PVB Monthly Webinar: Incorporating ACOG/SMFM Guidelines for Cesarean Delivery

March 22nd, 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

- Updates
- PVB Data Review
- Incorporating ACOG/SMFM Guidelines into C/S decisions
  - *Dr. David Lagrew, CMQCC*
- Team Talk: Ann Kurz from Loyola
- Launching your Labor Culture Survey
- PVB Next Steps
- PVB Office Hours
  - *Join us after the call to ask specific data questions!*
2021
FACE-TO-FACE VIRTUAL MEETING
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
## 2021 OB F2F Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session/Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00 am</td>
<td>Welcome &amp; Overview; Working Together in 2021- Ann Borders</td>
</tr>
<tr>
<td>9:00 – 9:45 am</td>
<td>Birth Equity Plenary Session- Audra Meadows</td>
</tr>
<tr>
<td>9:45 – 9:55 am</td>
<td>Break</td>
</tr>
<tr>
<td>9:55 – 10:40 am</td>
<td>PVB QI Team Panel: Sharing Strategies for Success- ILPQC PVB Teams</td>
</tr>
<tr>
<td>10:40 – 11:10 am</td>
<td>Unpacking the Birth Equity Initiative and Toolkit- Ann Borders</td>
</tr>
<tr>
<td>11:10 – 11:30 pm</td>
<td>QI Team Awards</td>
</tr>
<tr>
<td>11:30 – 1:00 pm</td>
<td>Virtual Storyboard Review &amp; Lunch</td>
</tr>
<tr>
<td>1:00 – 1:35 pm</td>
<td>Break</td>
</tr>
<tr>
<td>1:35 – 1:45 pm</td>
<td>Break</td>
</tr>
<tr>
<td>1:45 – 2:20 pm</td>
<td>Break</td>
</tr>
<tr>
<td>2:20 – 2:30 pm</td>
<td>Break</td>
</tr>
<tr>
<td>2:30 – 3:15 pm</td>
<td>Engaging Patients in QI Work- Ann Borders &amp; LaToshia Rouse</td>
</tr>
<tr>
<td>3:15-3:30 pm</td>
<td>Wrap up and Next Steps for 2021- Ann Borders</td>
</tr>
</tbody>
</table>
OB F2F Storyboard Session

- All teams will be asked to create a story board for the May 2021 “Face to Face” to share their QI teams progress on ILPQC initiatives

- Storyboard should focus on...
  - PVB Successful Launch
    - Baseline data display
    - 30/60/90d plan
    - Progress on key imitative aims
  - MNO-OB Sustainability
    - Sustainability plan
    - MNO-OB Data
    - Strategies for improving Narcan Counseling and Prenatal Screening

Check out your PVB newsletter for more info!
You are ILPQC!

• Get READY... ILPQC wants to celebrate you during our virtual Face-to-Face Meeting!

• Coordinate with your colleagues to create a slide or send in a picture to celebrate your QI team

• Ideas to include on slide:
  – Team/Hospital Picture
  – Picture of QI bulletin board
  – Location/Region
  – Birth Volume/NICU Beds
  – Perinatal Level and Network
  – Current & Future Initiatives
  – Contact information for your team for collaboration

• Submit by emailing your slide or picture to info@ilpqc.org
2021 OUTSTANDING LAUNCH AWARDS
ILPQC 2021 FACE-TO-FACE MEETING

PVB

AWARD CRITERIA

✓ Team Roster sent to ILPQC
  +
✓ All 2019 Q4 Baseline Data Submitted
  +
✓ All Data Submitted *
  +
✓ PVB Readiness Survey Submitted

*ALL DATA SUBMITTED (HOSPITAL + PATIENT LEVEL)
JANUARY THROUGH MARCH 2021 by APRIL 30TH
PVB DATA REVIEW
## ILPQC Hospital Team Data Submission (95 Teams Total)

<table>
<thead>
<tr>
<th>Month</th>
<th>Teams Reporting Patient Data</th>
<th>Teams Reporting Hospital Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (Q4 2019)</td>
<td>80</td>
<td>70</td>
</tr>
<tr>
<td>January 2021</td>
<td>71</td>
<td>61</td>
</tr>
<tr>
<td>February 2021</td>
<td>63</td>
<td>55</td>
</tr>
</tbody>
</table>

*Use your hospital data form as a QI team meeting roadmap to guide your efforts. Please contact us if you need help getting started with reviewing and entering your data.*

*If hospital data is not submitted for a given month you will not have access to team’s NTSV C-Section rate over time.*
Supporting ILPQC teams

ILPQC is here to help!

• ILPQC is working to connect with Hospital Teams who are working to submit data.
• Opportunity for one-on-one calls to discuss data collection strategies and answer questions.
• Reach out to ellie.suse@northwestern.edu and schedule your QI Support call today!
## 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
Implemented provider and nurse education and other strategies to achieve buy-in.
Structure Measures

Implemented standardized protocol/processes for induction, labor support management and response to labor and FHR abnormalities
Implemented and integrated PVB order sets, protocols, and documentation into the EMR

- **Baseline**: 100% In Place
- **January**: 30% Working on it, 70% Not Started
- **February**: 20% Working on it, 80% Not Started
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 labor and delivery clinical teams
February: NTSV C-Section Rates

Goal: 24.7%

Total ILPQC rate: 26%
NTSV C-Sections Meeting ACOG/SMFM Criteria

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

Goal: 80%

Failed Induction
Labor Dystocia
Fetal Heart Rate Concerns
Total NTSV C-Sections

Baseline
January
February
INCORPORATING ACOG/SMFM GUIDELINES INTO C/S DECISIONS
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

1. Facilitate clinical culture change that promotes, and supports vaginal birth
   - Create a QI team of providers, staff & administrators to lead the effort & cultivate buy-in
   - Conduct the Labor Culture Survey to understand current attitudes and beliefs of labor and delivery staff and unit norms.
   - Educate physicians/midwives and nurses on ACOG/SMFM labor management guidelines and labor support techniques
   - Develop patient education with positive messaging to women and families about intended vaginal birth strategies/techniques that prevent cesareans through prenatal classes and patient education
   - Utilize care team huddles/deb briefs to identify and review delivery decisions for consistency with process flows/protocols/checklist
   - Integrate order sets, protocols, and documentation for the safe reduction of primary cesareans into EMR
   - Share provider-level measures with department with the goal of working to transparency/open data

2. Develop standardized processes for induction and labor support
   - Implement policies, protocols and support tools for women who present in latent (early) labor to safely encourage early labor at home
   - Implement policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women
   - Implement policies and protocols for induction of labor

3. Develop standardized protocols for identification and response to labor challenges / abnormalities
   - Implement standard criteria for diagnosis and treatment of labor dystocia, arrest disorders and failed induction
   - Develop checklist for ensuring ACOG/SMFM criteria for c/s is met
   - Implement training/procedures for identification and appropriate interventions for malpositions (e.g. OP/OT)
   - Implement standardized assessment, and response to fetal heart rate concerns
   - 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)
1. Facilitate clinical culture change that promotes, and supports vaginal birth

- Facilitate clinical culture change that promotes, and supports vaginal birth
- Create a QI team of providers, staff & administrators to lead the effort & cultivate buy-in
- Conduct the Labor Culture Survey to understand current attitudes and beliefs of labor and delivery staff and unit norms.
- Educate physicians/midwives and nurses on ACOG/SMFM labor management guidelines and labor support techniques
1. Facilitate clinical culture change that promotes, and supports vaginal birth

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

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

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

• Share provider-level measures with department with the goal of working to transparency/open data
2. Develop standardized processes for induction and labor support

• Implement policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women
• Implement policies and protocols for induction of labor
• Implement policies and protocols for pain management and labor support
3. Develop standardized protocols for identification and response to labor challenges / abnormalities

• Implement **standard criteria** for diagnosis and treatment of labor dystocia, arrest disorders and failed induction

• Implement **standardized assessment, and response to fetal heart rate concerns**

• Develop checklist for ensuring **ACOG/SMFM criteria** for c/s is met

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

- **FPQC** Sample Checklists
  - Hackensack Meridian Health Pre-Cesarean Checklist and Team Huddle Form
  - Tampa General Pre-cesarean Huddle form

- **CMQCC**: Pre-Cesarean Checklist for Labor Dystocia or Failed Induction
ILPQC Toolkit Items: Process Flow Diagrams for ACOG/SMFM Criteria
Proven Strategies in Lowering CSR

David C. Lagrew Jr. MD
Medical Director, Women’s and Children’s Clinical Institute, PSJH Southern CA
Clinical Professor, University of California Irvine
Our discussion

Where does this strategy come from and has it been successful and safely used?

What are the components and steps forward?

A real world example.
Cesarean Delivery Checklist for Labor Dystocia or Failed Induction

Patient Name: ___________________________
MR#: ___________________________________
Gestational Age: ______
Date of C-section: _______________; Time: _____________
Obstetrician: ___________________________; Initial: ____
Bedside Nurse: ___________________________; Initial: ____

Indication for Primary Cesarean Delivery:

❑ Failed Induction: Duration in hours: _________________
❑ Latent Phase Arrest: Duration in hours: _________________
❑ Active Phase Arrest: Duration in hours: _________________
❑ Second Stage Arrest: Duration in hours: _________________
❑ Although not fulfilling contemporary criteria for labor dystocia, my clinical judgment deem this cesarean delivery indicated

Comments: ____________________________________________________________
The Toolkit is Aligned with the ACOG/SMFM Consensus Statement and the AIM Patient Safety Bundle

- Readiness
- Recognition and Prevention
- Response to Every Labor Challenge
- Reporting
Implementation Guide

“How-To Guide”
Translates recommendations from the toolkit into practical advice for implementation

Provides methodology to identify:
Your key focus areas
Strategies to implement first: TOP TEN LIST!
Process design for sustainability
Key QI principles
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).

### Table 3

**Recommendations for safe prevention of primary cesarean delivery**

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Grade of recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First stage of labor</strong></td>
<td></td>
</tr>
<tr>
<td>A prolonged latent phase (e.g., &gt; 20 h in multiparous women and &gt; 14 h in multiparous women) should not be considered the indication for cesarean delivery</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td>Slow but progressive labor in first stage of labor should not be considered the indication for cesarean delivery</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td>Cervical dilation of 6 cm should be considered a threshold for active phase of labor in women in labor. Thus, before 6 cm of dilation is achieved, standards of active phase progress should not be applied</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td>Cesarean delivery for active phase arrest in first stage of labor should be reserved for women with uncontrolled labor who fail to progress despite 4 h of adequate uterine activity or at least 6 h of oxytocin administration with inadequate uterine activity and no cervical change.</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td><strong>Second stage of labor</strong></td>
<td></td>
</tr>
<tr>
<td>A specific absolute maximum length of time spent in second stage of labor beyond which all women should undergo operative delivery has not been identified</td>
<td>Strong recommendation, low-quality evidence</td>
</tr>
<tr>
<td>Before diagnosing arrest of labor in second stage, if maternal and fetal conditions permit, allow for following:</td>
<td></td>
</tr>
<tr>
<td>- At least 3 h of pushing in multiparous women (1B)</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td>- At least 3 h of pushing in multiparous women (1B)</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td>Longer durations may be appropriate on individualized basis (e.g., with use of suprapubic aspiration or with fetal malpresentation as long as progress in being documented, 1B)</td>
<td></td>
</tr>
<tr>
<td>Operative vaginal delivery in second stage of labor by experienced and well-trained physicians should be considered a safe, acceptable alternative to cesarean delivery. Training in, and ongoing maintenance of, practical skills necessary to perform vaginal delivery should be encouraged.</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td>Manual rotation of fetal occiput in setting of fetal impaction in second stage of labor is reasonable intervention to consider before moving to operative vaginal delivery or cesarean delivery. To safely prevent cesarean deliveries in setting of impaction, it is important to assess fetal position in second stage of labor, particularly in setting of abnormal fetal descent.</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td><strong>Fetal heart rate monitoring</strong></td>
<td></td>
</tr>
<tr>
<td>Arrhythmias for repetitive variable fetal heart rate decelerations may safely reduce rate of cesarean delivery</td>
<td>Strong recommendation, high-quality evidence</td>
</tr>
<tr>
<td>Cardiotocography can be used as means of assessing fetal acid-base status when abnormal or indeterminate (formerly, nonmeasuring fetal heart patterns e.g., minimal variability) are present and is safe alternative to cesarean delivery in this setting.</td>
<td>Strong recommendation, low-quality evidence</td>
</tr>
</tbody>
</table>


**Table 3 (continued)**

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Grade of recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Induction of labor</strong></td>
<td></td>
</tr>
<tr>
<td>Before 41/2 wk of gestation, induction of labor should be considered if gestational age is 41/2 wk of gestation should be performed based on maternal and fetal medical indications. Inductions at &gt; 41/2 wk of gestation should be performed to reduce risk of cesarean delivery and risk of perinatal morbidity and mortality.</td>
<td>Strong recommendation, high-quality evidence</td>
</tr>
<tr>
<td>Cervical ripening should be used when labor is induced in women with unripe cervix.</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td>If maternal and fetal status allow, cesarean deliveries for failed induction of labor in latent phase can be avoided by allowing longer durations of latent phase (up to 24 h) and requiring that oxytocin be administered for at least 12–20 h after membrane rupture before declining induction failure.</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td><strong>Fetal malpresentation</strong></td>
<td></td>
</tr>
<tr>
<td>Fetal presentation should be assessed and documented beginning at 36 1/2 wk of gestation to allow for external cephalic version to be offered.</td>
<td>Strong recommendation, low-quality evidence</td>
</tr>
<tr>
<td><strong>Suspected fetal macrosomia</strong></td>
<td></td>
</tr>
<tr>
<td>Cesarean delivery to avoid potential birth trauma should be limited to estimated fetal weights of at least 5000 g in women without diabetes and at least 4000 g in women with diabetes. Prevalence of birth weight &gt; 5000 g is rare, and patients should be counseled that estimates of fetal weight, particularly late in gestation, are imprecise.</td>
<td>Weak recommendation, low-quality evidence</td>
</tr>
<tr>
<td><strong>Excessive maternal weight gain</strong></td>
<td></td>
</tr>
<tr>
<td>Women should be counseled about IOM maternal weight guidelines in attempt to avoid excessive weight gain.</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td><strong>Twin gestations</strong></td>
<td></td>
</tr>
<tr>
<td>Perinatal outcomes for twin gestations in which first twin is in cephalic presentation are not improved by cesarean delivery. Thus, women with either cephalic/ cephalic- presenting twins or cephalic/face cephalic presenting twins should be counseled to attempt vaginal delivery.</td>
<td>Strong recommendation, moderate-quality evidence</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>Individuals, organizations, and governing bodies should work to ensure that research is conducted to provide better knowledge base to guide decisions regarding cesarean delivery and to encourage policy changes that safer lower rate of primary cesarean delivery.</td>
<td>Strong recommendation, low-quality evidence</td>
</tr>
</tbody>
</table>

*EM: Institute of Medicine.*

<table>
<thead>
<tr>
<th>Latent Phase</th>
<th>Active Phase Arrest</th>
<th>Arrest Descent</th>
<th>Fetal Concern</th>
<th>No Labor</th>
<th>Other</th>
</tr>
</thead>
</table>
| • Failed induction  
  • Latent phase arrest (<6 cm) | • 6-9.5 cm | • Complete/pushing | | | |
| • Induction with ripe cx only  
  • No admission <4cm  
  • Triage scripted communication  
  • Triage send home options/support  
  • Outpt cervical ripening  
  • Oxytocin protocol/monitoring | • Labor support training  
  • Birthing balls/aids  
  • Prompt treatment with augmentation  
  • Labor curve adherence | • Manual rotation OP-OA  
  • 2\textsuperscript{nd} stage labor support training  
  • Using 3 hr mult/4hr prim cutoffs | • EFM training for interpretation and communication  
  • Cat II algorithm adoption  
  • EFM Strip Review training  
  • ABG with each delivery | • Declined trial of labor consent  
  • Declined trial of labor class  
  • Review of EFW/Actual Wts Adherence  
  • ACOG criteria | • General  
  • Herpes  
  • Breech |
| • Caregiver ed risk and benefits  
  • Transparent provider CSR feedback  
  • Weekly huddles data analysis  
  • Doula program  
  • Adoption CNMs  
  • Patient liaison  
  • Herpes protocol/monitoring  
  • Term breech monitoring  
  • Breech version |
Use Data / Share Data
Leadership and Providers
For Example
5 months Pre/Post 2/1/2020

What Drives Our Nulliparous Term Singleton Vertex (NTSV) CS Rate of 20.0%?

The NTSV CS rate is comprised of 3 major, mutually exclusive sub-populations (Spontaneous labor resulting in CS, Induced Labor Resulting in CS, and CS with no Labor). This breakdown of the NTSV CS rate should help determine where QI efforts can best be applied. The most common issue among most hospitals is a high rate of CS during NTSV spontaneous labor. Some hospitals may also have a high rate during induced labor.

What Drives Our Nulliparous Term Singleton Vertex (NTSV) CS Rate of 32.3%?

The NTSV CS rate is comprised of 3 major, mutually exclusive sub-populations (Spontaneous labor resulting in CS, Induced Labor Resulting in CS, and CS with no Labor). This breakdown of the NTSV CS rate should help determine where QI efforts can best be applied. The most common issue among most hospitals is a high rate of CS during NTSV spontaneous labor. Some hospitals may also have a high rate during induced labor.
No Labor: 5 months Pre/Post 2/1/2020
Induced Labor: 5 months Pre/Post 2/1/2020
Gestational Age Matters a bit but Cervical Dilation Matters More

21%  24%  12%  15%  9%  11%  5%  9%  6%  7%  5%  5%
Spontaneous Labor: 5 months Pre/Post 2/1/2020
Cervix Data: 5 months Before and After 2/1/2020
(Note more admissions prior to 4 cm and more CS done before 6 cm)
Leadership All Hands-on Deck

- Fallouts from weekly review discussed one-on-one with surgeon.
- Review weekly NTSV CSR by all senior leaders/ELT.
- Monthly MEC updates from Quality Council.
- Monthly meetings with Regional WC team to review/revise action planning.
- CE/CMO Hallway conversations with fallout physicians.
- OB Director daily walk-through discussion with staff.
- CNO weekly walkthrough/touch base with labor and delivery staff.
- Making LAIP goals.
- Begin planning for Natural Labor Program.
**Weekly NTSV CSR Review**
(sent to all Ministry Leaders)

**SJO NTSV Executive Summary by week**

**July 2020**

<table>
<thead>
<tr>
<th>Week</th>
<th>N: # NTSV fallouts</th>
<th>D: # of cases</th>
<th>% for week</th>
<th>Documented c/s reason</th>
<th>Attending</th>
<th>Decision making MD/Nurse</th>
<th>notes</th>
<th>Recommodation</th>
<th>ACOG Criteria met</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 3-9</td>
<td>2</td>
<td>20</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>Non-Reassuring FHR</td>
<td></td>
<td></td>
<td>38.3 weeks death in utero; attempted ind, multiple prolonged decels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>Failed Induction</td>
<td></td>
<td></td>
<td>40.1 weeks sent from MFT for ind.</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>July 10-16</td>
<td>5</td>
<td>25</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>Non-Reassuring FHR</td>
<td></td>
<td></td>
<td>40 weeks labor (bates, temp, mec)</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>Non-Reassuring FHR</td>
<td></td>
<td></td>
<td>39.2 weeks admitted for decels</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>Maternal Request</td>
<td></td>
<td></td>
<td>37.7ind for elevated BPs, 24 day labor and patient requested for maternal exhaustion an 8cm for 5 hrs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>2nd Stage Labor Dystoica</td>
<td></td>
<td></td>
<td>40.5 ind.</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td>2nd Stage Labor Dystoica</td>
<td></td>
<td></td>
<td>40.4 ind</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>July 17-23</td>
<td>6</td>
<td>36</td>
<td>16.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>Non-Reassuring FHR</td>
<td></td>
<td></td>
<td>39 weeks admitted for Dec. FM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Nursing Checklist

<table>
<thead>
<tr>
<th>Action</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Refresh</strong></td>
<td>Refresh labor techniques training/Spinning Baby/2nd Stage</td>
</tr>
<tr>
<td><strong>Strip</strong></td>
<td>Strip review at shift change</td>
</tr>
<tr>
<td><strong>Review</strong></td>
<td>Review oxytocin policies and procedures for timely advancement of oxytocin and restarting after tachysystole/decelerations.</td>
</tr>
<tr>
<td><strong>Work</strong></td>
<td>Work with medical leadership to invoke hard stop labor admissions before 4 cm without medical indications.</td>
</tr>
<tr>
<td><strong>No Labor Cesarean Reduction</strong></td>
<td></td>
</tr>
<tr>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td>Signed consent by patient acknowledging the unique risks and benefits to future health and pregnancies.</td>
<td></td>
</tr>
<tr>
<td>Attendance at Elective Cesarean Section Risk/Benefit Class prior to case being scheduled.</td>
<td></td>
</tr>
<tr>
<td>Mandatory second opinion by MFM prior to case being scheduled.</td>
<td></td>
</tr>
<tr>
<td>Approval for CS Macrosomia only if meets ACOG criteria, otherwise consider elective.</td>
<td></td>
</tr>
<tr>
<td>Tracking of estimated vs. actual EFWs and outcomes.</td>
<td></td>
</tr>
</tbody>
</table>
Induction of Labor

- Hard stop for oxytocin or ROM prior to achieving ripe cervix.
- Outpatient cervical ripening unless medically indicated.
- Follow standard recommendations for medical inductions.
- Combination cervical ripening for all inpatients.
- Allowing elective inductions at 39 0/7ths weeks for patients with ripe cervices and physicians who have nulliparous CSR after induction of <25%.
- Elective induction with aggressive cervical ripening at 40 3/7th for all other patients and physicians.
- Induction progress reports at all hand off huddles.
Fetal Intolerance to Labor/Failure to Progress/Descent

- Mandatory raining on NICHD categories/5 Tier FHR Analysis with management planning.
- Strip review by hospitalists and nursing on all changes of shift.
- All FIL cesareans have medical director review for appropriateness.
- Cord gases for FIL cesareans.
- Hard stop for labor admissions prior to 4 cm unless medical indication.
- Timely augmentation following appropriate policy procedure review.
- Avoidance of laboring down and varying pushing techniques.
- Operative Vaginal Delivery training.
- Manual Rotation of Occiput Posterior/Transverse (define hospitalist role).
How did they do?
Q&A
You have Questions
We have Answers
TEAM TALK: ANN KURZ, MSN, RN, C-EFM
PERINATAL EDUCATOR AT LOYOLA MEDICINE
PVB WEBINAR
LUMC UPDATES

Ann Kurz, MSN, RN, C-EFM
Perinatal Educator
February 2021 Audit Details

February 2021

- N – 12 (random stratified)
- NTSV Vaginal Deliveries – 10
- NTSV Cesarean Deliveries – 2

Our CS Rate: 16.6%
HP2020 Goal: 24.7%
Steps to Launching LCS

- Inquiry form completed 1/26
- Who should be involved?
  - Nurses
  - LUFOG OB Attending/Residents
  - MFM Attendings/Fellows
  - Midwives
  - Anesthesia Attendings/Residents
  - Manager and Educators
  - Outpatient MDs and NPs
  - Nursing Administration
- Obtain buy-in and inform Administration.
- **Creating Clinical Culture Change**
## 30-60-90 Day Plan

### Overall Goal: 30-Day Plan
Outline of information to share with nursing staff, residents, attendings to promote buy-in.

<table>
<thead>
<tr>
<th>TASKS TO ACHIEVE GOAL:</th>
<th>RESPONSIBLE PARTY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Use consistent verbiage.</td>
<td>Champions + Ann</td>
</tr>
<tr>
<td>2. Grand Round slide sets/staff meeting.</td>
<td>Ann + Dr. Frenn</td>
</tr>
<tr>
<td>3. Data collection strategy.</td>
<td>Champions + Ann</td>
</tr>
</tbody>
</table>

### Overall Goal: 60-Day Plan
Detailed education on interventions, action plan to promote vaginal birth: policy binder after Tier 1 Huddle.

<table>
<thead>
<tr>
<th>TASKS TO ACHIEVE GOAL:</th>
<th>RESPONSIBLE PARTY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. RN &amp; MD communication i.e. fetal monitoring</td>
<td>Champions + Ann</td>
</tr>
<tr>
<td>3.</td>
<td>Dr. Frenn</td>
</tr>
</tbody>
</table>

### Overall Goal: 90-Day Plan

<table>
<thead>
<tr>
<th>TASKS TO ACHIEVE GOAL:</th>
<th>RESPONSIBLE PARTY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Break room board with “stars” with recognition and definitions.</td>
<td>Champions + Ann</td>
</tr>
<tr>
<td>2. Updated policy to include ACOG/SMFM guidelines.</td>
<td>Ann</td>
</tr>
<tr>
<td>3. Encourage staff compliance with LCS</td>
<td>Champions + Ann</td>
</tr>
</tbody>
</table>
Thank you for all your hard work!

- Camille's audit: Failed Induction + 4 NSVD
- Joan's audit: FHR Concerns/Indications + 3 NSVD
- Teri's audit: Labor Dystocia/Failure to Progress + 3 NSVD
- If you're auditing a chart, think about the "straw the broke the camel's back" if there are multiple reasons for cesarean section.
- March 2021 data due to Ann by April 9th, 2021
- **Next Meeting:** Monday, April 19, 2021
LAUNCHING THE LABOR CULTURE SURVEY
Get ready... the ILPQC LABOR CULTURE SURVEY is open...

Link coming in your newsletter!

LAST CHANCE to submit your LCS inquiry form!
See link in Chat and PVB newsletter.
Successfully launching your Labor Culture Survey (LCS)

- Meet with your QI Team to go over the following dates:

<table>
<thead>
<tr>
<th>Date</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>March 29</strong>&lt;sup&gt;th&lt;/sup&gt; (or sooner)</td>
<td>Send <strong>launch email</strong> to all participating staff</td>
</tr>
<tr>
<td><strong>March 29</strong>&lt;sup&gt;th&lt;/sup&gt; (or sooner)</td>
<td>Post <strong>flyers with QR code</strong> around L&amp;D Unit</td>
</tr>
<tr>
<td>Weekly</td>
<td>Review <strong>weekly participation reports</strong> from ILPQC</td>
</tr>
<tr>
<td><strong>April 12</strong>&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Send <strong>follow-up email</strong> to all staff</td>
</tr>
<tr>
<td><strong>April 26</strong>&lt;sup&gt;th&lt;/sup&gt;</td>
<td>Send <strong>final reminder email</strong></td>
</tr>
<tr>
<td><strong>May 3</strong>&lt;sup&gt;rd&lt;/sup&gt;</td>
<td>Survey closes</td>
</tr>
</tbody>
</table>
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!
NEXT STEPS FOR ALL PVB TEAMS
Keeping on track with PVB

- Schedule regular QI Team meetings develop a plan to engage provider/nurse buy-in
- Launch the Labor Culture Survey
- Complete baseline data collection for Q4 2019
- Submit monthly data collection for January, February and March 2021
- Review checklist and huddle toolkit materials
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
# Upcoming Monthly Webinars

**4th Monday of the Month**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, April 26&lt;sup&gt;th&lt;/sup&gt; 12:30-1:30</td>
<td>Utilizing Cesarean Delivery decision huddles and checklists</td>
</tr>
<tr>
<td>May 26&lt;sup&gt;th&lt;/sup&gt; (VIRTUAL)</td>
<td>Virtual Face-to-Face</td>
</tr>
</tbody>
</table>

Register and Join here: https://northwestern.zoom.us/j/91684580832?pwd=eXo3U3VsTIVTOHI5QjRvUjdQeWRtdz09
4 Steps to Get Ready for the ILPQC Face-to-Face

1. Save the date
   • Save the date - Registration opening soon!
   • Held Virtually May 26th (OB) & May 27th (Neo) 2021
   • Meeting will be from 8:30am-3:30pm (OB) 8:15am-3:00pm (Neo)

2. Qualify for an award
   • Please submit all initiative baseline data
   • Complete and submit hospital and patient level data Jan thru March. 2021 (Q1) by April 30th

3. Submit Storyboard
   • Coordinate with your colleagues working across initiatives to complete the ILPQC storyboard template
   • Have one person from your hospital submit by April 30th

4. Email Hospital slide
   • Please upload your team photo/slide collage via the AC survey or email to info@ilpqc.org by April 30th
ILPQC After Office Hours

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!
COVID-19
COVID-19 Sharing Strategies

OB & Neonatal providers from across the state present cases and share strategies

Where are the HOT SPOTS for COVID-19 in your network?

April 9th, at 12pm
Sharing Covid-19 Cases

• Please send questions, comments and recommendations, cases / willingness to share for future COVID-19 OB/Neo discussion webinars to info@ilpqc.org

• Registration for the next webinar on Friday, 4/9/21 will be available at https://northwestern.zoom.us/webinar/register/ WN_VBb5dGnwT9KoWIOC7zHmcA
THANKS TO OUR FUNDERS

In Kind Support
Promoting Vaginal Birth (PVB)

APPENDIX
Baseline: NTSV C-Section Rates

Baseline (Q4 2019) NTSV C-Section Rate

Goal: 24.7%

Total ILPQC rate: 26.9%
January: NTSV C-Section Rates

January 2021
NTSV C-Section Rate

Goal: 24.7%

Total ILPQC rate: 23%