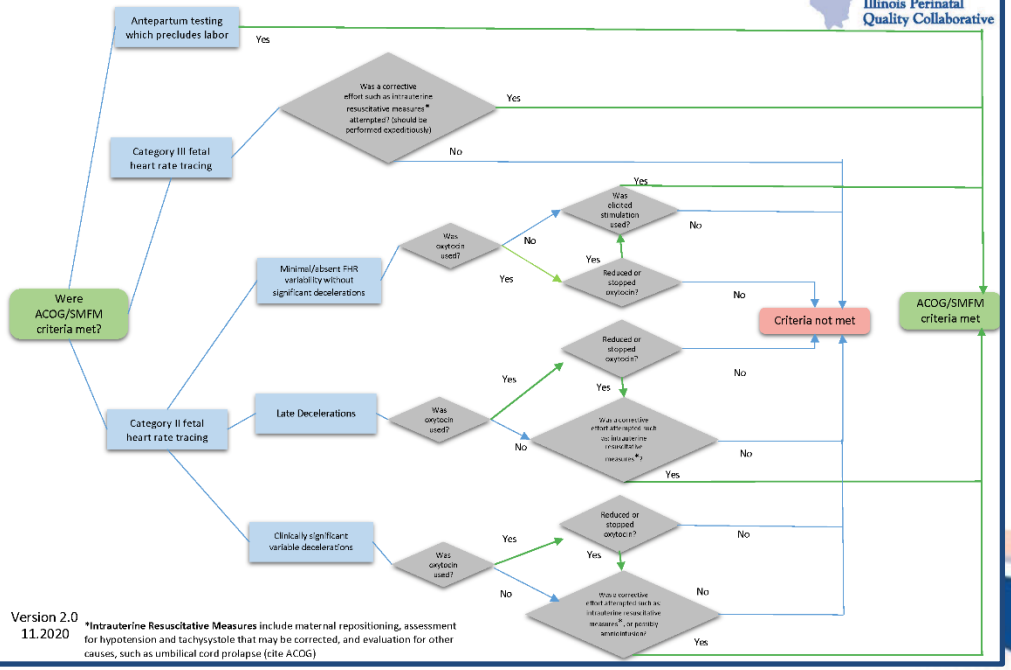
PVB Process Flow ACOG/SMFM Criteria for Review: Labor Dystocia/ Failure to Progress

Version 2.0
11.2020

*Longer durations may be appropriate (e.g. epidural or malposition)

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

Illinois Perinatal Quality Collaborative



Version 2.0
11.2020

***Intrauterine Resuscitative Measures** include maternal repositioning, assessment for hypotension and tachysystole that may be corrected, and evaluation for other causes, such as umbilical cord prolapse (cite ACOG)

Monthly Data Collection: Hospital Level Measur

Total NTSV Rate

Process Measures

Structure Measures

ILPQC PVB Monthly Hospital Level Data Form

REDCAP Study Identifiers

1. REDCap Record ID	REDCap Record ID: _____
2. Hospital ID Number	Hospital ID Number: _____
3. Please select the time period for	☐ Baseline (Oct-Dec 2019) ☐ June 2021 ☐ December 2021 ☐ uary 2021 ☐ ruary 2021 ☐ rch 2021 ☐ il 2021 ☐ May 202
4. Total NTSV Deliveries	
5, Total NTSV Cesarean Deliveries	

Structure Measures

6. Implement provider and nurse education and other strategies to achieve buy-in.	☐ Haven't ☐ Workin ☐ In place
7. Implement standardized protocol/processes for induction, labor support management and response to labor and fetal heart rate abnormalities.	☐ Haven't ☐ Workin ☐ In place
8. Implement and integrate PVB order sets, protocols and documentation into the EMR.	☐ Haven't ☐ Workin ☐ In place
9. Implement cesarean decision checklist using ACOG/SMFM labor guidelines.	☐ Haven't ☐ Workin ☐ In place
10. Implement decision huddles and/or decision debriefs with appropriate care team to standardize use of ACOG/SMFM guidelines and checklist.	☐ Haven't ☐ Workin ☐ In place
11. 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)	☐ Haven't ☐ Workin ☐ In place
12. Implement standardized patient education with positive messaging promoting vaginal birth strategies and techniques for women and families.	☐ Haven't ☐ Workin ☐ In place
13. Integrate process to review and share data that includes provider-level data with labor and delivery clinical teams.	☐ Haven't ☐ Workin ☐ In place

Process Measures

14. Percentage of providers receiving standardized education regarding: ACOG/SMFM labor guidelines to date	☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%
14b. Percentage of nurses receiving standardized education regarding: ACOG/SMFM labor guidelines to date	☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%
15. Percentage of providers receiving standardized education regarding: Labor Management strategies/response for labor challenges to date	
15b. Percentage of nurses receiving standardized education regarding: Labor Management strategies/response for labor challenges to date	
16. Percentage of providers receiving standardized education regarding: Protocol for facilitating decision huddles and/or decision debriefs to date	☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%
16b. Percentage of nurses receiving standardized education regarding: Protocol for facilitating decision huddles and/or decision debriefs to date	☐ 0% ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%

Helping you use your data for PVB success

Coming Soon!!!

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!

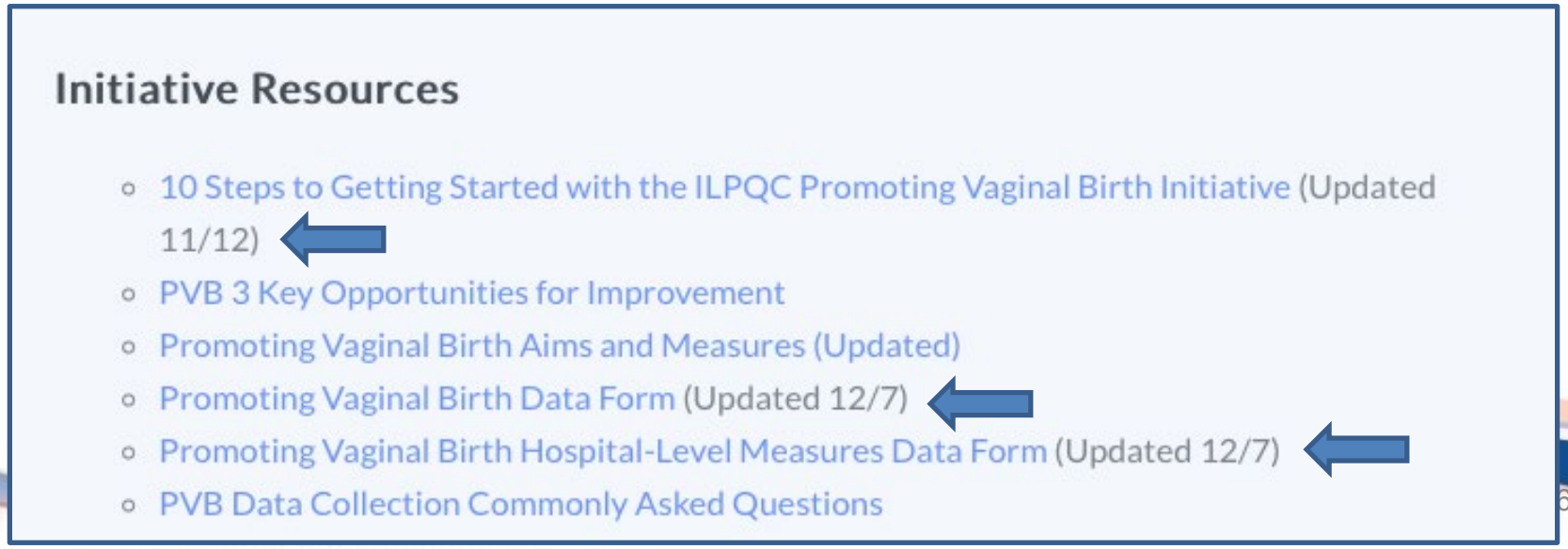
PVB Toolkit: What's Inside?

- 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

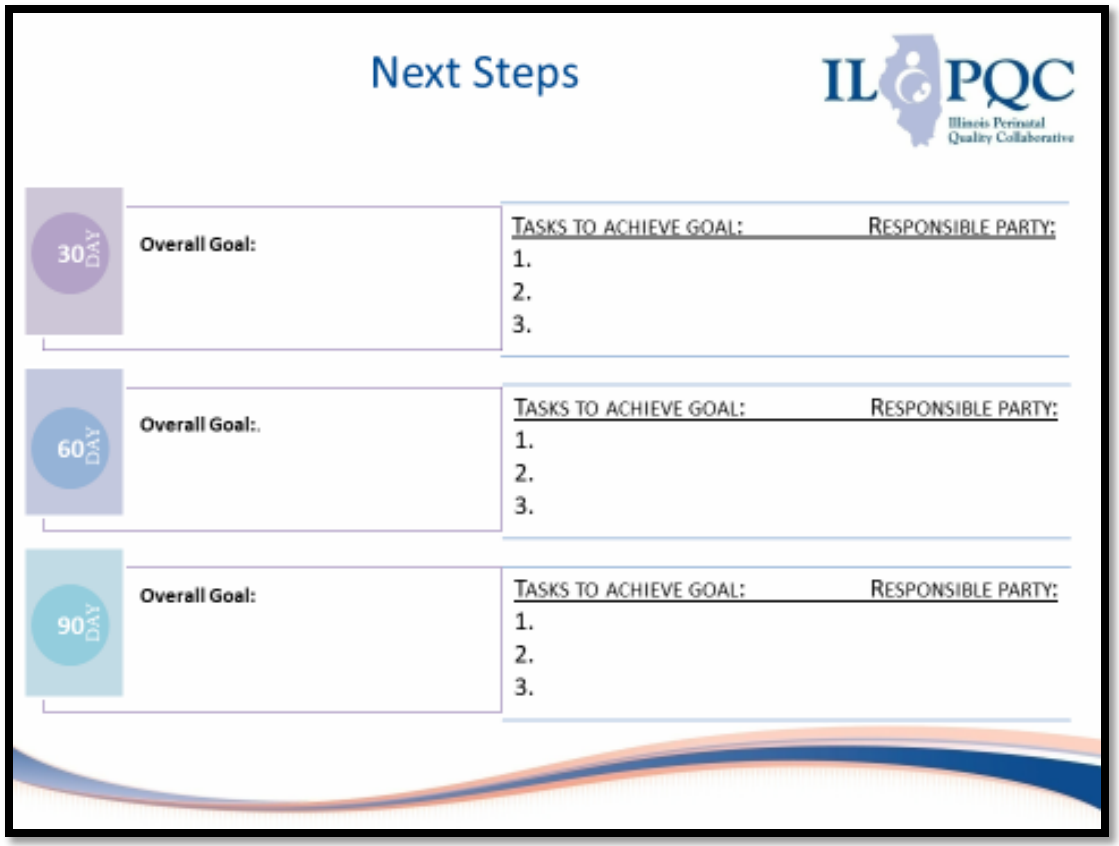
PVB Toolkit

- 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



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

Illinois Perinatal Quality Collaborative

30 DAY

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

Tasks to Achieve Goal	Responsibility
1. Review RedCap data form	• QI Team
2. Assign Data Collection Tasks	• Team Lead
3. Schedule monthly meetings	• Team Lead

60 DAY

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

Tasks to Achieve Goal	Responsibility
1. Collect Baseline data	• QI Team
2. Review baseline data	• Team Lead
3. Identify areas for improvement	• QI Team

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	Responsibility
1. Send survey to all providers and nurses	• L&D Manger
2. Meet with QI team to develop PDSA cycle	• QI Team

10 Steps to Getting Started

ILPQC
Illinois Perinatal Quality Collaborative

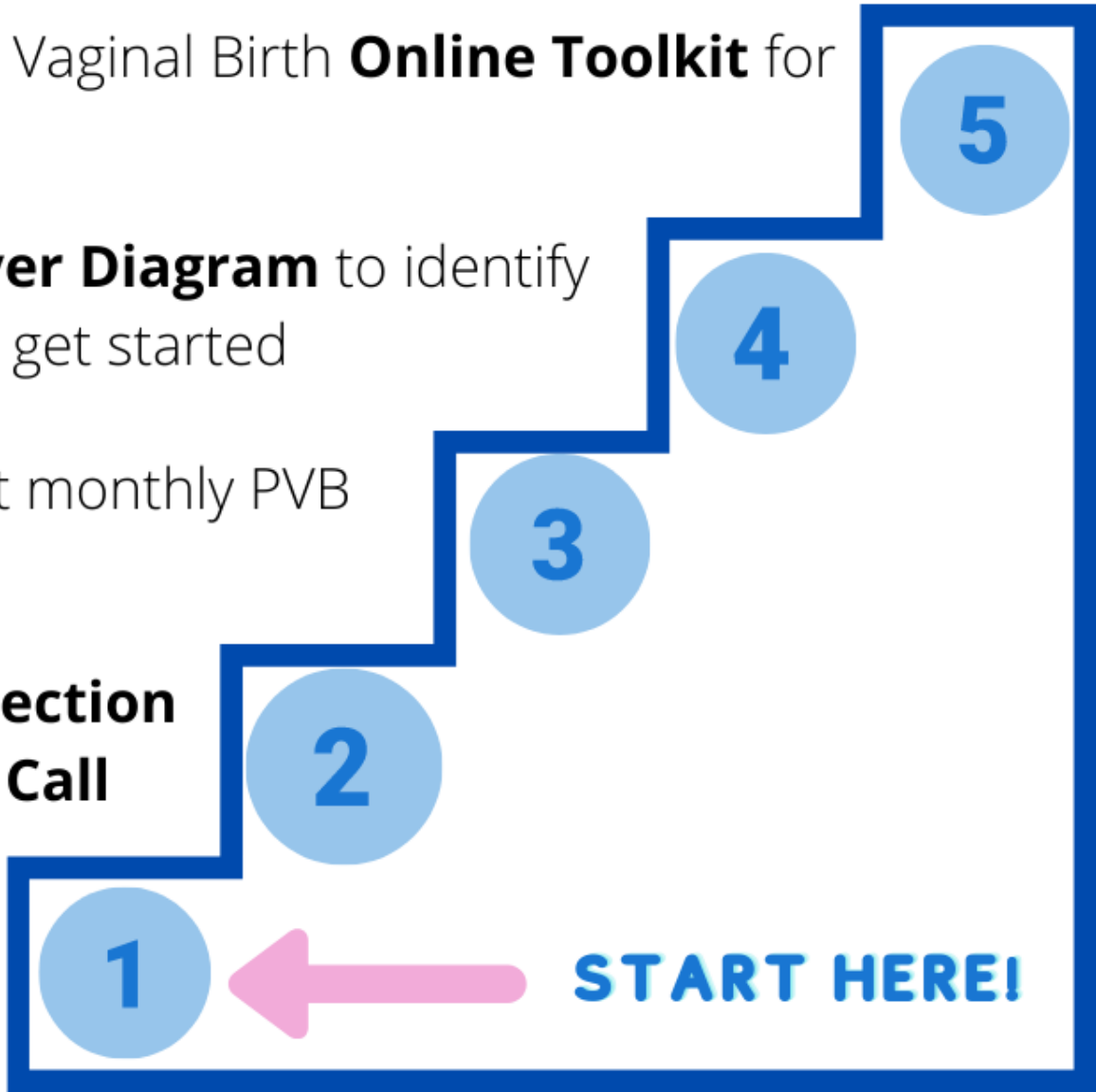
Submit Roster and complete **PVB Teams Readiness Survey**

Review **ILPQC Data Collection Form** and **Attend Data Call**

Schedule regular, at least monthly PVB QI **team meetings**

Reference **PVB Key Driver Diagram** to identify possible interventions to get started

Review ILPQC Promoting Vaginal Birth **Online Toolkit** for resources to help



10 Steps to Getting Started

IL PQC
Illinois Perinatal Quality Collaborative

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

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

Date	Topic
Monday, January 25 12:30-1:30	Labor Culture Survey and getting started
Monday, February 22 12:30-1:30	Creating Buy-in and overcoming resistance to change
M**onday, March 22** 12:30-1:30	Developing and implementing an ACOG/SMFM checklist and used a shared decision-making approach
Monday, April 26 12:30-1:30	Labor Management Support
May 26	Virtual Face-to-Face

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?

THANKS TO OUR

FUNDERS

IDPH Illinois Department of Public Health

CDC Centers for Disease Control and Prevention

IDHS

AIM Alliance for Innovation on Maternal Health

I PROMOTE-IL Innovations to Improve Maternal Outcomes in Illinois

JB & MK PRITZKER Family Foundation

In Kind Support

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