PVB Monthly Webinar: Creating Buy-In

February 22th, 2021
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

- Housekeeping items
- PVB Baseline Data Review
- Guest Speaker
  - *Strategies for Engagement and Success in Promoting Vaginal Births, Dr. Karen Bruder, FPQC*
- ILPQC Team Talk
  - *Sara Polonsky & Blake Thoren, NorthShore University Evanston Hospital*
- PVB Next Steps
- PVB Data Corner: Commonly asked Q&A?
- PVB after Office Hours
  - *Join us after the call to ask specific data questions!*
WE INVITE YOU TO
MARK YOUR CALENDARS!
for the 2021 Virtual Face to Face Conference

MAY 26, 2021 | OBSTETRIC DAY
MAY 27, 2021 | NEONATAL DAY

REGISTRATION COMING SOON! VISIT ILPQC.ORG
Patient Level Data: **71** (76%) teams reporting

Hospital Level Data: **58** (62%) teams reporting

Make sure to submit your hospital-level data to track structure measures!

The ILPQC QI support team will be reaching out to teams to check in on data collection & reporting progress. Please take a moment to connect with us.
PVB Data Collection: Two Data Forms

Patient-level Data
- Vaginal Deliveries
- NTSV c/s Deliveries

Hospital-level Data
- NSTV hospital data
- Structure Measures

Obtained from random patient sample
Obtained from Hospital data & status on key initiative elements
Make sure you are including Race/Ethnicity Data for ALL NTSV c/s deliveries for the month, not just the random sample of patients.
PVB AIMs & Measures

<table>
<thead>
<tr>
<th>Overall Initiative Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>70% of participating hospitals at or below 24.7% C/S delivery rate (Healthy People 2020) among NTSV births</td>
</tr>
<tr>
<td>Overall state C/S rate among NTSV births at or below 24.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structure Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement provider and nurse education and other strategies to achieve buy-in.</td>
</tr>
<tr>
<td>Implement standardized protocol/processes for induction, labor support management and response to labor and fetal heart rate abnormalities.</td>
</tr>
<tr>
<td>Implement and integrate PVB order sets, protocols and documentation into the EMR.</td>
</tr>
<tr>
<td>Implement cesarean decision checklist using ACOG/SMFM labor guidelines.</td>
</tr>
<tr>
<td>Implement decision huddles and/or decision debriefs with appropriate care team to standardize use of ACOG/SMFM guidelines and checklist.</td>
</tr>
<tr>
<td>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).</td>
</tr>
<tr>
<td>Implement standardized patient education with positive messaging promoting vaginal birth strategies and techniques for women and families.</td>
</tr>
<tr>
<td>Integrate process to review and share data that includes provider-level data with clinical team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of providers and nurses receiving standardized education regarding:</td>
</tr>
<tr>
<td>a) ACOG/SMFM labor guidelines</td>
</tr>
<tr>
<td>b) labor management strategies/response for labor challenges</td>
</tr>
<tr>
<td>c) protocol for facilitating decision huddles and/or decision debriefs</td>
</tr>
<tr>
<td>80% of cesarean deliveries among NTSV births meeting ACOG/SMFM criteria for cesarean (based on random sample of deliveries):</td>
</tr>
<tr>
<td>a) NTSV spontaneous labor arrest/labor dystocia/FTP/CPD;</td>
</tr>
<tr>
<td>b) NTSV induced labor management;</td>
</tr>
<tr>
<td>c) FHR abnormalities</td>
</tr>
</tbody>
</table>
PVB Baseline Data (Q4 2019): Structure Measures

Implemented provider and nurse education and other strategies to achieve buy-in
PVB Baseline Data (Q4 2019): Structure Measures

Implemented standardized protocol/processes for induction, labor support management and response to labor and fetal heart rate abnormalities.
Implemented and integrated PVB order sets, protocols, and documentation into the EMR.
Implemented cesarean decision checklist using ACOG/SMFM labor guidelines.
Implemented decision huddles and/or decision debriefs with appropriate care team to standardize use of ACOG/SMFM guidelines and checklist.
Implemented workflow process to incorporate shared decision making with the patient
Implemented standardized patient education with positive messaging promoting vaginal birth strategies and techniques for women and families.
Integrated process to review and share data that includes provider-level data with clinical team.
NTSV C-Section Rates

ILPQC Baseline Data: NTSV C Section Rate

Goal: 24.7%

Total ILPQC rate: 26.9%
NTSV C-Sections Meeting ACOG/SMFM Criteria

% of NTSV C-Sections Meeting ACOG/SMFM Criteria for ILPQC Hospitals Baseline Data

Goal: 70%
ILPQC HOSPITAL TEAMS NTSV C-SECTIONS

- Black: 16%
- White: 52%
- Hispanic: 17%
- Other: 15%

OVERALL ILLINOIS BIRTHS

- Black: 55%
- White: 17%
- Hispanic: 21%
- Other: 7%
NTSV C-Sections by Insurance Status Baseline Data

**NTSV C-SECTIONS BY INSURANCE STATUS**

- **39.1%** of all Illinois births are covered by public insurance
- **61%**
- **35%**

- Public Insurance
- Private Insurance
- Uninsured/Self Pay
- Other
PVB – Improvement opportunities for all hospitals

How is participating in PVB initiative beneficial for teams with low NTSV C-section rates?

- Equity: Understand PVB data by race, ethnicity, & Medicaid status
- Implement and use systematically ACOG/SMFM guidelines
- Identify ways to optimize patient centered decision making
- Access to labor management support for nurses and providers
- Learn strategies for continued sustainability of your success.
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. Conduct the Labor Culture Survey to understand current attitudes and beliefs of labor and delivery staff and unit norms.

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

4. 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

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

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

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

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

9a. Implement policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women

9b. Implement policies and protocols for induction of labor

9c. Implement policies and protocols for pain management and labor support

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

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

12a. Implement training/procedures for identification and appropriate interventions for malpositions (e.g. OP/OT)

12b. Implement standardized assessment, and response to fetal heart rate concerns

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

14. 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)
Achieving Buy In

• Important first step!
• Making sure your OB providers and Nurses are aware of the PVB Initiative, that they are supportive of the initiative and they know what they need to do to help your hospital achieve its PVB goals
• Ongoing process
DR. KAREN BRUDER- FPQQC
Strategies for Engagement and Success in Promoting Vaginal Births

Karen L. Bruder, MD
Associate Professor,
USF Morsani College of Medicine, Department of OB/GYN
Clinical Co-Lead FPQC PROVIDE Initiative
Partnering to Improve Health Care Quality for Mothers and Babies
The PROVIDE Experience

Success

what people think it looks like

Success

what it really looks like
Structural vs. Cultural change
What you will hear....

- It’s not a good time
- It’s been done
- It’s NEVER been done
- It’s not in our policies
- It’s not the way we do it here
- We don’t have that

- This doesn’t apply to my “high risk” patients
- My patient’s won’t like it
- You can’t tell me what to do with my patients
- My liability will be increased
- My productivity will suffer

- The doctors won’t like it
- I don’t want to get in trouble
What all that means....

NO WAY

IS THAT

GOING

TO

HAPPEN!!!
Classic reasons to resist change

FEAR and EMOTIONS

• Scared of transition, not idea- Fear of the unknown, confusion
• I feel like I have no say/how do I fit in? Fear of rejection, powerlessness
• What am I going to give up? Fear of loss
• What if my job changes? Fear of failure
• I’m fed up with PHONY change that goes nowhere. Cynicism! Exhaustion!
How do managers react to resistance?

- Take it personally
- Address behaviors directly with arguments, rather than reasons
- Blame other people for not changing (character, personality)

**VS.**

- If we don’t change, we had a valid reason
What is UP with the doctors???

Learn the craft of medicine, “craft based autonomy”, not “cookbook medicine”

Surgeons “fix” things (want permanent fix vs improvement)

Very competitive

We “own” mistakes, pride in personal competence

Aren’t taught that errors are systemic and do not reflect personal competence
What we give and what we get

Give:
• years of training
• debt
• sacrifices in personal life
• acceptance of liability

Get:
• autonomy
• control over professional life
• respect
• personal fulfillment

Current situation:
• business pressures
• regulatory agencies
• doing more for less with increasing risk
• peers deciding what we do (AKA best practices)
• process management (QI/QA)
• Patient satisfaction
Engaging physicians

- Involve them early, make them part of the team
- Put the patient in the center
- Share your data, be transparent (no one wants to be an outlier)
- Change culture, not “stuff”
- Value physicians time
- Changes should make their lives/jobs easier
  - Less time at the hospital, less liability, fewer hassles, minimize meetings
- Be generous with praise
- Help them see reality and be proactive
Changing your culture to value vaginal birth

- GET STRONG CHAMPIONS! Change them if you need to or have more than one
- Recognize that different types of provider practices will have different concerns/solutions
- Have achievable, stated goals
- Give everyone tools- algorithms, order sets, new policies, patient education materials, labor support workshops, peer based education on best practices
- Engage in patient education,

Practice shared decision making
Specific Strategies

Do. Or do not. There is no try.
Meetings/Communication

- Make sure meetings are organized and succinct to decrease the impact on available time
- Offer meetings at multiple times; consider web-based meetings/education for those who may be off site
- Utilize regularly scheduled department meetings to highlight project and results—be succinct
- Be prepared to answer questions
Education

Peer based education
Use ACOG, ACNM, AWHONN best practices
Provide high quality peer-reviewed research and evidence to support change, data from CMQCC
Invest in web-based learning
Leverage education opportunities that exist because of students at institution
Be prepared for new research and how it may affect practice patterns
Induction of Labor

The goal of induction is to have a vaginal birth!

- Educate patients
- Use an Induction Scheduling Checklist
- Focus on cervical ripening.
  - Outpatient
  - Multiple simultaneous induction agents
  - Sequential agents
- Make admission easier or more timely so less doctor time in the hospital (example: order sets for cytotec dosing)
Labor Dystocia

- Labor Support workshop
- Changes in position
- Intermittent auscultation
- Resist admission in early labor

- Empower nurses to advocate for patients in early labor
- Non-pharmacologic strategies for pain control
- Doulas
FHR concerns

- Nurses and providers mandated to take same courses (online) to standardize discussion
- Strip review - at bedside rounds, safety huddle, 5 minutes at department meeting
Cesarean section checklist

Pre-Cesarean Huddle Form

The intent of this form/ huddle is to define criteria for arrest of dilatation, failed induction and interventions for NRHFT’s as defined by the FPQC. It is also meant to explore safe options to prevent cesarean sections in an interdisciplinary setting on the OB unit.

Huddle should occur when a c/s is being considered due to labor dystocia, failed IOL or NRHFT’s. Huddles can occur for other reasons as deemed necessary by the providing team.

- **Date and time of huddle:**
- **O’s and P’s and Gestational age:** Current room
- **ROM time:** Last Cervical exam Length of time since exam changed

**Attendees: list names:**
- Attending physician* required
- Safety Nurse 8/Charge Nurse* 1 required
- Bedside provider (CNM/Resident) *1 required
- Primary RN (if available)
- Anesthesia (if available)

**Reason for huddle: circle all that apply:**
- C/S being considered
- Labor Dystocia (Arrest of dilatation)
- Failed IOL
- NRHFT
- Maternal Condition
- Other

- **Labor Dystocia:** (dystocia cannot be labor dystocia only if spontaneous labor not IOL’s)
  - Is the patient 6-9.5 cm? Has the patient had adequate CTG for at least 4h or 6h if inadequate CTG?
  - If not, she needs more time.
  - Is thepg 10cm? - Prime: should push for minimum 3h, 4h with epidural. Multiparous: push for minimum 2h, 3h with epidural. If not, she needs more time.

- **Failed IOL:** If the patient was an IOL on admission, she will not be considered labor dystocia she is a failed IOL
  - If the pg is 4-6cm were there at least 12h of oxytocin after ROM? If no, needs more time.
  - If the pg is 6-10 cm was there at least 4h adequate or 6h inadequate CTG with oxytocin? If not, she needs more time.
  - 10 cm pt-3h of pushing, 4h with epidural. If not, needs more time.

- **FHT agreed upon interpretation at the time of huddle:** Baseline Variability
- Decals present (circle all that apply): Early Variable Late Prolonged
- Accel present: Yes/No
- Category of tracing: 1 2 3

- **Interventions done thus far (circle all that apply):** Reposition
  - IVF bolus for hypotension
  - O2
  - Terbutaline
  - *Decrease Pitocin
  - Stop Pitocin
  - *Amnioinfusion for variable decels
  - *Remove Cervidil
  - *Remove balloon/Cook
  - *Vaginal exam/VAS to elicit fetal response for minimal variability

- **FHR Outcome:**
  - *Vas or CP
  - *C/S

See back of page for FHR Algorithm diagram and explanations. Please document huddle in Progress note/obhuddle

Version 1.3 6/25/2020
Data Transparency

💡 Post NTSV CS rates for MDs or practices
💡 Consider increasing transparency gradually, anonymous rates first, then name top three
💡 Recognize individual success, use positive reinforcement, ribbons or buttons “Ask me about my cesarean section rate”
💡 Use Data
  • holds us accountable for our own performance,
  • creates examples of how our practice can be better
💡 Fully transparent data allows competitive encouragement among team members
💡 Introduce reality: Advise that CS rates will become available to the public soon!
Key Messages

- Keep patients in the center
- Find effective champions (physician, CNM, nurse, administrator)
- Educate with reputable sources.
- Use checklists in each of the focus areas. Particularly effective is a “pre-cesarean” checklist
- Post provider and/or practice level data
- Meet the people where they are
- Don’t try to change everything at once
Questions?

www.FPQC.org

FPQC@usf.edu

Kbruder@usf.edu
Sara Polonsky & Blake Thoren, NorthShore University Evanston Hospital

TEAM TALK
1. 3520 births per year
2. Location: Evanston, IL
3. Perinatal level III
4. One hospital in a 6 hospital Health System – 4 with L&D
5. Multiple medical groups
## Our Team

### Evanston Hospital

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB Chair</td>
<td>Emmet Hirsch, MD</td>
</tr>
<tr>
<td>OB Medical Director</td>
<td>Mark Neerhof, DO</td>
</tr>
<tr>
<td>Project Team Lead</td>
<td>Sara Polonsky, RN, MPH</td>
</tr>
<tr>
<td>OB Provider</td>
<td>Jennifer Kim, MD; Miriah Plawer, MD; Emma Clear, MD</td>
</tr>
<tr>
<td>OB Nurse Champion</td>
<td>Diana Campbell, RN; Blake Thoren, RN</td>
</tr>
<tr>
<td>Family Practice Champion</td>
<td>Emily White VanGompel, MD</td>
</tr>
<tr>
<td>Patient/Family Member/Community Member</td>
<td>Malik Turley, CD</td>
</tr>
<tr>
<td>Midwife</td>
<td>Gaye Koconis, APN-CNM</td>
</tr>
<tr>
<td>QI</td>
<td>Marci Adams</td>
</tr>
<tr>
<td>Other Team Members</td>
<td>Josie Nowak, RN; Janice Hopson, RN; Suzanne Guy, RN; Caroline MCGowan</td>
</tr>
</tbody>
</table>
Getting Started With PVB

- Promoting Vaginal Birth OBGYN Grand Rounds Nov. 18th
- Scheduled meetings with NorthShore team (currently 3 hospitals):
  - Oct. 13th: Kick-off
  - Dec. 18th: Clarification of roles, data collection and analysis, review of ACOG recommendations, prioritizing interventions, work process, 30/60/90 day goals
  - Jan. 15th: Deadlines and responsibilities, Hospital Level Data Form
  - Feb. 19th
- Baseline data entry
- 30/60/90 day goals
30/60/90 Day Goals for 1/15/21

**30**

**Overall Goal:**
Administer the Labor Culture Survey – assess attitudes toward C/S among L&D staff

**Tasks to Achieve Goal:**
- Emily send survey link to teams
- Distribute survey to L&D staff
- Advertisement at Grand Rounds

**Responsible Party:**
- Emily
- Hospital team leads
- Sara

**60**

**Overall Goal:**
Institute a uniform C/S checklist throughout NorthShore hospitals – be assured that each labor is evaluated subjectively before C/S

**Tasks to Achieve Goal:**
- Swedish to share checklist
- Individual hospitals meet
- Combine or create protocols

**Responsible Party:**
- Michaela/Sara
- Hospital Teams
- NS Wide PVB Team Meeting

**90**

**Overall Goal:**
Institute educational strategies to address needs to be identified by Labor Culture Survey

**Tasks to Achieve Goal:**
- Review results of survey
- Decide next steps
- Attend ILPQC training sessions

**Responsible Party:**
- Emily and PVB team
- PVB Team
- PVB Team Meeting for ideas
Because Emily White VanGompel, MD is on our team, we were able to pilot the Labor Culture Survey.

Survey launched via email and fliers with QR codes on 1/5/21.

Survey link and explanation about PVB initiative mentioned in the Weekly Update distributed to all staff.

Word of mouth.

Staff informed of survey launch and importance of participation.
• Initial low participation among attending physicians
  – Survey championed by Emmet Hirsch, MD among physicians
  – Emails sent out to all residents, fellows and providers

• Anesthesiologist participation
  – Who should participate?
  – Email was sent to head of anesthesia asking for link to be distributed
• Fliers posted in nurse’s lounge, at nurse’s station, in resident room
• Promoted during launch email, weekly follow-up emails, and at every shift report with nurses
• Email with survey sent to physicians and residents by OB Medical Director
• Promoted at OBGYN Grand Rounds and endorsed by OBGYN Department Chair
• Championing among attendings and residents
Labor Culture Survey Completion by Staff

Jan. 11 Jan. 18 Jan. 25 Feb. 1
RN OBGYN Resident CNM
Labor Culture Survey Pilot Key Takeaways

• Get medical leadership buy-in

• Use a variety of modalities for advertising

• Use updates on survey completion to problem solve and reach out to groups who may not be engaged
Questions?
NEXT STEPS FOR ALL PVB TEAMS
Keeping on track with PVB

- Scheduled regular QI Team meetings and start thinking about Buy In for providers/nurses
- Complete baseline data collection for Q4 2019
- Submit monthly data collection started Jan 2021
- Complete LCS REDCap Inquiry Form- **Due TODAY!**
- Develop a plan to launch Labor Culture Survey
Successfully launching your Labor Culture Survey (LCS)

1. Determine **launch strategy** with your QI Team

2. Create plan to **obtain buy-in** and inform administration to assist with

3. After ILPQC survey link is received- **share with staff** by using the ILPQC LCS Resources *(see next slide)*
LCS Resources Available

1. Administration Buy-in Email
   • Sample language for teams to share with administration to assist with buy-in and help with LCS distribution

2. Labor Culture Launch Email
   • Explanation of LCS and instructions that can be used for all clinical staff

3. LCS Follow-up Email #1
   • Sample email that can be personalized to assist with LCS completion

4. LCS Follow-up Email #2:
   • Sample email that can be personalized to share your breakdown and nurse and physician participation

5. LCS Flyer
   • Post around your unit in break rooms, bathrooms, nurses stations, physician workrooms etc.

Resources will be sent via email and are available on the ILPQC website!
PVB DATA CORNER
1. If a patient comes in with SROM, but is not contracting, would they be considered an induction or an augmentation?

2. How do I decide whether to enter the delivery is a failed induction, labor dystocia or FHR concern if multiple c/s reasons are indicated in the chart?

3. Stay on the line after this call if you have additional questions
PVB Grand Rounds

ILPQC is excited to announce that we are now taking requests to schedule ILPQC facilitated Virtual Grand Rounds!

Email ILPQC to schedule a meeting for your hospital providers today!

Email ellie.suse@northwestern.edu to schedule
PVB Wrap-up

- Submit your **LCS Inquiry form** - Due TODAY!
- Have a **LCS Distribution plan** with QI team in place
- Complete **data submission** from baseline - Jan 2021
- Hold your **QI team meeting** and discuss hosting an ILPQC Grand Rounds
  - QI team leads- be sure to check out the PVB newsletter for a sample agenda!
### Upcoming Monthly Webinars

4th Monday of the Month

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monday, March 22\textsuperscript{nd}</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\textsuperscript{th}</strong> 12:30-1:30</td>
<td>Labor Management Support</td>
</tr>
<tr>
<td><strong>May 26\textsuperscript{th} (VIRTUAL)</strong></td>
<td>Virtual Face-to-Face</td>
</tr>
</tbody>
</table>

Register and Join here: https://northwestern.zoom.us/j/91684580832?pwd=eXo3U3VsTIVTOHI5QjRvUjdQeWRtdz09
We want to hear from you

- Unmute your line to ask a question
- We will be available for 30 minutes after this call for Office Hours
- Get answers to your questions live!
THANKS TO OUR
FUNDERS

In Kind Support