# 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***

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

REGISTRATION COMING SOON!

REGISTRATION COMING SOON! VISIT ILPQC.ORG

Northwestern Medicine
Feinberg School of Medicine

# 2021 OB F2F Agenda

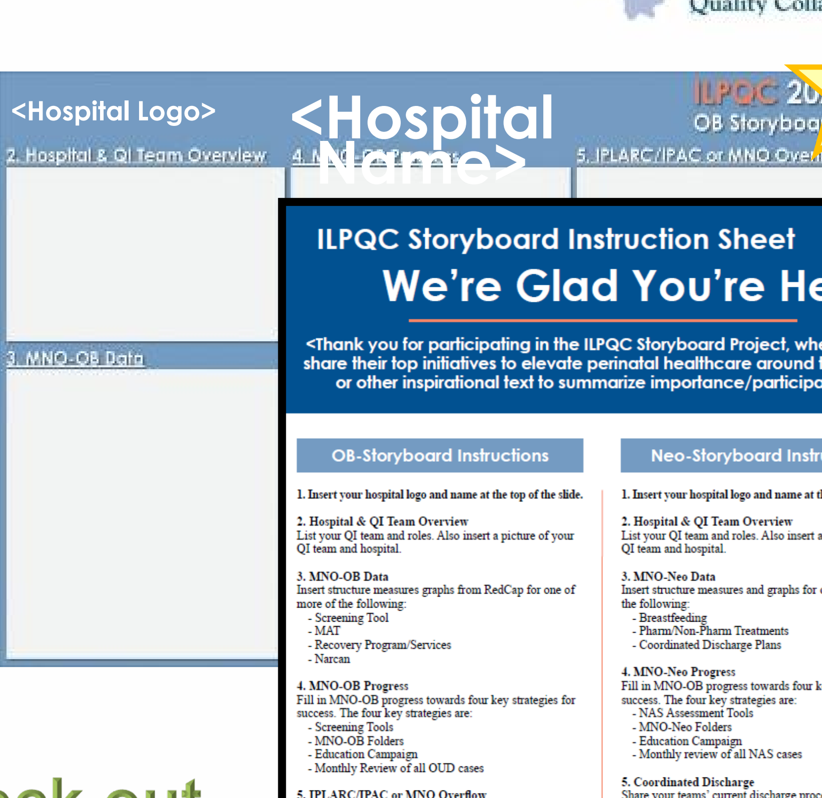
| Time | Session/Speaker |
| --- | --- |
| 8:30 – 9:00 am | **Welcome & Overview; Working Together in 2021- Ann Borders** |
| 9:00 – 9:45 am | **Birth Equity Plenary Session- Audra Meadows** |
| 9:45 – 9:55 am | Break |
| 9:55 – 10:40 am | **PVB QI Team Panel: Sharing Strategies for Success- ILPQC PVB Teams** |
| 10:40 – 11:10am | **Unpacking the Birth Equity Initiative and Toolkit- Ann Borders** |
| 11:10 – 11:30 pm | QI Team Awards |
| 11:30 – 1:00 pm | Virtual Storyboard Review & Lunch |
| 1:00 – 1:35 pm | **Breakout Session 1: Small Group Key Topic Discussions on Implementation Strategies** |
| 1:35 – 1:45 pm | Break |
| 1:45 – 2:20 pm | **Breakout Session 2: Small Group Key Topic Discussions on Implementation Strategies** |
| 2:20 – 2:30 pm | Break |
| 2:30 – 3:15 pm | **Engaging Patients in QI Work-Ann Borders & LaToshia Rouse** |
| 3:15-3:30 pm | **Wrap up and Next Steps for 2021- Ann Borders** |

ILPQC PVB Teams

# 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




ILPQC Storyboard Instruction Sheet

We’re Glad You’re Here!

<Thank you for participating in the ILPQC Storyboard Project, where teams share their top initiatives to elevate perinatal healthcare around the state… or other inspirational text to summarize importance/participation.>

**OB-Storyboard Instructions**

1. Insert your hospital logo and name at the top of the slide.

2. Hospital & QI Team Overview
List your QI team and roles. Also insert a picture of your QI team and hospital.

3. MNO-OB Data
Insert structure measures graphs from RedCap for one of more of the following:
- Screening Tool
- MAT
- Recovery Program/Services
- Narcan

4. MNO-OB Progress
Fill in MNO-OB progress towards four key strategies for success. The four key strategies are:
- Screening Tools
- MNO-OB Folders
- Education Campaign
- Monthly Review of all OUD cases

5. IPLARC/IPAC or MNO Overflow
Use this area to insert IPLARC & IPAC reports or as additional space to share your MNO Progress.

6. PVB
Tell us about your PVB QI Team and about your 30/60/90 day plan if team has a draft ready to share.

**Neo-Storyboard Instructions**

1. Insert your hospital logo and name at the top of the slide.

2. Hospital & QI Team Overview
List your QI team and roles. Also insert a picture of your QI team and hospital.

3. MNO-Neo Data
Insert structure measures and graphs for one of more of the following:
- Breastfeeding
- Pharm/Non-Pharm Treatments
- Coordinated Discharge Plans

4. MNO-Neo Progress
Fill in MNO-OB progress towards four key strategies for success. The four key strategies are:
- NAS Assessment Tools
- MNO-Neo Folders
- Education Campaign
- Monthly review of all NAS cases

5. Coordinated Discharge
Share your teams' current discharge process and materials.

6. BASIC
Share your:
- Anticipated team members and role on the team
- Current tools or materials (ex. National Sepsis calculator) your hospital has implemented prior to the launch of the initiative
- Potential barriers and strategies to overcome them

7. Save the document and send completed storyboard by May XX, 2020 to jb@thejbcreative.com.

Thank you for your participation!
Please contact Jodie Brooks at jb@thejbcreative.com with questions.

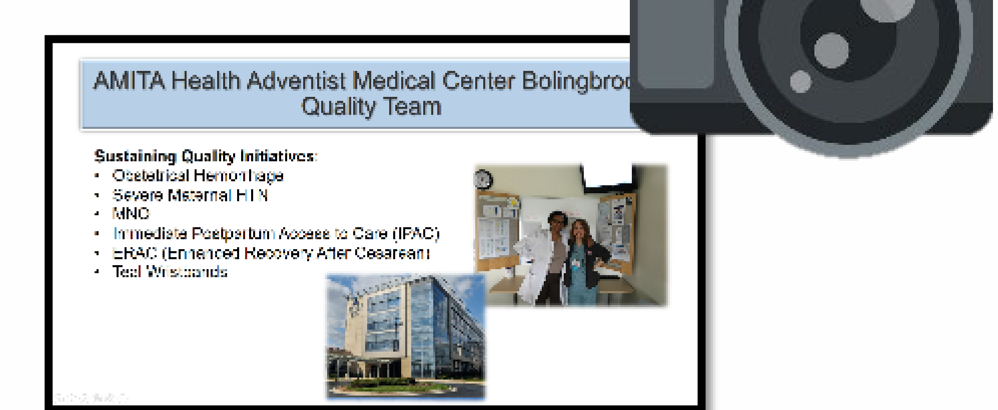
Check out your PVB newsletter for more info!

# 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)

| Month | Teams Reporting Patient Data | Teams Reporting Hospital Data |
|---|---|---|
| Baseline (Q4 2019) | 80 | 70 |
| January 2021 | 71 | 61 |
| February 2021 | 63 | 55 |

**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 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 question
- 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

# Structure Measures

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

| | In Place | Working on it | Not Started |
|---|---|---|---|

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Baseline January February

In Place Working on it Not Started

# Structure Measures

## Implemented standardized protocol/processes for induction, labor support management and response to labor and FHR abnormalities

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Baseline
January
February

In Place
Working on it
Not Started

# Structure Measures

## Implemented and integrated PVB order sets, protocols, and documentation into the EMR

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Baseline
January
February
In Place
Working on it
Not Started

# Structure Measures

Implemented cesarean decision checklist using ACOG/SMFM labor guidelines

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Baseline
January
February
In Place
Working on it
Not Started

# Structure Measures

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

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Baseline January February

In Place Working on it Not Started

# Structure Measures

Implemented workflow process to incorporate shared decision making with the patient

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Baseline
January
February
In Place
Working on it
Not Started

# Structure Measures

Implemented standardized patient education with positive messaging promoting vaginal birth strategies and techniques for women and families

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Baseline
January
February

In Place
Working on it
Not Started

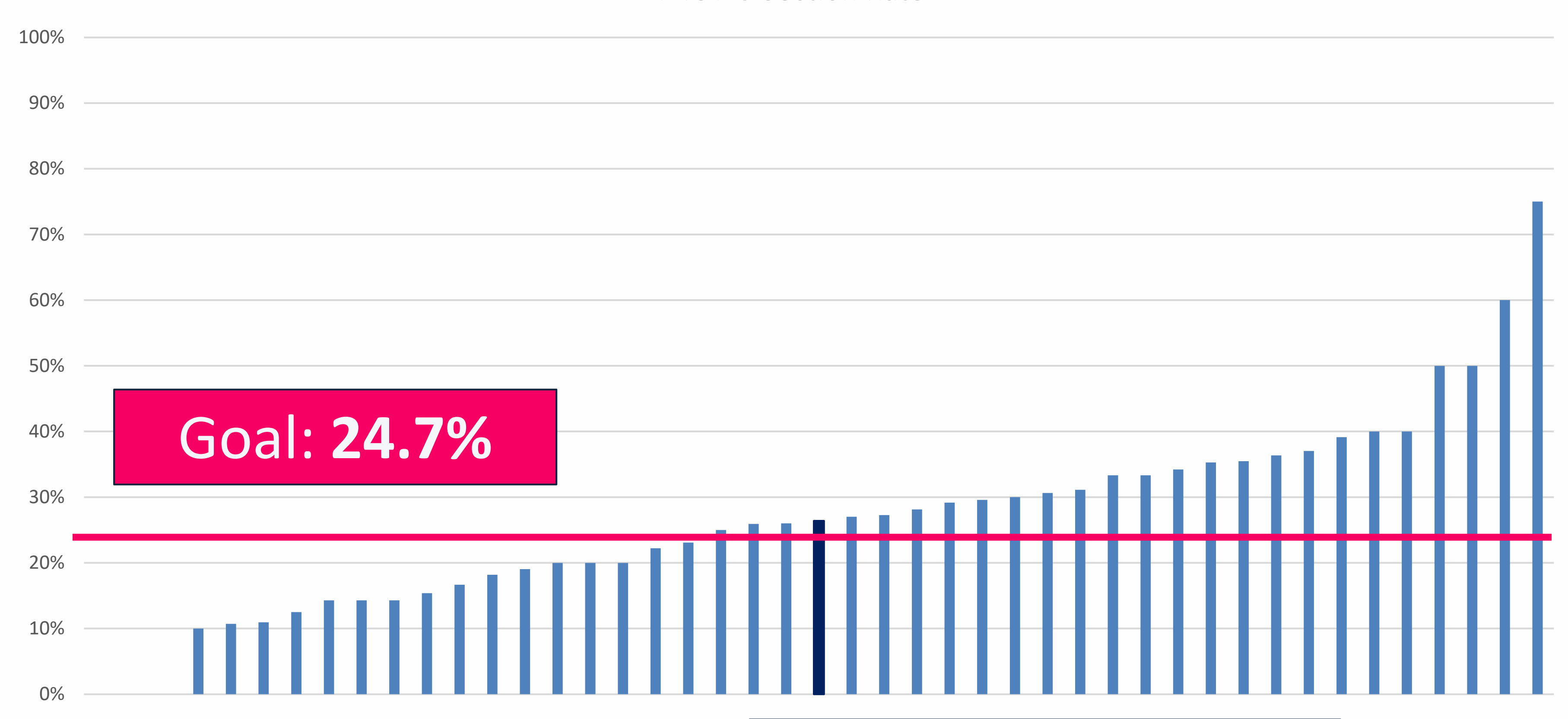
# Structure Measures

Integrated process to review and share data that includes provider-level data with labor and delivery clinical teams

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Baseline
January
February
In Place
Working on it
Not Started

# February: NTSV C-Section Rates

ILPQC Illinois Perinatal Quality Collaborative




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%

100
90
80
70
60
50
40
30
20
10
0

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

Baseline
January
February

# INCORPORATING ACOG/SMFM GUIDELINES INTO C/S DECISIONS

# 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. 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. 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

ILPQC Illinois Perinatal Quality Collaborative

- 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

ILPQC
Illinois Perinatal Quality Collaborative

- 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

Hackensack Meridian Health

Pre-Cesarean Checklist for Labor Dystocia, Failed Induction and Fetal Heart Rate Abnormalities

**Pre-Cesarean Huddle Form**

TGH Tampa General Hospital

CMQCC
California Maternal Quality Care Collaborative

Appendix J

Pre-cesarean 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 (must have both criteria if cervix unfavorable, Bishop Score < 8 for nullips and <6 for multips)

___ Cervical Ripening used (when starting with unfavorable Bishop scores as noted above). Ripening agent used: ___ Reason ripening not used if cervix unfavorable: ___

AND

___ Unable to generate regular contractions (every 3 minutes) and cervical change after oxytocin administered for at least 12-18 hours after membrane rupture.* *Note: at least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

___ Latent Phase Arrest <6 cm dilation (must fulfill one of the two criteria)

___ Moderate or strong contractions palpated for > 12 hours without cervical change

OR

___ IUPC > 200 MVU for > 12 hours without cervical change

*As long as cervical progress is being made, a slow but progressive latent phase e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women is not an indication for cesarean delivery as long as fetal and maternal statuses remain reassuring. Please exercise caution when diagnosing latent phase arrest and allow for sufficient time to enter the active phase.

___ Active Phase Arrest ≥ 6 cm Dilation (must fulfill one of the two criteria)

Membranes ruptured (if possible), then:

___ Adequate uterine contractions (e.g. moderate or strong to palpation, or ≥ 200 MVU, for ≥ 4 hours) without improvement in dilation, effacement, station or position

OR

___ Inadequate uterine contractions (e.g. < 200 MVU) for ≥ 6 hours of oxytocin administration without improvement in dilation, effacement, station or position

___ Second Stage Arrest (must fulfill any one of four criteria)

___ Nullipara with epidural pushing for at least 4 hours

OR

___ Nullipara without epidural pushing for at least 3 hours

OR

___ Multipara with epidural pushing for at least 3 hours

OR

___ Multipara without epidural pushing for at least 2 hours

___ Although not fulfilling contemporary criteria for labor dystocia as described above, my clinical judgment deems this cesarean delivery indicated

___ Failed Induction: Duration in hours: ___
Latent-Phase Arrest: Duration in hours: ___
Active-Phase Arrest: Duration in hours: ___
Second-Stage Arrest: Duration in hours: ___

Comments:

Adapted with permission from Miller Children's and Women's Hospital.

110 | CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

# ILPQC Toolkit Items: Process Flow Diagrams for ACOG/SMFM Criteria

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

Were ACOG/SMFM criteria met?

Patient is <6 cm dilated

Patient is ≥6 cm dilated

Patient is completely dilated

Version 2.0
11.2020

PVB Process Flow ACOG/SMFM Criteria for Review: Induction

Were ACOG/SMFM criteria met?

Patient is <6 cm dilated

Patient is ≥6 cm dilated

Patient is completely dilated

Version 2.0
11.2020

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

ILPQC Illinois Perinatal Quality Collaborative

Were ACOG/SMFM criteria met?

Criteria not met

ACOG/SMFM criteria met

Version 2.0
11.2020

# DR. DAVID LAGREW CMQCC

# 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.

# ACOG/SMFM Labor Dystocia Checklist

ACOG/SMFM Consensus www.AJOG.org

ACOG/SMFM OBSTETRIC CARE CONSENSUS

## Safe prevention of the primary cesarean delivery

This document was developed jointly by the American College of Obstetricians and Gynecologists (the College) and the Society for Maternal–Fetal Medicine with the assistance of Aaron B. Caughey, MD, PhD; Alison G. Cahill, MD, MSCI; Jeanne-Marie Guise, MD, MPH; and Dwight J. Rouse, MD, MSPH

**The information reflects emerging clinical and scientific advances as of the date issued, is subject to change, and should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.**

In 2011, 1 in 3 women who gave birth in the United States did so by cesarean delivery. Cesarean birth can be lifesaving for the fetus, the mother, or both in certain cases. However, the rapid increase in cesarean birth rates from 1996 through 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused. Variation in the rates of nulliparous, term, singleton, vertex cesarean births also indicates that clinical practice patterns affect the number of cesarean births performed. The most common indications for primary cesarean delivery include, in order of frequency, labor dystocia, abnormal or indeterminate (formerly, nonreassuring) fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia. Safe reduction of the rate of primary cesarean deliveries will require different approaches for each of these, as well as other, indications. For example, it may be necessary to revisit the definition of labor dystocia because recent data show that contemporary labor progresses at a rate substantially slower than what was historically taught. Additionally, improved and standardized fetal heart rate interpretation and management may have an effect. Increasing women's access to nonmedical interventions during labor, such as continuous labor and delivery support, also has been shown to reduce cesarean birth rates. External cephalic version for breech presentation and a trial of labor for women with twin gestations when the first twin is in cephalic presentation are other of several examples of interventions that can contribute to the safe lowering of the primary cesarean delivery rate.

### Background

In 2011, 1 in 3 women who gave birth in the United States did so by cesarean delivery.[1] Even though the rates of primary and total cesarean delivery have plateaued recently, there was a rapid increase in cesarean rates from 1996 through 2011 (Figure 1). Although cesarean delivery can be lifesaving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused.[2] Therefore, it is important for health care providers to understand the short-term and long-term tradeoffs between cesarean and vaginal delivery, as well as the safe and appropriate opportunities to prevent overuse of cesarean delivery, particularly primary cesarean delivery.

### Balancing risks and benefits

Childbirth by its very nature carries potential risks for the woman and her baby, regardless of the route of delivery. The National Institutes of Health has commissioned evidence-based reports over recent years to examine the risks and benefits of cesarean and vaginal delivery[3] (Table 1). For certain clinical conditions—such as placenta previa or uterine rupture—cesarean delivery is firmly established as the safest route of delivery. However, for most pregnancies, which are low-risk, cesarean delivery appears to pose greater risk of maternal morbidity and mortality than vaginal delivery[4] (Table 1).

It is difficult to isolate the morbidity caused specifically by route of delivery. For example, in one of the few randomized trials of approach to delivery, women with a breech presentation were randomized to undergo planned cesarean delivery or planned vaginal delivery, although there was crossover in both treatment arms.[5] In this study, at 3-month follow-up, women were more likely to have urinary, but not fecal, incontinence if they had been randomized to the planned vaginal delivery group. However, this difference was no longer significant at 2-year follow-up.[6] Because of the size of this randomized trial, it was not powered to look at other measures of maternal morbidity.

A large population-based study from Canada found that the risk of severe maternal morbidities—defined as hemorrhage that requires hysterectomy or

The authors report no conflict of interest.

This article is being published concurrently in the March 2014 issue of Obstetrics & Gynecology (Obstet Gynecol 2014;123:693-711).

http://dx.doi.org/10.1016/j.ajog.2014.01.026



## 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:

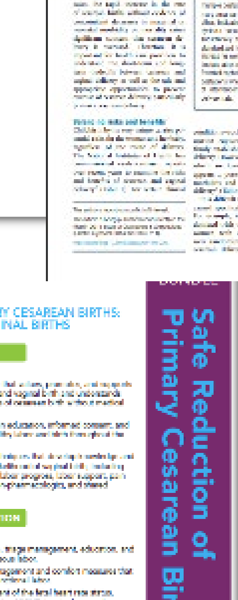
- ❑ Failed Induction (**must have both criteria if cervix unfavorable, Bishop Score ≤ 8 for nullips and $<6$ for multips**)
  - ❑ Cervical Ripening used for those starting with Bishop scores as noted above
    - Ripening agent used: _____________
    - Reason ripening not used if cervix unfavorable: _________________________
    - AND
  - ❑ Unable to generate regular contractions (every 3 minutes) and cervical change after oxytocin administered for at least 12-18 hours after membrane rupture." *Note: at least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit
- ❑ Latent Phase Arrest ❑ Moderate or strong contractions palpated for ≥ 12 hours
  - OR
  - ❑ IUPC ≥ 200 MVU for ≥ 12 hours
- ❑ Labor Dystocia ≥ 6 cm Dilation—Active Phase Arrest (**must fulfill one of the two criteria**)
  - ❑ Membranes ruptured (if possible), then:
    - ❑ Adequate uterine contractions (e.g. ≥ 200 MVU for ≥ 4 hours) without improvement in dilation, effacement, station or position)
    - OR
    - ❑ Inadequate uterine contractions (e.g. $<$ 200 MVU) for ≥ 6 hours of oxytocin administration without improvement in dilation, effacement, station or position
- ❑ Labor Dystocia in the Second Stage (**must fulfill any one of four criteria**)
  - ❑ Nullipara with epidural in the second stage $>$ 4 hours inclusive of laboring down (if applicable)
  - OR
  - ❑ Nullipara without epidural in the second stage $>$ 3 hours inclusive of laboring down (if applicable)
  - OR
  - ❑ Multipara with epidural in the second stage $>$ 3 hours inclusive of laboring down (if applicable)
  - OR
  - ❑ Multipara without epidural in the second stage $>$ 2 hours inclusive of laboring down (if applicable)
- ❑ Although not fulfilling contemporary criteria for labor dystocia, my clinical judgment deem this cesarean delivery indicated
  - ❑ Failed Induction: Duration in hours: ________________
  - ❑ Latent-Phase Arrest: Duration in hours: ________________
  - ❑ Active-Phase Arrest: Duration in hours: ________________
  - ❑ Second-Stage Arrest: Duration in hours: ________________

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



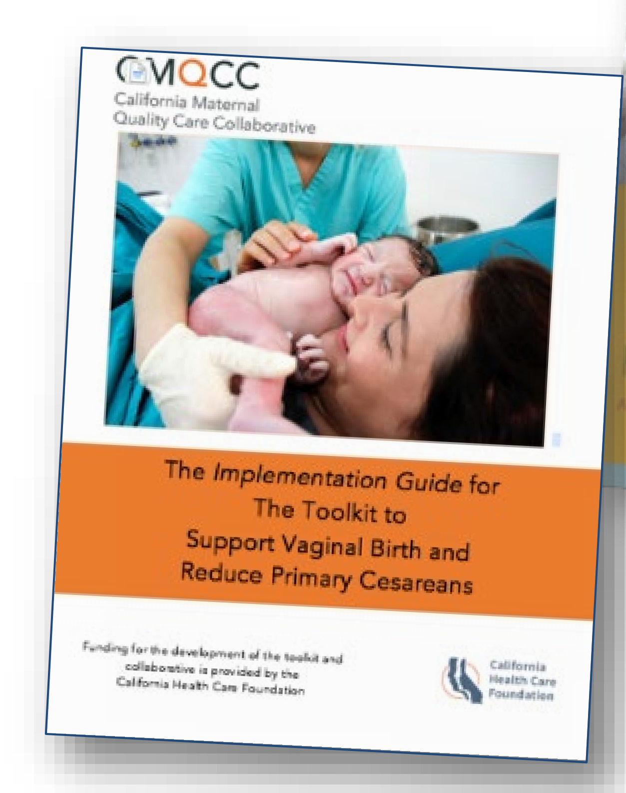
# Implementation Guide

"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



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

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).**

Main EK, Chang SC, Cape V, Sakowski C, Smith H, Vasher J. Safety Assessment of a Large-Scale Improvement Collaborative to Reduce Nulliparous Cesarean Delivery Rates. *Obstet Gynecol*. 2019;133(4):613-623

# ACOG/SMFM Consensus
## Recommendations

TABLE 3
**Recommendations for safe prevention of primary cesarean delivery**

| Recommendations | Grade of recommendations |
|---|---|
| **First stage of labor** | |
| A prolonged latent phase (eg, >20 h in nulliparous women and >14 h in multiparous women) should not be indication for cesarean delivery. | 1B Strong recommendation, moderate-quality evidence |
| Slow but progressive labor in first stage of labor should not be indication for cesarean delivery. | 1B Strong recommendation, moderate-quality evidence |
| Cervical dilation of 6 cm should be considered threshold for active phase of most women in labor. Thus, before 6 cm of dilation is achieved, standards of active-phase progress should not be applied. | 1B Strong recommendation, moderate-quality evidence |
| Cesarean delivery for active-phase arrest in first stage of labor should be reserved for women ≥6 cm of dilation with ruptured membranes 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. | 1B Strong recommendation, moderate-quality evidence |
| **Second stage of labor** | |
| 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. | 1C Strong recommendation, low-quality evidence |
| Before diagnosing arrest of labor in second stage, if maternal and fetal conditions permit, allow for following: • At least 2 h of pushing in multiparous women (1B) • At least 3 h of pushing in nulliparous women (1B) Longer durations may be appropriate on individualized basis (eg, with use of epidural analgesia or with fetal malposition) as long as progress is being documented. (1B) | 1B Strong recommendation, moderate-quality evidence |
| Operative vaginal delivery in second stage of labor by experienced and well-trained physicians should be considered safe, acceptable alternative to cesarean delivery. Training in, and ongoing maintenance of, practical skills related to operative vaginal delivery should be encouraged. | 1B Strong recommendation, moderate-quality evidence |
| Manual rotation of fetal occiput in setting of fetal malposition 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 malposition, it is important to assess fetal position in second stage of labor, particularly in setting of abnormal fetal descent. | 1B Strong recommendation, moderate-quality evidence |
| **Fetal heart rate monitoring** | |
| Amnioinfusion for repetitive variable fetal heart rate decelerations may safely reduce rate of cesarean delivery. | 1A Strong recommendation, high-quality evidence |
| Scalp stimulation can be used as means of assessing fetal acid-base status when abnormal or indeterminate (formerly, nonreassuring) fetal heart patterns (eg, minimal variability) are present and is safe alternative to cesarean delivery in this setting. | 1C Strong recommendation, low-quality evidence |

*ACOG. Safe prevention of primary cesarean delivery. Am J Obstet Gynecol 2014.* *(continued)*

TABLE 3
**Recommendations for safe prevention of primary cesarean delivery** *(continued)*

| Recommendations | Grade of recommendations |
|---|---|
| **Induction of labor** | |
| Before 41 0/7 wks of gestation, induction of labor generally should be performed based on maternal and fetal medical indications. Inductions at ≥41 0/7 wks of gestation should be performed to reduce risk of cesarean delivery and risk of perinatal morbidity and mortality. | 1A Strong recommendation, high-quality evidence |
| Cervical ripening methods should be used when labor is induced in women with unfavorable cervix. | 1B Strong recommendation, moderate-quality evidence |
| 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 12-18 h after membrane rupture before deeming induction failure. | 1B Strong recommendation, moderate-quality evidence |
| **Fetal malpresentation** | |
| Fetal presentation should be assessed and documented beginning at 36 0/7 wks of gestation to allow for external cephalic version to be offered. | 1C Strong recommendation, low-quality evidence |
| **Suspected fetal macrosomia** | |
| 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 4500 g in women with diabetes. Prevalence of birth weight of ≥5000 g is rare, and patients should be counseled that estimates of fetal weight, particularly late in gestation, are imprecise. | 2C Weak recommendation, low-quality evidence |
| **Excessive maternal weight gain** | |
| Women should be counseled about IOM maternal weight guidelines in attempt to avoid excessive weight gain. | 1B Strong recommendation, moderate-quality evidence |
| **Twin gestations** | |
| 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/noncephalic presenting twins should be counseled to attempt vaginal delivery. | 1B Strong recommendation, moderate-quality evidence |
| **Other** | |
| 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 safely lower rate of primary cesarean delivery. | 1C Strong recommendation, low-quality evidence |

*IOM, Institute of Medicine.*

*ACOG. Safe prevention of primary cesarean delivery. Am J Obstet Gynecol 2014.*

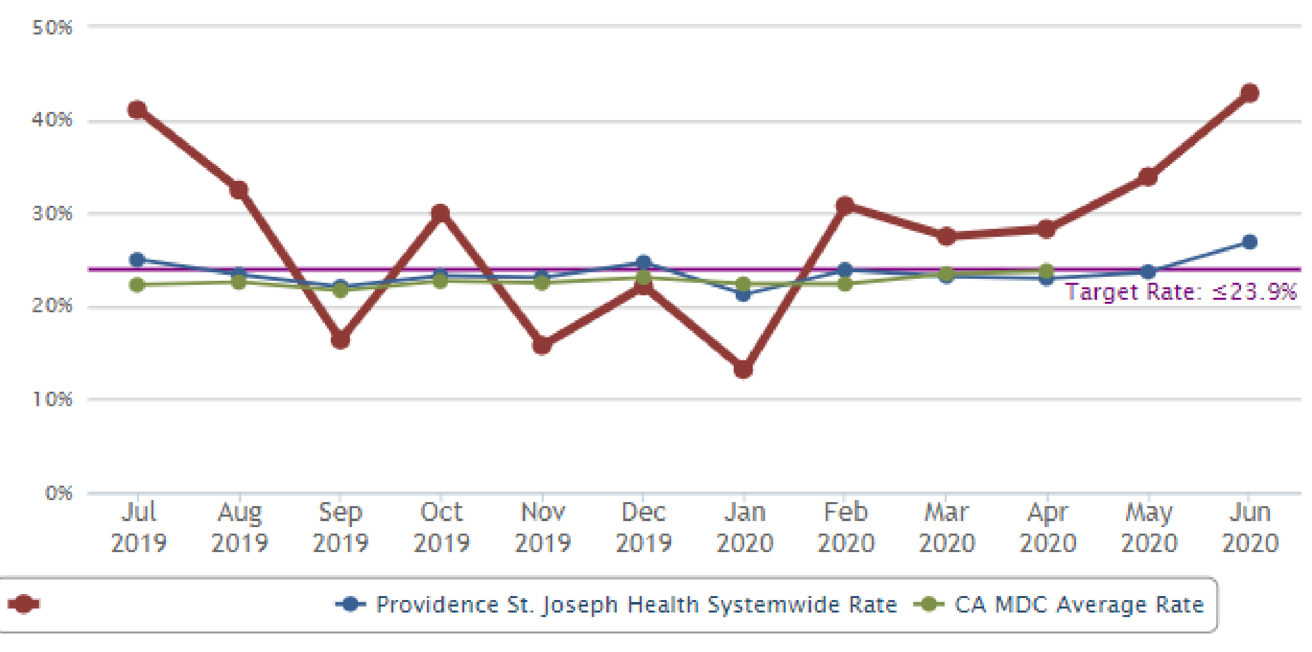
# "My Bucket List"

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

# Use Data / Share Data

Leadership and Providers

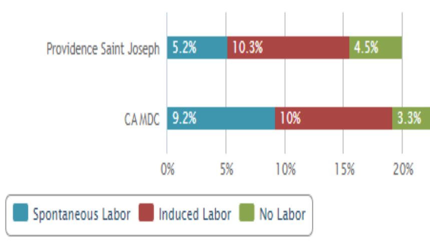
# For Example



# 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.




Period: Feb - Jun 2020 (5 months)

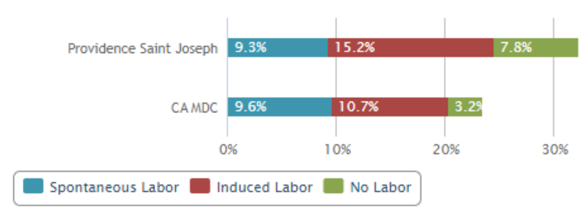
PDF Download

**Start Date** 02/01/2020 **Duration** 5 Months

**Comparison Population** All CA MDC Go

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

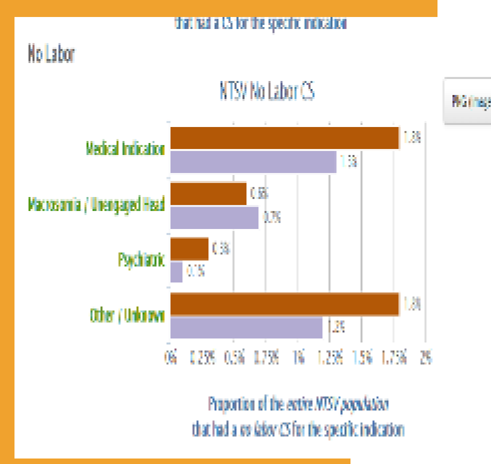
The NTSV CS rate is comprised of 3 major, mutually exclusive sub-populations (Spontaneous labor resulting in CS, Induced Labor Resulting in CS, and CS with no Labor). This breakdown of the NTSV CS rate should help determine where QI efforts can best be applied. The most common issue among most hospitals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

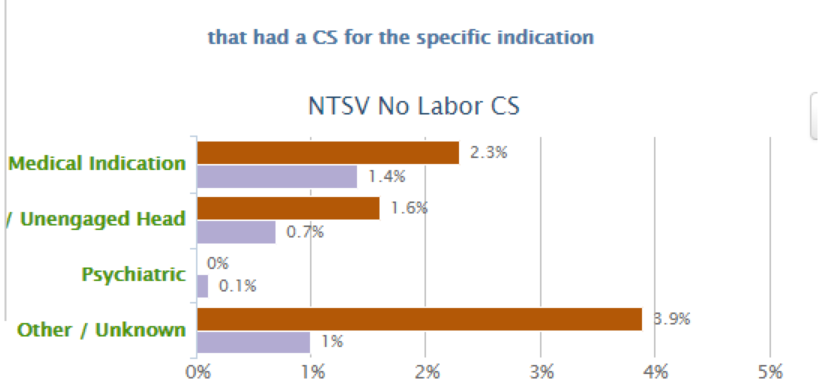



PNG (image) CSV (Excel)

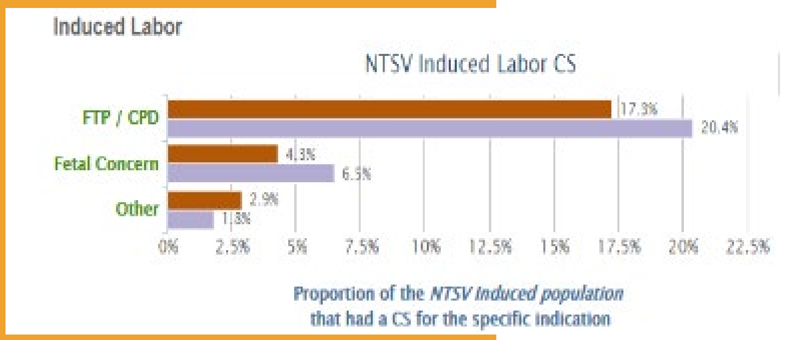
| | Spontaneous Labor | Induced Labor | No Labor | Total NTSV CS Rate |
|---|---|---|---|---|
| **Providence Saint Joseph** | 9.3% | 15.2% | 7.8% | 32.3% |
| **CA MDC** | 9.6% | 10.7% | 3.2% | 23.5% |

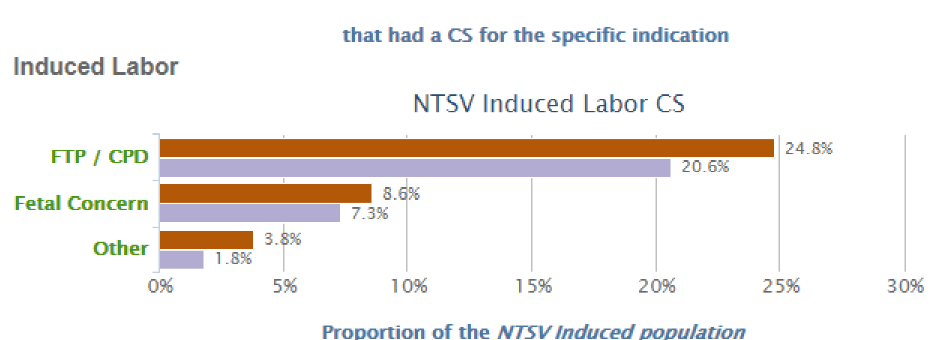
# No Labor: 5 months Pre/Post 2/1/2020



# Induced Labor: 5 months Pre/Post 2/1/2020

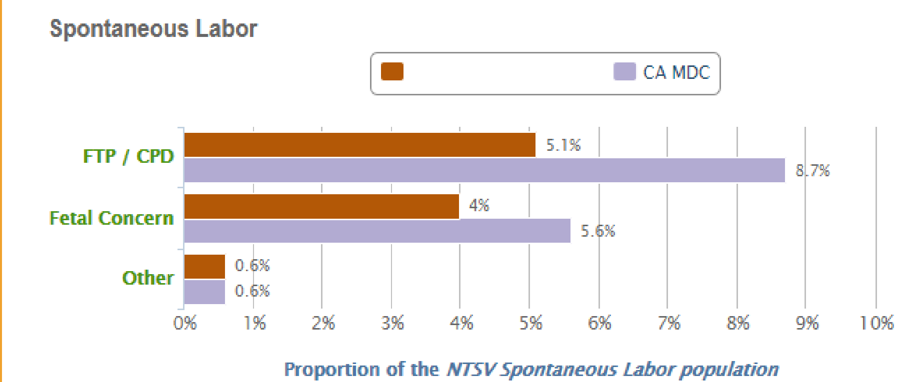


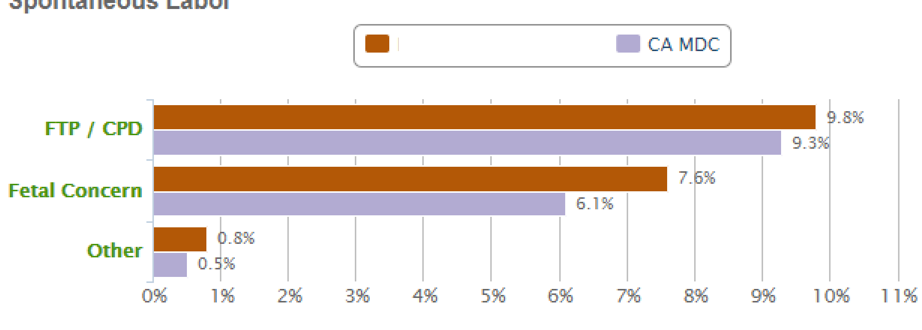



# Gestational Age Matters a bit but Cervical Dilation Matters More

21% 24% 12% 15% 9% 11% 5% 9% 6% 7% 5% 5%

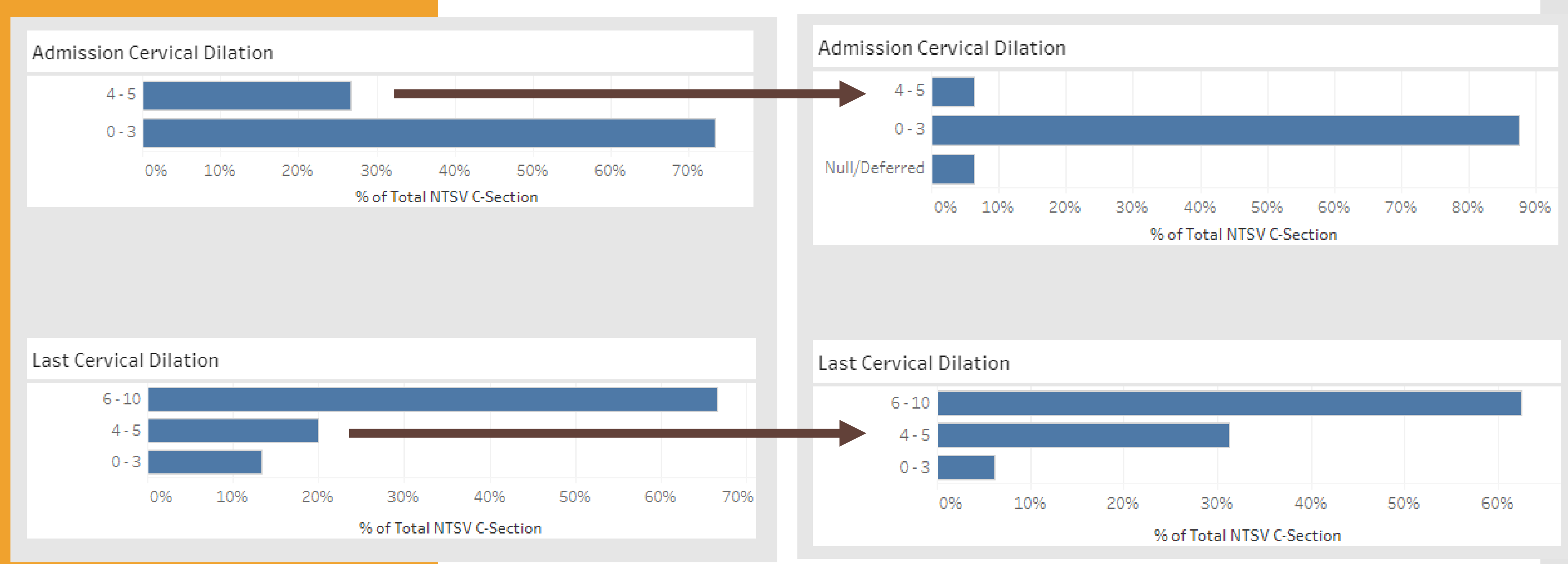
# Spontaneous Labor: 5 months Pre/Post 2/1/2020



# 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.

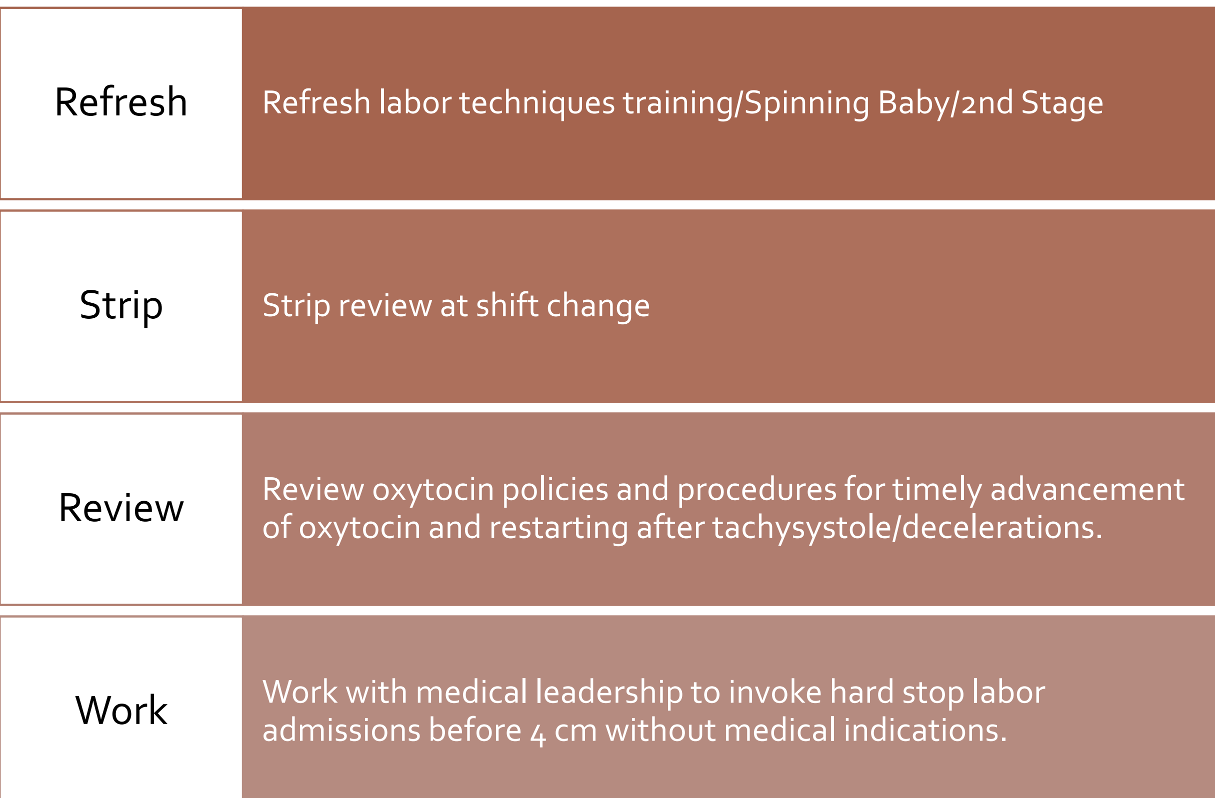
# Weekly NTSV CSR Review (sent to all Ministry Leaders)

SJO NTSV Executive Summary by week

July 2020

| Week: | N: # NTSV fallouts | D: # of cases | % for week | Documented c/s reason | Attending | Decision making MD/Nurse | notes | Recommendation | ACOG Criteria met |
|---|---|---|---|---|---|---|---|---|---|
| July 3-9 | 2 | 20 | 10% | | | | | | |
| 1 | | | | Non Reassuring FHR | | | 38.3 weeks decels in office; attempted ind. multiple prolonged decels | | Yes |
| 2 | | | | Failed Induction | | | 40.1 weeks sent from MFT for ind. | | No |
| July 10-16 | 5 | 25 | 20% | | | | | | |
| 1 | | | | Non Reassuring FHR | | | 40 weeks labor (lates, temp, mec) | | Yes |
| 2 | | | | Non-Reassuring FHR | | | 39.2 weeks admitted for decels | | Yes |
| 3 | | | | Maternal Request | | | 37.2ind for elevated BP's. 2+ day labor and patient requested for maternal exhaustion an 8cm for 5 hrs | | |
| 4<br><br>5 | | | | 2nd Stage Labor Dystocia<br>2nd Stage Labor Dystocia | | | 40.5 ind.<br><br>40.4 ind | | Yes<br><br>Yes |
| July 17-23 | 6 | 36 | 16.7% | | | | | | |
| 1 | | | | Non-Reassuring FHR | | | 39 weeks admitted for Dec. FM | | Yes |

# Nursing Checklist



# No Labor Cesarean Reduction

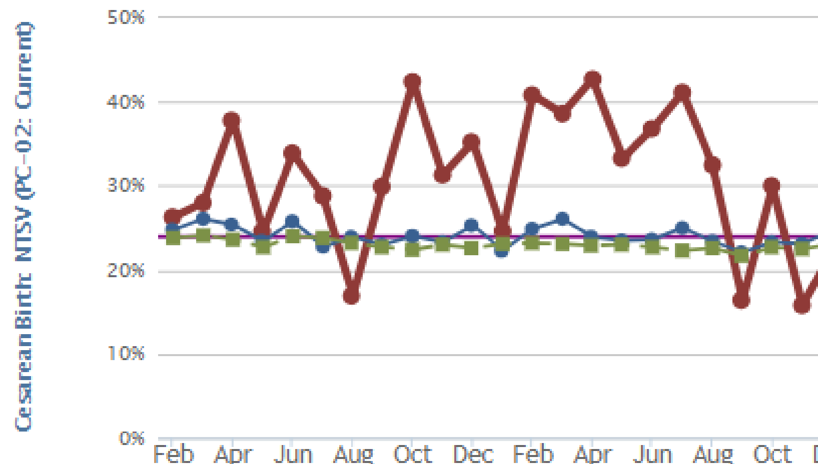
- Signed consent by patient acknowledging the unique risks and benefits to future health and pregnancies.
- Attendance at Elective Cesarean Section Risk/Benefit Class prior to case being scheduled.
- Mandatory second opinion by MFM prior to case being scheduled.
- Approval for CS Macrosomia only if meets ACOG criteria, otherwise consider elective.
- Tracking of estimated vs. actual EFWs and outcomes.

# 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 3/7$^{th}$ 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

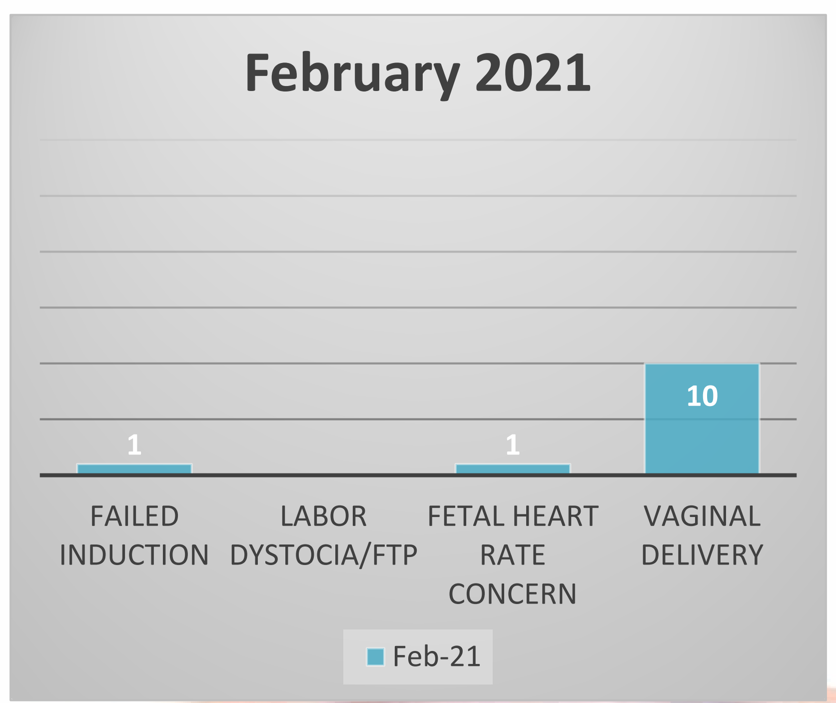
Ann Kurz, MSN, RN, C-EFM

Perinatal Educator

# February 2021 Audit Details

February 2021

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



# 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

## 30 DAY

**Overall Goal:**

Outline of information to share with nursing staff, residents, attendings to promote buy-in.

| TASKS TO ACHIEVE GOAL: | RESPONSIBLE PARTY: |
|---|---|
| 1. Use consistent verbiage. | Champions + Ann |
| 2. Grand Round slide sets/staff meeting. | Ann + Dr. Frenn |
| 3. Data collection strategy. | Champions + Ann |

## 60 DAY

**Overall Goal:**

Detailed education on interventions, action plan to promote vaginal birth: policy binder after Tier 1 Huddle.

| TASKS TO ACHIEVE GOAL: | RESPONSIBLE PARTY: |
|---|---|
| 1. Labor strategies: e-learnings, videos | Champions + Ann |
| 2. RN & patient support & education. | Champions + Ann |
| 3. RN & MD communication i.e. fetal monitoring | Champions + Ann + Dr. Frenn |

## 90 DAY

**Overall Goal:**

Incorporate ACOG/SMFM Guidelines Documentation into practice: Cesarean Decision Checklist, Decision huddle, Patient engagement

| TASKS TO ACHIEVE GOAL: | RESPONSIBLE PARTY: |
|---|---|
| 1. Break room board with "stars" with recognition and definitions. | Champions + Ann |
| 2. Updated policy to include ACOG/SMFM guidelines. | Ann |
| 3. Encourage staff compliance with LCS | Champions + Ann |

IL PQC

# Thank you for all your hard work!

IL PQC

Illinois Perinatal

ative

- 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

# LCS Announcement

## Get ready… the ILPQC

## LABOR CULTURE SURVEY is open…

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:

| Date | Task |
|---|---|
| March 29th (or sooner) | Send **launch email** to all participating staff |
| March 29th (or sooner) | Post **flyers with QR code** around L&D Unit |
| Weekly | Review **weekly participation reports** from ILPQC |
| April 12th | Send **follow-up email** to all staff |
| April 26th | Send **final reminder email** |
| May 3rd | Survey closes |

# 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.

**Calling ALL Labor & Delivery Clinicians and Staff: Complete your Labor Culture Survey today!**

**What:** A quick survey that provides unique opportunity for our team to gain a deeper understanding of our current labor & delivery clinical culture. All entries will remain anonymous.

**Who:** All nurses, doctors, midwives and other clinical staff should participate and complete the survey.

**When:** Complete the survey between Date and Date

**How:** Follow the directions below to complete your survey now in **10-15 minutes**. Remember all survey entries will remain anonymous.

Complete your survey now:

- Step 1: Scan the QR code
- Step 2: Choose your hospital from the drop-down menu
- Step 3: Answer the questions and submit

Questions? Please contact:
ILQPC Central: info@ilpqc.org
Francesca Carlock: FCarlock@northshore.org
Dr. Emily White VanGompel: EWhiteVangompel@northshore.org

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!

BOOK NOW

Email ellie.suse@northwestern.edu to schedule

# Upcoming Monthly Webinars

## 4th Monday of the Month

IL PQC
Illinois Perinatal Quality Collaborative

| Date | Topic |
| --- | --- |
| **Monday, April 26th**<br>12:30-1:30 | Utilizing Cesarean Delivery decision huddles and checklists |
| **May 26th (VIRTUAL)** | Virtual Face-to-Face |

**Register and Join here:**
https://northwestern.zoom.us/j/91684580832?pwd=eXo3U3VsTlVTOHI5QjRvUjdQeWRtdz09

# 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**

## 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

JB & MK PRITZKER
Family Foundation

## In Kind Support

Northwestern Medicine®
Feinberg School of Medicine

Promoting Vaginal Birth (PVB)

# APPENDIX

# Baseline: NTSV C-Section Rates

Total ILPQC rate: **26.9%**

# January: NTSV C-Section Rates

January 2021
NTSV C-Section Rate

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Goal: **24.7%**

Total ILPQC rate:
**23%**