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California Maternal Quality Care Collaborative

Introduction to the Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Funding for the development of this toolkit was provided by the California Health Care Foundation

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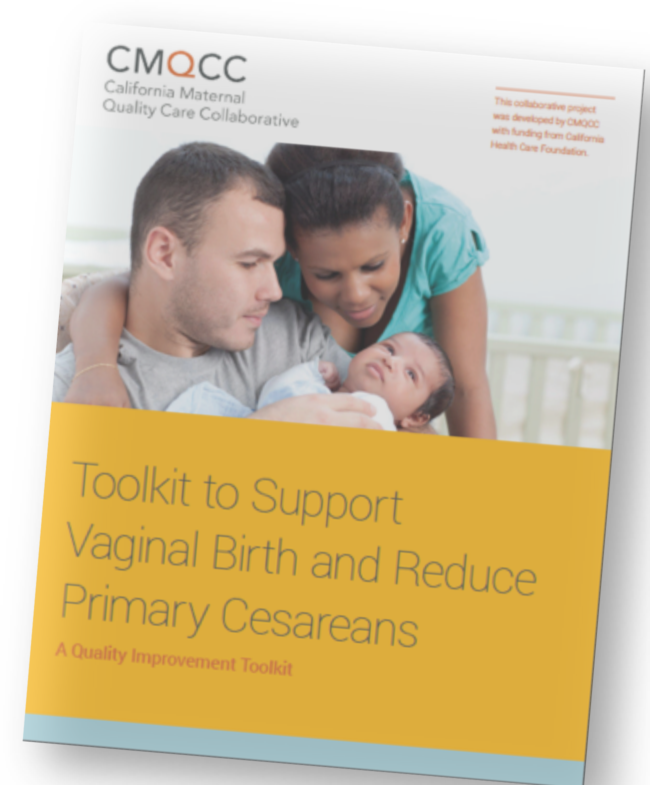
The CMQCC Toolkit

- Comprehensive, evidence-based "How-to Guide" to reduce primary cesarean delivery in the NTSV population
- Will be the resource foundation for the CA QI collaborative project
- The principles are generalizable to all women giving birth
- Released on the CMQCC website April 28, 2016
- Has a companion *Implementation Guide*



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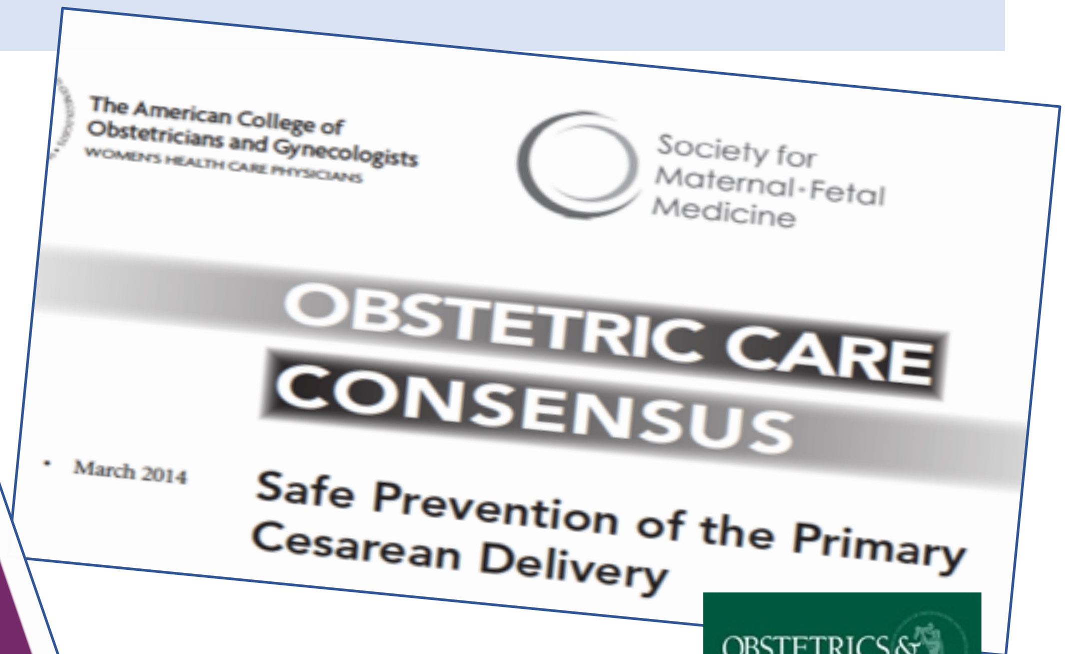
The toolkit is…

The product of multi-disciplinary collaboration and is aligned with key ACOG documents:



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National Cesarean Reduction Bundle

SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

READINESS

Every Patient, Provider and Facility

- Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.

RECOGNITION AND PREVENTION

Every patient

- Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
- Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Use standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using NICHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.

PATIENT SAFETY BUNDLE

Safe Reduction of Primary Cesarean Births

RESPONSE

To Every Labor Challenge

- Have available an in-house maternity care provider or alternative coverage which guarantees timely and effective responses to labor problems.
- Uphold standardized induction scheduling to ensure proper selection and preparation of women undergoing induction.
- Utilize standardized evidence-based labor algorithms, policies, and techniques, which allow for prompt recognition and treatment of dystocia.
- Adopt policies that outline standard responses to abnormal fetal heart rate patterns and uterine activity.
- Make available special expertise and techniques to lessen the need for abdominal delivery, such as breech version, instrumented delivery, and twin delivery protocols.

REPORTING/SYSTEMS LEARNING

Every birth facility

- Track and report labor and cesarean measures in sufficient detail to: 1) compare to similar institutions, 2) conduct case review and system analysis to drive care improvement, and 3) assess individual provider performance.
- Track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety.

Used as model for the CMQCC toolkit

READINESS

Developing a maternity culture that values, and supports intended vaginal birth

Strategies

- Improve access and quality to modern childbirth education
- Improved shared decision making at critical points
- Bridge provider knowledge and skills gap
- Transition to value based payments

Examples

- Sources of best childbirth education tools
- Tools/policies/concepts of "mother friendly" hospital
- Approaches to shared decision making and training aspects
- Payment models for value based results

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Available Childbirth Education Tools

TOOLS FOR PART I OF TOOLKIT - FOR WOMEN				
Strategy#	Name of Tool	CMQCC Tool	External Tool	Location
1	Childbirth Connection - Index of Best Pregnancy Resources A-Z		•	http://childbirthconnection.org/article.asp?Clicked-Link=547&ck=10332&area=27
1	Childbirth Connection – What Every Pregnant Woman Needs to Know about Cesarean Section		•	http://www.childbirthconnection.org/pdfs/cesareanbooklet.pdf
1	Lamaze International - Online Parent Education Courses		•	http://www.lamaze.org/ParentOnlineEducation
1	Lamaze International – Healthy Birth Practices		•	http://www.lamazeinternational.org/d/do/653
1	ACNM - Share With Women (printable consumer education series from the Journal of Midwifery and Women's Health)		•	http://www.midwife.org/Share-With-Women
2	CMQCC Birth Preferences Guide (Birth Plan)	•		Appendix E
2	AHRQ Know Your Questions Infographic		•	http://www.ahrq.gov/sites/default/files/publications/files/optionsposter.pdf

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Readiness

Birth Preferences Worksheet

- Collaborate with healthcare provider to determine birth preferences
- Tailor choices to what is available at each facility

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My Preferences for Labor and Birth: A Plan to Guide Decision Making and Inform My Care Team

Your Name and Date of Birth:

Your Due date:

Physician/Midwife:

Pediatrician/Family Doctor:

Your Labor Support Team (please include partner, doula, friends, relatives, or children who will be present):

Some of your decisions before and during childbirth may affect your risk of cesarean. These decisions are best made in collaboration with your provider during prenatal care visits, well in advance of the time of birth. Here are some common decision points:

- whether to wait for labor to begin on its own (induction of labor may increase your risk of cesarean)
- whether to be admitted to the hospital in early labor or to wait until active labor (being admitted in active labor improves your chances of having a vaginal birth)
- how to monitor your baby's fetal heart rate (low-risk women who are continuously monitored may be more likely to have a cesarean)
- whether to have continuous labor support by a trained caregiver like a doula (continuous labor support improves your chances of having a vaginal birth)
- how to help manage labor pain and labor progress

While low-risk women will need very little intervention, women with certain medical conditions may need procedures, such as continuous monitoring or induction of labor, to improve safety and ensure a healthy delivery. Your provider can tell you about the benefits, risks and alternatives of the decisions you may face during labor and birth. This is an opportunity to share your values and preferences and make informed decisions together, based on your specific needs. This form should go with you to the hospital to be shared with your care team and reviewed as labor progresses.

Environment:

Which options will make you most comfortable?

- [ ] I would like to limit the number of guests in my room while I am in labor by having a sign posted on the door to my labor and delivery room
- [ ] I would like to have the lights dimmed during labor
- [ ] I plan to bring in music from home (my own MP3 player, CD player, etc.)
- [ ] I plan to bring in essential oils/aromatherapy (no flames, please).
- [ ] I plan to bring in a "focal point" from home

Preferences for Food and Fluids

- [ ] I prefer to keep myself hydrated by drinking fluids. I would like to avoid intravenous fluids unless it is medically necessary
- [ ] I do not mind receiving intravenous hydration during labor
- [ ] If it is safe for me to do so, I would like to eat lightly during labor

Labor Preferences

- [ ] If safe to do so, I prefer to labor at home during the early phase of labor, and be admitted to the hospital when I am in active labor
- [ ] I would like to have freedom of movement while I am in labor (walking, standing, sitting, kneeling, using the birth ball, etc.), if safe and possible
- [ ] I prefer to move around or change positions to improve my labor progress before trying Pitocin to increase my labor progress
- [ ] If labor is progressing normally, I prefer to be patient and let it

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Readiness

Sharing in decision making

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RECOGNITION AND PREVENTION

Key Strategies for Supporting Intended Vaginal Birth

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Strategies

- Implement institutional policies which support vaginal birth
- Early labor management and supportive care
- Labor support personnel (e.g. doulas)
- Infrastructure/equipment
- Best practices for regional anesthesia
- Protocols for intermittent auscultation
- Protocols for modifiable conditions like HSV and breech position

Recognition

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Examples

Recognition

- Model policies for intermittent monitoring, freedom of movement, early labor support, etc.
- Coping with labor algorithm
- Guidelines for working with doulas
- Patient education and decision guides

In fact, there are over 27 Tools in this section alone

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Pre-cesarean Checklist for Labor Dystocia or Failed Induction

Patient Name: ___ MR#: ___

Gestational Age: ___ Date of C-section: ___

Time: ___; Initial: ___

Obstetrician: ___; Initial: ___

Bedside Nurse: ___

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

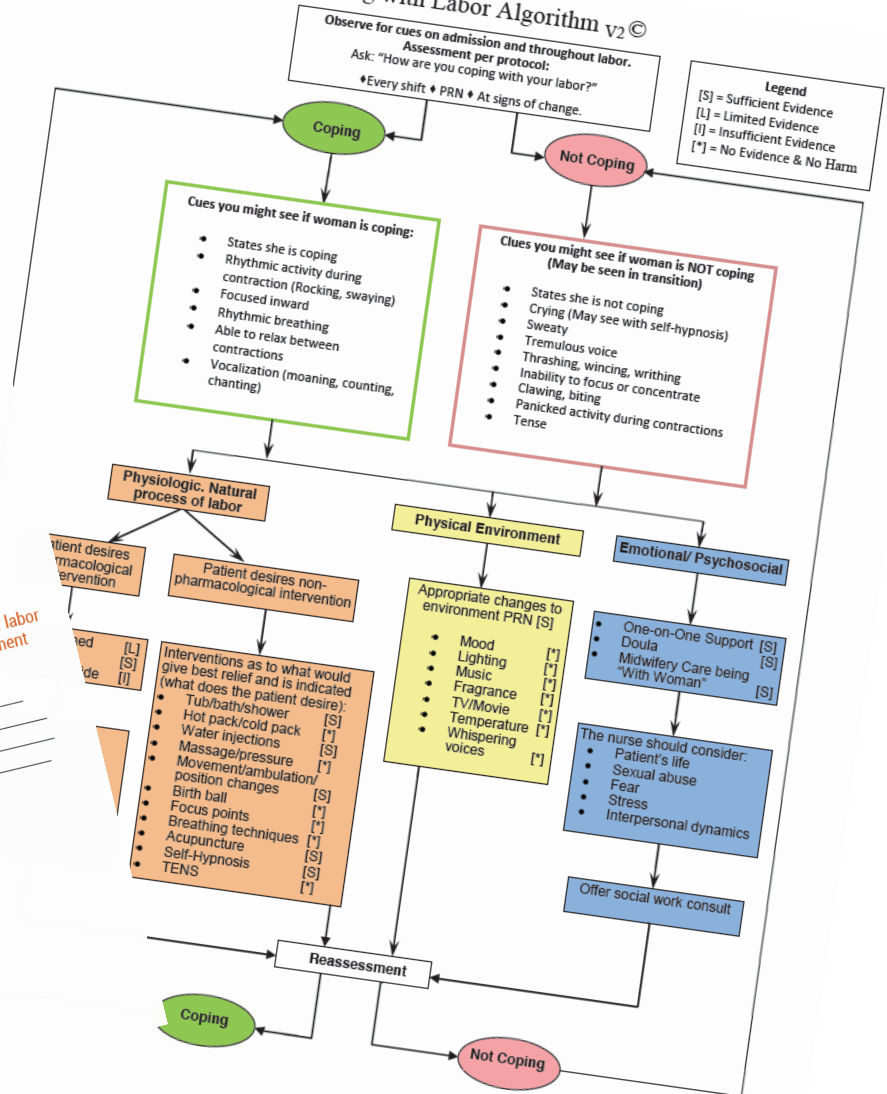
___ Failed Induction: Duration in hours: ___

___ Latent-Phase Arrest: Duration in hours: ___

Active-Phase Arrest: Duration in hours: ___

Second-Stage Arrest: Duration in hours: ___

Comments:



Transforming Maternity Care

A Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

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Promoting mobility in labor/birth

Recognition

- For both patients with and without regional anesthesia/analgesia
- Know your labor beds and what they can do
- Use of birthing balls and peanut balls
- Posters in labor rooms of labor positions
- Use of telemetry EFM

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Peanut Ball

Recognition

- Decrease length of labor
- Decreasing CS rate in patients with epidurals

Tussey, C. M., Botsios, E., Gerkin, R. D., Kelly, L. A., Gamez, J., & Mensik, J. (2015). Reducing length of labor and cesarean surgery rate using a peanut ball for women laboring with an epidural. *The Journal of Perinatal Education*, *24*(1), 16-24. http://dx.doi.org/10.1891/1058-1243.24.L16

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RESPONSE

Management of Labor Abnormalities

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Strategies

Response

- Create highly reliable teams and improve interdisciplinary communication
- Adopt standard measures for labor and FHR abnormalities
- Utilize operative vaginal deliveries in appropriate cases
- Identify malposition and perform manual rotation
- Develop alternative coverage patterns such as hospitalist/midwives

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Examples

Response

- Spontaneous labor algorithms/dystocia checklists
- Induction algorithms/checklists/policies for timing, scheduling, proper selection
- Algorithms for standard intervention for FHR changes
- Model policies for oxytocin
- Tools for effective communication

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Response

CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

1. Diagnosis of Dystocia/Arrest Disorder (all 3 should be present)

- ☐ Cervix 6 cm or greater
- ☐ Membranes ruptured, then
- ☐ No cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hours of oxytocin administration with inadequate uterine activity

2. Diagnosis of Second Stage Arrest (only one needed)

No descent or rotation for:

- ☐ At least 4 hours of pushing in nulliparous woman with epidural
- ☐ At least 3 hours of pushing in nulliparous woman without epidural
- ☐ At least 3 hours of pushing in multiparous woman with epidural
- ☐ At least 2 hour of pushing in multiparous woman without epidural

3. Diagnosis of Failed Induction (both needed)

- ☐ Bishop score ≥6 for multiparous women and ≥ 8 for nulliparous women, before the start of induction (for non-medically indicated/elective induction of labor only)
- ☐ Oxytocin administered for at least 12-18 hours after membrane rupture, without achieving cervical change and regular contractions. *Note: At least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

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Induction of Labor Algorithm

Response

INDUCTION
Per ACOG guidelines, induction of labor before 41 weeks should only be performed if there is a maternal or fetal medical indication to do so. If 39 - 41 weeks without a medical indication for induction of labor, do so only with a favorable cervix.

Unfavorable Cervix:
Bishop Score ≤ 8 for Nulliparas, ≤ 6 for Multiparas
(proceed only if medical indication for induction exists)

Favorable Cervix:
Bishop Score ≥ 8 for Nulliparas, ≥ 6 for Multiparas

Mechanical or Pharmacological Cervical Ripening

Initiate Oxytocin

Cervical Change, and Cervix ≥ 6cm

Cervical Change, but Cervix < 6 cm

No Cervical Change

No Cervical Change

If successful, follow right side of algorithm (favorable cervix)

See active labor partogram and/ or labor duration guidelines

Continue/Start Oxytocin And Consider ROM

Repeat with Different Method

No Response Consider Oxytocin Trial

Home (if appropriate) or Cesarean.
(*Note: ACOG guidelines state that failed induction in the latent phase can be avoided by allowing for longer durations of the latent phase, 24 hours or more)

AROM and No Cervical Change for 12-18 hours of Oxytocin.
(*Note: 24 hours of oxytocin is preferable if fetal and maternal statuses permit)

Cervix < 6 cm, UNABLE To AROM and No Cervical Change with 24 Hours Oxytocin

Failed Induction

Proceed to Cesarean

Consider Home if Elective and/or Medically Stable

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Active Labor Partogram

ACTIVE LABOR PARTOGRAM

Term ≥ 37 Weeks Gestation

NORMAL LABOR PROGRESS	CONSIDER INTERVENTIONS	≥ 95TH PERCENTILE MAKE DELIVERY PLAN

10 cm
9 cm
8 cm
7 cm
6 cm

0 1 2 3 4 5 6 7 8 9 10 11

Refs: Zhang J. et al. Obstet Gynecol. 2010; 116(6):1281-1287. Neal JL, Lowe NK. Med Hypothesis. 2012; 78(2):319-326. Hoppe K, et al. Am J of Obstet Gynecol. 2016; 214(1):S421.

SWEDISH

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Response

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Example Algorithm: Management of Intrapartum FHR Tracings

Appendix Q

Example Algorithm for the Management of Intrapartum Fetal Heart Rate Tracings

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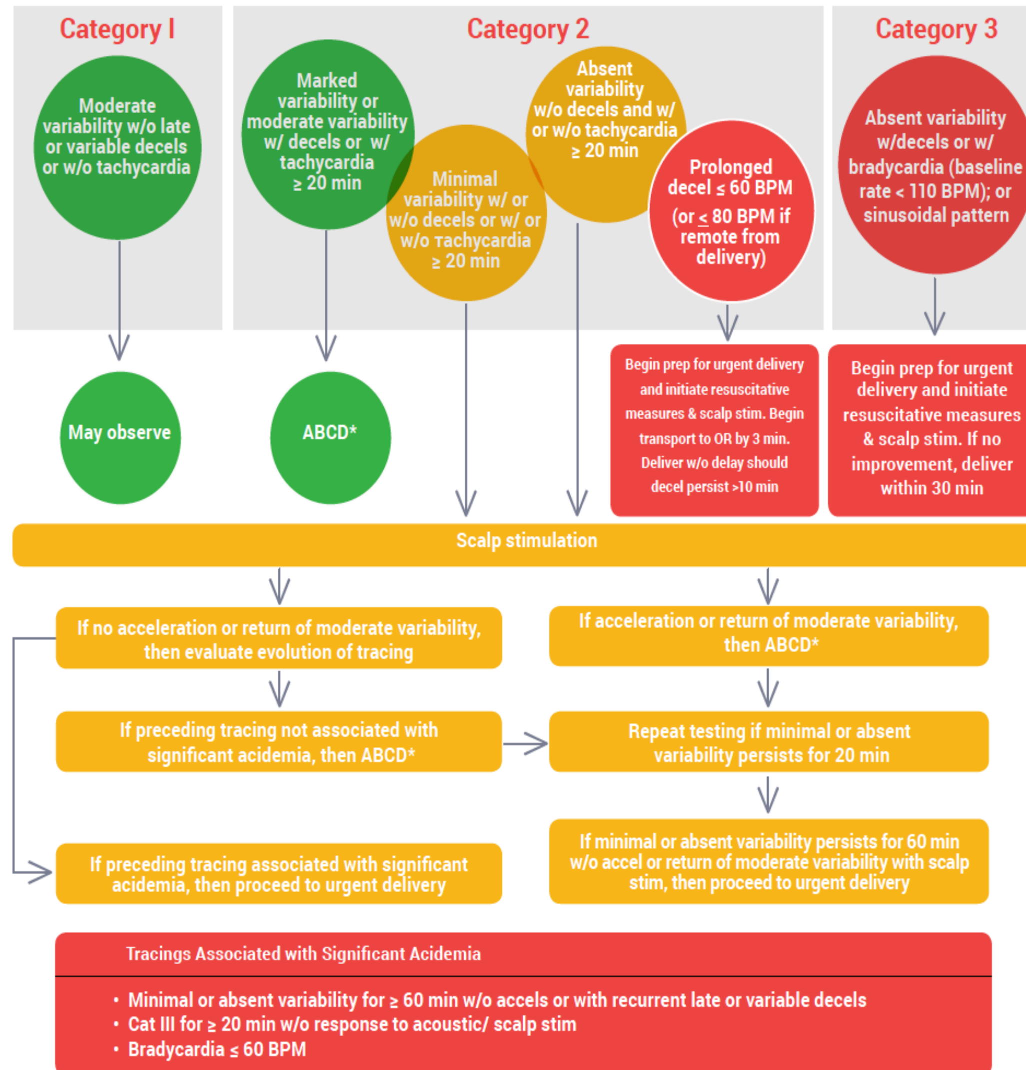

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REPORTING/SYSTEMS

Using Data to Drive Improvement

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Key Strategies for Using Data to Reduce Cesareans

Reporting

- Make data compelling to Providers
- Assist organizations to understand data associated with their hospital
- Assist providers to understand their CS rates
- Engage women, employers, and the general public in the improvement process

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Use strategies to engage women, employers and the general public in the improvement project

Reporting

- Public release of selected hospital-level measures that have been well-vetted
- Provide a lay explanation of the measures
- Widely distribute these measures through multiple media channels to capture the greatest attention

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Success Stories/Lessons Learned

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Example Hospitals With Sustained Success

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John Muir – Walnut Creek

(Non-profit Private Practice Hospital with ~2,800 annual births)

NTSV Rate 17.4%

- Turning point – embedded practices in the culture
  - Patience with length of labor
  - External Cephalic version
  - Skilled attendants in singleton vaginal breech births

- A safe oxytocin use policy
- Non-medically indicated induction elimination
- Intermittent monitoring for low-risk women
  - With telemetry
  - Delayed pushing in second stage
- Delivery in OR not necessarily cesarean
  - Be prepared, but not committed to cesarean

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Kaiser Permanente – Roseville
(Staff-Model HMO Hospital with ~5,300 annual births)

NTSV Rate
16.9%

- 24/7 staffing with OB Hospitalist
- Utilizes midwives
- Adherence to quality improvement principles
- Early adopters of Preventing the First Cesarean Delivery
- Recognition of the team contribution – nurses are key
- Data frequently shared
- Tailored messaging to different disciplines
- OB Medical Director

Challenges:

- 23% Obese/Morbidly Obese (pre-pregnant)
- 19% over 35yrs of age

Take-home Lessons from the Pilot Hospitals

- Power of provider-level data
- Key role of nurses
- Need a reason to change
- National guidelines very helpful
- Needs “constant gardening”
- Medical and Nursing leadership important

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Thank You!

Visit: CMQCC.org