Reducing First Birth (NTSV) Cesareans in California

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Regional PSF Contacts

Jenna Fischer, CPPS
Vice President of Quality & Patient Safety
Hospital Council of Northern & Central California (HCNCC)
TEL: (925) 746-5106
jfischer@hqinstitute.org

Alicia Munoz, FACHE
Vice President of Quality Improvement & Patient Safety
Hospital Association of San Diego & Imperial Counties (HASDIC)
TEL: (858) 614-1541
amunoz@hqinstitute.org

Julia Slininger, RN, BS, CPHQ
Vice President of Quality & Patient Safety
Hospital Association of Southern California (HASC)
TEL: (213) 538-0766
jslininger@hqinstitute.org
Statewide Webinars

Flyer w/registration links will be provided in a follow up email . . .
Presentation Overview

OBJECTIVES

1. Identify the critical quality improvement components of a hospital cesarean reduction program

2. Describe the essential changes in labor and delivery unit culture and the labor management strategies to reduce rates of primary cesarean

3. Understand the CMQCC hospital collaborative, what it has to offer, and how to be involved
Holly Smith, MPH, MSN, CNM
Co-Chair for the Toolkit to Support Vaginal Birth and Reduce Primary Cesarean – CMQCC
hollymsmith77@gmail.com

Kim Mikes, BSN, RN, CNOR
Executive Nursing & Operations Director of Women’s Health Institute - Hoag Memorial Hospital Presbyterian
kim.mikes@hoag.org

Kim Werkmeister, RN, BA, CPHQ
Implementation Lead, Supporting Vaginal Birth Collaborative – CMQCC
kim.mikes@hoag.org
Holly Smith, MPH, MSN, CNM
Toolkit Co-Chair, CMQCC

Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

A Quality Improvement Toolkit
California Maternal Quality Care Collaborative
Leader for Maternity QI Projects

- Statewide multi-disciplinary Taskforces that develop QI toolkits and implementation guides
- Large-scale quality collaboratives in California
- Widespread adoption by other states and national agencies

Elimination of Early Elective Delivery (2010)

Response to OB Hemorrhage (2010; 2nd Ed 2015)

Response to Preeclampsia (2013)
Maternal Mortality: California and U.S. 1999-2013


©California Department of Public Health, 2015; supported by Title V funds. Developed in partnership with California Maternal Quality Care Collaborative Cardiovascular Disease in Pregnancy and Postpartum Taskforce. Visit: [www.CMQCC.org](http://www.CMQCC.org) for details.
### Hospital Clinical Performance Measures: By Name

**32 Nationally Recognized Hospital Clinical Quality Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1 2015 Rate</th>
<th>2014 Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>3rd &amp; 4th Degree Lacerations in Instrument-Assisted Vaginal Deliveries</td>
<td>17.9%</td>
<td>11.4%</td>
</tr>
<tr>
<td>3rd &amp; 4th Degree Lacerations in NON-Instrument-Assisted Vaginal Deliveries</td>
<td>1.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>3rd &amp; 4th Degree Lacerations in Vaginal Deliveries</td>
<td>2.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>5 Minute APGAR, &lt;7 Among All Deliveries, &gt;39 weeks (HEN)</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>5 Minute APGAR, &lt;7 in Early Term Newborns (HEN)</td>
<td>0.9%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Antenatal Steroids (PC-03)</td>
<td>100.0%*</td>
<td>N/A</td>
</tr>
<tr>
<td>Appropriate DVT Prophylaxis in Women Undergoing CS</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth Trauma: Injury to Neonate (AHRQ PSI 17)</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Cesarean Birth: Low Risk-NTSV (PC-02)</td>
<td>23.5%</td>
<td>26.1%</td>
</tr>
<tr>
<td>Cesarean Birth: Low Risk-NTSV Age Adjusted</td>
<td>22.1%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Cesarean Birth: Overall</td>
<td>31.9%</td>
<td>32.5%</td>
</tr>
<tr>
<td>Cesarean Birth: Primary</td>
<td>18.8%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Cesarean Birth: Primary, Term, Singleton, Vertex (AHRQ IQI 33)</td>
<td>13.5%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Cesarean Birth: Term, Singleton, Vertex (AHRQ IQI 21)</td>
<td>28.7%</td>
<td>29.2%</td>
</tr>
<tr>
<td>Elective Delivery (PC-01)</td>
<td>0.0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Ectopic Rate</td>
<td>11.4%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Exclusive Breast Milk Feeding (PC-05)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Exclusive Breast Milk Feeding Considering Initial Feeding Plan (PC-05a)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Failed Induction</td>
<td>14.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>Hemorrhage: Blood Product Units Transfused per 1000 Delivery Cases &gt; 20 wks</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Hemorrhage: Massive Transfusions (&gt; 4 Units) per 1000 Delivery Cases &gt; 20 wks</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Hemorrhage: Risk assessment on Admission</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Induction Rate</td>
<td>14.2%</td>
<td>N/A</td>
</tr>
<tr>
<td>Newborn Bilirubin Screening Prior to Discharge</td>
<td>100.0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Operative Vaginal Delivery Rate</td>
<td>8.4%</td>
<td>N/A</td>
</tr>
<tr>
<td>Pre-eclampsia: ICU Admit Rate among pre-eclamatic delivery cases &gt; 20 wks</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pre-eclampsia: ICU Days per 100 pre-eclamptic delivery cases &gt; 20 wks</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Timely Treatment for Severe Hypertension</td>
<td>56.7%*</td>
<td>N/A</td>
</tr>
<tr>
<td>Unexpected Newborn Complications</td>
<td>3.2%</td>
<td>3.9%</td>
</tr>
<tr>
<td>VLBW (&lt;1500g) NOT delivered at a Level III NICU</td>
<td>No Cases</td>
<td>0.6%</td>
</tr>
<tr>
<td>Vaginal Birth After Cesarean (VBAC) Rate, All (AHRQ IQI 34)</td>
<td>11.9%</td>
<td>10.6%</td>
</tr>
<tr>
<td>Vaginal Birth After Cesarean (VBAC) Rate, Uncomplicated (AHRQ IQI 22)</td>
<td>11.5%</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

**Focus on:** 

*NTSV C-Section*
Utilize the **CMQCC Maternal Data Center to:**

- **Monitor hospital rates**—in real time

- **Make peer comparisons**

- **Assess provider variation**

- **Identify QI opportunities**

  *(and lots more!)*
Transforming Maternity Care

CMQCC Maternal Data Center

Data Monitoring and Evaluation

CMQCC Toolkit

Evidence-Based Support Tools

CMQCC Collaborative

Engagement of Hospital Clinicians and Administrators

Improved Maternity Care

Your Hospital!
Test Question:

You are about to give birth. Pregnancy has gone smoothly. The birth seems as if it will, too. It’s one baby, in the right position, full term, and you’ve never had a cesarean section — in other words, you’re at low risk for complications.

What’s likely to be the biggest influence on whether you will have a Cesarean?

(A) Your personal wishes.
(B) Your choice of hospital.
(C) Your baby’s weight.
(D) Your baby’s heart rate in labor.
(E) The progress of your labor.
Why Focus on Cesarean Birth for Quality Improvement?

US 2013 = 32.7%
CA 2013 = 33.1%

Source: CDC, NCHS National Vital Statistics System
Cesarean birth is the most common hospital surgery in the U.S.

*In just 10 years, Cesarean birth rates rose by 50% in both California and the United States.*

Transforming Maternity Care
Long-term & Subsequent Maternal Risks Include:

- Subsequent cesarean births
- Placenta previa and accreta (every cesarean creates a step-wise significant increased risk for life threatening hemorrhage & hysterectomy)
- Uterine rupture
- Surgical adhesions, bowel injury, bowel obstruction
**NEONATAL RISKS OF CESAREAN BIRTH**

<table>
<thead>
<tr>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher risk of respiratory morbidity (respiratory distress syndrome, transient tachypnea of the newborn, and infections)</td>
</tr>
<tr>
<td>Higher NICU admission rates</td>
</tr>
<tr>
<td>Prolonged length of stay in NICU</td>
</tr>
<tr>
<td>Increased risk of asthma requiring hospitalization and inhaler use in childhood</td>
</tr>
<tr>
<td>Difficulty with breastfeeding</td>
</tr>
</tbody>
</table>
ABSTRACT Cesarean delivery is the most commonly performed surgical procedure in the United States, and cesarean rates are increasing. Working with 2009 data from 593 US hospitals nationwide, we found that cesarean rates varied tenfold across hospitals, from 7.1 percent to 69.9 percent. Even for women with lower-risk pregnancies, in which more limited variation might be expected, cesarean rates varied fifteenfold, from 2.4 percent to 36.5 percent. Thus, vast differences in practice patterns are likely to be driving the costly overuse of cesarean delivery in many US hospitals. Because Medicaid pays for nearly half of US births, government efforts to decrease variation are warranted. We focus on four promising directions for reducing these variations, including better coordinating maternity care, collecting and measuring more data, tying Medicaid payment to quality improvement, and enhancing patient-centered decision making through public reporting.
There is a Large Variation in Cesarean Rates Among California Hospitals

Figure 6a. Large Variation of the Total Cesarean Rate Among 251 California Hospitals: 2013

Range: 15.0%-71.4%
Median: 32.5%
Mean: 32.8%

But wait, you ask, my hospital only takes care of high risk patients!!
Why does the Toolkit Focus on NTSV Cesarean Rate?

- Nulliparity is a critical risk adjuster. Creates a standardized population.
- The NTSV population is the largest contributor to the recent rise in cesarean rates.
- The NTSV population exhibits the greatest variation for all sub-populations of cesarean births for both hospitals and providers.
Importance of the First Birth

- If you have a CS in the first labor, over 90% of ALL your subsequent births will be by cesarean.

- If you have a vaginal birth in the first labor, over 90% of ALL your subsequent births will be vaginal.

A Classic Example of “Path Dependency”
After adjusting for the NTSV cesarean rate, large variation between California hospitals still exists!

Figure 6b. Extreme Variation of the NTSV Cesarean Rate Among 251 California Hospitals: 2013

- Range: 10.0%-75.8%
- Median: 27.0%
- Mean: 27.7%

- Risk Adjustment did not reduce the variation

- Large Variation = Improvement Opportunity

- 36% of CA hospitals MEET THE NATIONAL TARGET
- 64% of CA hospitals NEED TO IMPROVE
What Indications have driven the RISE in CS?

<table>
<thead>
<tr>
<th>Cesarean Indication</th>
<th>Percent of the Increase in Primary Cesarean Rate Attributable to this Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yale (2003 v. 2009) (Total: 26% to 36.5%) Focus: all primary Cesareans</td>
</tr>
<tr>
<td></td>
<td>Kaiser So. Cal. (1991 v. 2008) (Primary: 12.5% to 20%) Focus: all primary singleton Cesareans</td>
</tr>
<tr>
<td>Labor complications (CPD/FTP)</td>
<td>28%</td>
</tr>
<tr>
<td>Fetal Intolerance of Labor</td>
<td>32%</td>
</tr>
<tr>
<td>Breech/Malpresentation</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Multiple Gestation</td>
<td>16%</td>
</tr>
<tr>
<td>Various Obstetric and Medical Conditions (Placenta Abnormalities, Hypertension, Herpes, etc.)</td>
<td>6%</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>10%</td>
</tr>
<tr>
<td>“Elective” (defined variously)</td>
<td>8% (Scheduled without “medical indication”)</td>
</tr>
</tbody>
</table>
It takes a Village to Reduce Unnecessary Cesareans

Insurers/Employers

Public Advocates/Consumers

Public Policy/Medicaid

Prof Orgs (Natl and Local)

Data-driven QI Projects
Who Created the Toolkit?

Over 50 expert writers and advisors:

- Doctors
- Midwives
- Nurses
- Childbirth Educators
- Doulas
- Public Health Experts and Policy Makers
- Health Care Purchasers
- Risk Management and Health Care Safety Experts
The experts who wrote and advised for the toolkit represent organizations such as:

- American Congress of Obstetricians and Gynecologists (including current Distrixt IX Chair)
- American College of Nurse-Midwives, California Nurse-Midwives Association
- Association of Women’s Health, Obstetric, and Neonatal Nurses (including current California Chair)
- American Association of Birth Centers, California Birth Center Association
- California Hospital Association/Hospital Quality Institute (including current President/CEO of HQI)
- Childbirth Connection/National Partnership for Women and Families
- Blue Shield of California
- BETA Healthcare Group
- Kaiser Permanente, Sutter Health, MemorialCare Health System, various university health systems, various birth centers, urban and rural hospitals alike
- Doulas of North America, Lamaze International, Coalition for Improving Maternity Services
What is the Toolkit?

- Comprehensive, evidence-based “How-to Guide” to reduce primary cesarean delivery in the NTSV population.

- Will be the foundation of the QI implementation efforts

- Although the focus of the toolkit is NTSV or “first birth” cesareans, the
The Toolkit is Aligned with the ACOG/SMFM Consensus Statement and the AIM Patient Safety Bundle
SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

- Readiness (Developing a maternity culture that values, promotes, and supports intended vaginal birth)
- Recognition and Prevention (General labor support)
- Response to every labor challenge (Management of labor abnormalities)
- Reporting (Using Data to Drive Improvement)
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Name of Tool</th>
<th>CMQCC Tool</th>
<th>External Tool</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AHRQ TeamSTEPPS® (strategies and tools to enhance team performance and patient safety)</td>
<td></td>
<td><a href="http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html">http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html</a></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CMQCC - Cesarean Checklist for Labor Dystocia or Failed Induction (adapted with permission from Miller Children’s and Women's Hospital)</td>
<td>*</td>
<td>Appendix K</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CMQCC - Dystocia Checklist</td>
<td>*</td>
<td>Appendix L</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Zuckerberg San Francisco General Hospital – Guidelines for Labor Duration and Management</td>
<td>*</td>
<td>[link to be added]</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CMQCC - Labor Duration Guidelines (Adapted with permission from Zuckerberg San Francisco General Hospital)</td>
<td>*</td>
<td>Appendix M</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CMQCC - Spontaneous Labor Algorithm (adapted with permission from Washington State Hospital Association)</td>
<td>*</td>
<td>Appendix N</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CMQCC - Algorithm for Management of the Second Stage Labor (adapted with permission from Kaiser Roseville Medical Center)</td>
<td>*</td>
<td>Appendix O</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>CMQCC – Active Labor Partogram (adapted with permission from Washington State Hospital Association)</td>
<td>*</td>
<td>Appendix P</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>ACOG - Optimizing Protocols in Obstetrics: Oxytocin for Induction of Labor (includes model policies for safe use of oxytocin and the Hospital Corporation of America’s pre-oxytocin and in-use checklists)</td>
<td>*</td>
<td><a href="http://mail.ny.acog.org/website/OxytocinForInduction.pdf">http://mail.ny.acog.org/website/OxytocinForInduction.pdf</a></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Steven Clark MD - Algorithm for the Management of Category II Fetal Heart Rate Tracings</td>
<td>*</td>
<td>Appendix Q</td>
<td></td>
</tr>
<tr>
<td>Strategy#</td>
<td>Name of Tool</td>
<td>CMQCC Tool</td>
<td>External Tool</td>
<td>Location</td>
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<td>----------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Part 2 ~ Strategy 6</td>
<td>Model Policy for Fetal Surveillance - Kaiser Permanente Northern California Region (includes decision tree for type of monitoring and procedures for intermittent methods)</td>
<td></td>
<td></td>
<td>Model Policies - Appendix T</td>
</tr>
</tbody>
</table>

Transforming Maternity Care
<table>
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<td>Part 3 ~ Strategy 2</td>
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<td>⋅</td>
<td></td>
<td>Appendix P</td>
</tr>
</tbody>
</table>
Thus, the ability to improve comfort and decrease anxiety according to each patient’s distinct preference is fundamental to promoting labor progress and preventing dysfunctional labor.
Benefits of Continuous Labor Support

- Less likely to have a cesarean birth
- Slightly shorter labor
- More likely to report satisfaction with birth experience
- Less likely to need the assistance of vacuum or forceps
- Less likely to need pain medication
- Babies less likely to have low 5-minute Apgar scores
How to Improve Labor Support on the Unit:

- Improve nursing knowledge and skill in supportive care during labor
- Improve unit infrastructure and supportive tools
- Work collaboratively with doulas to provide effective and continuous labor support
<table>
<thead>
<tr>
<th>Support coping and comfort through:</th>
<th>Support progress through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing and relaxation techniques</td>
<td>Freedom of movement in labor</td>
</tr>
<tr>
<td>Touch techniques and massage</td>
<td>Upright and ambulatory positioning</td>
</tr>
<tr>
<td>Positions to promote comfort</td>
<td>Techniques and tools (such as the peanut ball) that facilitate fetal rotation, flexion, and descent for women with epidural anesthesia</td>
</tr>
<tr>
<td>Heat and cold therapy</td>
<td>Maternal exercises and positioning that facilitate fetal rotation in women with and without epidural anesthesia</td>
</tr>
<tr>
<td>Hydrotherapy (shower, tub)</td>
<td></td>
</tr>
<tr>
<td>Sterile water injections for back labor</td>
<td></td>
</tr>
<tr>
<td>Use of TENS</td>
<td></td>
</tr>
<tr>
<td>Physical Environment should allow:</td>
<td>Policies should:</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Low lighting and privacy</td>
<td>Encourage movement, standing, walking, and frequent position changes at one’s own discretion (for patients without an epidural)</td>
</tr>
<tr>
<td>Comfortable space with adequate room for movement and walking</td>
<td>Support upright positioning, frequent position changes, and tools/techniques that promote optimal fetal positioning (such as peanut balls) for women with epidurals</td>
</tr>
<tr>
<td>Adequate availability non-pharmacologic coping tools such as tubs or showers, rocking chairs, birthing balls, squat bars, and peanut balls</td>
<td>Encourage intermittent monitoring for eligible patients, or use of telemetry for patients who must be continuously monitored and desire to be mobile</td>
</tr>
<tr>
<td>Freely available snacks with high nutritional value</td>
<td></td>
</tr>
</tbody>
</table>

**KEY COMPONENTS OF A SUPPORTIVE UNIT INFRASTRUCTURE**
Toolkit Spotlight

Implement Standard Diagnostic Criteria and Standard Responses to Labor Challenges and Fetal Heart Rate Abnormalities

Nonreassuring Fetal Tracing (23%)

Labor Arrest (34%)
Toolkit Spotlight: Implement Standard Diagnostic Criteria/Responses to Labor Abnormalities (continued)

- Diagnosis of labor dystocia
- Safe use of oxytocin
- Response to abnormal heart rate patterns
- Induction of labor
ACTIVE LABOR PARTOGRAM
Term ≥ 37 Weeks Gestation

CAUTION ZONE: Consider AROM, Augmentation if not already done and no contraindications.

At 6cms or more, 4 hours without cervical change is ≥ 95th percentile. Successful vaginal delivery is less likely and maternal & neonatal complications increase.
Pre-Cesarean Checklist for Labor Dystocia or Failed Induction

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 <6 cm dilation (must fulfill one of the two criteria)

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

OR

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. > 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 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 as described above, my clinical judgment deems this cesarean delivery indicated

___ Failed Induction: Duration in hours: ____________

___ Latent-Phase Arrest: Duration in hours: ____________
Algorithm for Management of Category II Tracings
Algorithm for management of category II fetal heart rate tracings

1. Moderate variability or accelerations
   - Yes
   - No

2. Significant decelerations with ≥50% of contractions for 1 hour
   - Yes
   - No
   - Latent Phase
     - Normal labor progress
     - No
     - Yes
     - Cesarean
   - Active Phase
     - Normal progress
     - No
     - Yes
     - Observe

3. Significant decelerations with ≥50% of contractions for 30 minutes
   - Yes
   - No
   - Second Stage
     - Normal progress
     - No
     - Yes
     - Cesarean or OVD
   - Observe

4. Observe for 1 hour
   - Yes
   - No
   - Persistent pattern
     - Yes
     - No
     - Manage per algorithm

CVD, operative vaginal delivery.

*a*That have not resolved with appropriate conservative corrective measures, which may include supplemental oxygen, maternal position changes, intravenous fluid administration, correction of hypotension, reduction or discontinuation of uterine stimulation, administration of uterine relaxant, amniinfusion, and/or changes in second stage breathing and pushing techniques.

Model Policies for Induction of Labor, Induction of Labor Scheduling, and Safe Use of Oxytocin

Category: Patient Care Services

Owner: Labor and Delivery OR Manager

Title: Cesarean Delivery / Induction of Labor Scheduling

PURPOSE: To eliminate non-medically indicated (elective) deliveries prior to 39 weeks of gestation.

To be completed by Chief of Maternal Fetal Medicine or OB Hospitalist

Procedure Scheduling Determination:
☐ Schedule: Medically indicated and necessitates delivery < 39 weeks gestation
☐ Schedule: Gestation age ≥ 39 weeks on scheduled date

Completed by: ___________________________ Date/Time: ___________________________

[Chief of Maternal Fetal Medicine/OB Hospitalist]
3 Pilot QI Projects Informed the Development of the Toolkit

- Hoag Hospital, Newport Beach CA
- Miller Children’s and Women’s Hospital, Long Beach CA
- Saddleback Memorial Medical Center, Laguna Hills CA
Data Measurement Support

Quality Improvement Support

Payment Reform

Transforming Maternity Care
Astonishing Results

HOSPITAL 1
- Baseline: 32.6%
- After QI: 24.7%
- Reduction: 24.2%

HOSPITAL 2
- Baseline: 31.2%
- After QI: 24.3%
- Reduction: 22.1%

HOSPITAL 3
- Baseline: 27.2%
- After QI: 21.9%
- Reduction: 19.5%
CMQCC Data-Driven QI: NTSV CS

Pilot Hospital: PBGH / RWJ CS Collaborative

National Target for NTSV CS = 23.9%

QI Project Started: Jan 2014

<table>
<thead>
<tr>
<th>Year/Month</th>
<th>NTSV CS Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>32.9%</td>
</tr>
<tr>
<td>2012</td>
<td>33.6%</td>
</tr>
<tr>
<td>2013</td>
<td>31.2%</td>
</tr>
<tr>
<td>Jan-14</td>
<td>31.8%</td>
</tr>
<tr>
<td>Feb-14</td>
<td>28.3%</td>
</tr>
<tr>
<td>Mar-14</td>
<td>24.3%</td>
</tr>
<tr>
<td>Apr-14</td>
<td>25.0%</td>
</tr>
<tr>
<td>May-14</td>
<td>23.4%</td>
</tr>
</tbody>
</table>
Any Downsides? – Balancing Measures

- More vaginal births—Any increase in 3rd or 4th degree lacerations?
  - Zero change from the prior 4 year baseline

- Most important outcome is a healthy baby
  - NQF measure “Unexpected Newborn Complications”
    - Asks whether term babies without preexisting conditions had any major complications during birth or neonatal period
  - No change in the 3 hospitals’ rates
Kim Mikes, BSN, RN, CNOR
Executive Nursing and Operations Director, Hoag Women’s Health Institute

The Experience at Hoag Hospital: What Worked?

Transforming Maternity Care
What is the Collaborative?

Leaders from:

California ACOG, California AWHONN, California ACNM, Childbirth Connection, California Hospital Quality Institute, Pacific Business Group on Health, the California HealthCare Foundation, and others

In respect for the women of California, all working together with birthing hospitals to:

Improve NTSV cesarean delivery rates through the use of the Supporting Vaginal Birth and Reducing Primary Cesareans Toolkit.
Together, Working Towards

A **Consistent** effort to implement bundle elements:

- **Readiness** – Developing a maternity culture that values, promotes and supports intended vaginal birth
- **Recognition and prevention** – General labor support
- **Response to every labor challenge** – Management of labor abnormalities
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Transforming Maternity Care
Why Should My Hospital Be Involved?

- With the release of current data and newly-released strategies for improvement in the Toolkit, reducing NTSV cesarean deliveries is a national patient safety focus for patients, providers, accreditation agencies and payer groups.

- 60% of California birthing hospitals are not meeting the goal yet.
What is Different about this Collaborative?

- In addition to the use of all of the features of the CMQCC Maternal Data Center:
  - Mentor support from experts for implementation of bundle elements in smaller groups
  - Access to national and local experts through grand rounds, in-person and virtual education and mentor/team monthly calls
Supporting Vaginal Birth Collaborative Mentor Model

Transforming Maternity Care
Features of the Mentor Model

- Monthly web based meetings facilitated by mentor physician and nurse
- Opportunity for focused attention to your team
- On-site assistance for grand rounds or other in-depth help

CMQCC Support
What is the Cost to Participate?

- **NO COST** to join collaborative

- Hospitals will provide the internal resources necessary for success during the Collaborative by identifying:
  - Clinician and Nursing champions
  - Time for the Perinatal Quality Improvement team to work on implementation, education and data analysis
Hospital Involvement Means:

- Sharing and collaboration with others through participation in monthly mentor web-based team calls, as well as in-person and virtual learning sessions.

- A commitment to de-identified data sharing of measures already being collected by the hospital through Active Track status in the CMQCC Maternal Data Center.
Collaborative Timelines

- Each hospital can expect to spend one year implementing changes and making improvements during their participation in the Supporting Vaginal Birth and Reducing Cesareans Collaborative.

- The first group of Collaborative hospitals will begin mostly in Southern California in May 2016, with the next statewide group beginning a few months later.
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- Peer to peer learning, networking and sharing of best practices are THE BEST WAY to improve further, faster
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- Ability to rapidly spread innovations that work
- Identify practical advice from peers sharing the same challenges on how to implement best practices
- Ability to integrate reliability and sustainability
Supporting Vaginal Birth Collaborative

What is the first step?
Gather your Perinatal Quality Improvement Team

- Primary Physician champion
- Nursing – CNS, Manager, Bedside RN
- Administration Quality Team Risk Mgr

Transforming Maternity Care
Complete a QI Readiness Assessment

Are you ready?
Take Action

- Sign your team up for the Supporting Vaginal Birth Collaborative
- More information available at www.cmqcc.org

To join the Collaborative or for any questions contact:

Kim Werkmeister at kwerkmeister@cmqcc.org
or
Julie Vasher at jvasher@cmqcc.org

Transforming Maternity Care
Our Approach

Standardize Scheduled Delivery Process

Education
Patients, Physicians, Staff

Data Transparency
California Maternal Quality Care Collaborative (CMQCC)
Standardize Scheduled Delivery Process

Cesarean Section Scheduling
- Documented Indication & EGA
- Patient Education Regarding Risks

Induction Scheduling
- Documented Indication & EGA
- Bishop Score
- Patient Education Regarding Risks
CESAREAN DELIVERY SCHEDULING REQUEST/ORDERS
HOAG MEMORIAL HOSPITAL PRESBYTERIAN

LDR Scheduling: (949) 764-8484 LDR Scheduling Fax: (949) 764-5735 Fetal Diagnostics Pre Op: (949) 764-8034

☐ Check if this is an update to a currently scheduled case
☐ Elective  ☐ Non-Elective  Date Submitted:

Requested Procedure Date:  Requested Procedure Start Time:

Surgeon:  Assistant Surgeon:  Pediatrician:

Pediatrician:  Alternate time availabilities (Surgeon):

Dating: EDC (month/day/year):  Gestational age at desired date of CD: weeks days

Type of Anesthesia:  ☐ Regional  ☐ General

Pre-Op Diagnosis:  Latex Allergy:  ☐ Yes  ☐ No

☐ Fetal Diagnostics Pre Op appointment (optional) Date/Time:

PATIENT INFORMATION:

Patient Name:  DOB:

Home #:  Work #:

Cell #:  Other #:

Office contact:  Phone #:  Fax #:

ORDERS:

LABORATORY TEST: ALL TESTS REQUIRE CLINICAL INDICATION/MEDICAL NECESSITY
☐ CBC  ☐ MRSA Nasal Swab (unless prior history of positive result)
☐ Other:

BLOOD BANK ORDERS (if required):

Testing must be done at Hoag laboratory no more than 14 days prior to surgery.
☐ Type and Screen (includes blood type and antibody screen)
If antibody screen is positive, Type and Cross 2 units to be available at surgery

Consent to Read (no abbreviations allowed):
☐ Primary Cesarean Delivery  ☐ Bilateral Tubal Ligation (ensure copy of State Sterilization form on chart)
☐ Repeat Cesarean Delivery

☐  ☐  ☐  ☐

A.M./P.M.  [Physician Signature – Required]  ID#  

[Date]  [Time]  

To Be Completed By Hoag Hospital LDR Scheduling

Confirmation Code:  OR Date:  OR Time:

FAX FORM TO LDR (949) 764-5735
Hoag Cesarean Delivery Scheduling Process

1. Patient will be educated utilizing the "Understanding the Risks" form by their OB physician in the office.
2. OB Physician to obtain their pre-authorization (if applicable).
3. OB Physician will complete Hoag Cesarean Delivery Scheduling Request/Order (PS 7598).
4. OB Physician office to fax form to Hoag LDR Scheduling; Hoag LDR Scheduling and Physician office will talk on phone to confirm tentatively scheduled date & time; Case entered into SIS.
5. Hoag Physician Leader (Chief of MCH or Laborist) will review Scheduling Request Form within 24 hours.
   N -> Hoag Physician Leader to contact physician directly for additional discussion/information.
7. Case Proceeds as Scheduled; Hoag will track Elective non-Medically Indicated Cesarean Deliveries.
8. Case Medically-Indicated?
   NO -> Case proceeds as scheduled.
   YES -> Hoag Physician Leader will work with LDR Scheduling to have the case removed from the schedule (SIS).
9. LDR Scheduling will contact physician office to let them know cesarean delivery has been removed from schedule.
Hoag Cesarean Delivery Scheduling Process

- Patient will be educated utilizing the “understanding the risks” form by their OB Physician in the office
- OB Physician will obtain pre-authorization (as applicable)
- OB Physician will complete Hoag Cesarean Delivery Scheduling Request/Order (Form # PS7598)
- OB Physician Office will fax the Hoag Scheduling Request/Order to LDR Scheduling (949) 764-5735
- OB Physician Office to call Hoag LDR Scheduling (949) 764-8484 to discuss tentative cesarean delivery date and time
- Case will be entered into SIS (Surgical Information System) by Hoag LDR Scheduling
- Within 24 hours, a Hoag Physician Leader (Chief of Maternal Child Health, Laborist, Department Head, etc.) will review the Scheduling Request/Order form
- If the Hoag Physician Leader approves, the case will proceed as scheduled. No further action taken.
  - If the Hoag Physician Leader feels additional discussion/information is needed, he/she will call the OB to discuss whether the case is medically indicated.
    - If after further discussion, both parties agree that the case is medically indicated, the case will proceed as scheduled. No further action required.
- If the case is not medically indicated and the OB decides to cancel the cesarean delivery, the Hoag Physician Leader will ensure that the case gets removed from the Surgery Schedule (SIS).
  - LDR Scheduling will call the OB Physician’s office to let them know that the case has been removed from the schedule.
- If the case is not medically indicated but the OB Physician wants to proceed with the case, it will continue as scheduled. Hoag MCH administration will track/log all Elective, non-medically indicated, cesarean deliveries.
Understanding the Risks of Elective Cesarean Delivery With Your First Pregnancy

Birth is a normal, natural process. The vast majority of women can have safe, normal vaginal births. There are health conditions where a cesarean birth is necessary for the wellbeing of the mother and/or her baby. Recently however, more mothers are giving birth by cesarean section for non-medical reasons. A cesarean poses risks as well as benefits for mother and baby, and should not be undertaken lightly. This educational material is provided by Hoag (modified from original document provided by the Coalition for Improving Maternity Services [CIMS]) to help all expectant parents become better informed about the risks of cesarean delivery.

Expectant Mother's Name: __________________________
Obstetrician (OB Physician): _______________________

A cesarean delivery is an operation where a baby is delivered by making a cut in the mother's lower abdominal wall (abdominal incision) and a cut in her uterus (uterine incision). A cesarean operation is a major surgical procedure with additional risks beyond those of a vaginal delivery.

Risks Associated With a Cesarean As Compared to a Vaginal Birth:
1. I am more likely to have more blood loss and a longer recovery time.
2. I am more likely to have accidental surgical cuts to my bladder, bowel, or gastrointestinal tract.
3. I am more likely to have a serious infection in my incision, uterus, or bladder.
4. I am more likely to have thick scarring (adhesions) inside my abdomen that may cause chronic pain for years after my cesarean. This scarring can make any future abdominal operation I may need more difficult.
5. I may have uncontrolled bleeding and need an emergency hysterectomy (removal of the uterus) if the bleeding cannot be stopped.
6. I am more likely to have complications from anesthesia.
7. I am more likely to develop blood clots that can travel to my lungs (pulmonary embolism) or my brain (stroke).
8. I am more likely to be admitted to intensive care.
9. I am more likely to need to return to the hospital for complications from the cesarean operation.
10. I am more likely to feel pain and/or numbness at the surgical site for several months after my surgery.
11. I am more likely to have a repeat cesarean delivery if I choose to undergo a cesarean for my first delivery.
12. I am more likely to experience "high risk" conditions in subsequent pregnancies, such as ectopic pregnancy, infertility, and abnormal attachments of the placenta to the uterine wall.

I have read and understand the risks associated with a cesarean delivery vs. a vaginal delivery.

PATIENT SIGNATURE ____________________________
PATIENT NAME ________________________________
DATE ________________________
**INDUCTION OF LABOR SCHEDULING REQUEST**

Please complete this form and FAX to Labor and Delivery at (949)764-5735
The Prenatal Record MUST be on file in Labor and Delivery or Faxed with this completed form.

Requesting Physician: ___________________________ Pediatrician: ___________________________
Office Contact: ___________________________ Phone: ___________________________ Fax: ___________________________
Patient Name: ___________________________ Date of Birth: ___________________________
Induction Date Requested: ___________________________ Time Requested: ___________________________
EDD: ___________________________ Gravida: ___________________________ Para: ___________________________ Gestational age on date of procedure: ___________________________

Indication for Induction:
- Maternal request
- History of rapid labor
- Term with favorable cervix
- ≥ 41 weeks gestation/post term pregnancy
- Gestational diabetes
- Other indications: ___________________________

Bishop Score

<table>
<thead>
<tr>
<th>Dilation (cm)</th>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
<th>≥ 5</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effacement (%)</td>
<td>0-30</td>
<td>40-50</td>
<td>60-70</td>
<td>≥ 80</td>
<td></td>
</tr>
<tr>
<td>Station (cm)</td>
<td>-3</td>
<td>-2</td>
<td>-1</td>
<td>≥ 0</td>
<td></td>
</tr>
<tr>
<td>Cervical Consistency</td>
<td>Firm</td>
<td>Medium</td>
<td>Soft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical Position</td>
<td>Posterior</td>
<td>Midline</td>
<td>Anterior</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A Bishop Score ≥ 6 is recommended in elective induction of multiparous patients.

Induction Order in CPOE (Sign & Hold)  □ Yes  □ No, will fax/send with patient

Special instructions: __________________________________________________________

Physician Signature: ___________________________ Date/Time: ___________________________

To be completed by Chief of Maternal Fetal Medicine or OB Hospitalist

Procedure Scheduling Determination:
- Schedule: Medically indicated and necessitates delivery < 39 weeks gestation
- Schedule: Gestation age ≥ 39 weeks on scheduled date

Completed by: ___________________________ Date/Time: ___________________________

**INDUCTION OF LABOR SCHEDULING REQUEST**

PS 0029  Rev 02/22/13
Hoag Induction Scheduling Process

- Patient will be educated utilizing the “Induction Education” form by their OB Physician in the office

- OB Physician will complete Induction of Labor Scheduling Request (Form PS 5529)

- OB Physician Office will fax the Hoag Scheduling Request to LDR Scheduling (949) 764-5735, no earlier than 9:00 am, 1 week prior to the requested induction date. Requests received more than 1 week prior to induction date will be discarded; requests received prior to 9:00 am will not receive priority.
  - For elective inductions, the office must also fax a completed/signed “Induction Education” sheet in order for the case to be scheduled.

- OB Physician Office can follow their fax with a call to Hoag LDR Scheduling (949) 764-8484 for confirmation of availability of requested date/time.

- Induction will be entered into SIS (Surgical Information System) by Hoag LDR Scheduling

- Within 24 hours, a Hoag Physician Leader (Chief of Maternal Child Health, Laborist, Department Head, etc.) will review the Scheduling Request form for completion and appropriate gestational age.

- If the Hoag Physician Leader feels additional discussion/information is needed, he/she will call the OB.

- Please ensure that your patients understand that the requested date and time is not a guarantee. Accommodation of this request is dependent upon capacity, patient acuity and staffing.

Rev. Nov 2012
Induction Education for Patients

Induction of labor is the use of medication or other interventions to get labor started. There are a number of medical reasons for which labor induction is indicated. An elective induction is done when a patient and her clinician decide to induce for non-medical reasons. In a first delivery, elective induction is not scheduled before 41 weeks of pregnancy. For women who have already delivered a baby, elective induction is not performed prior to 39 completed weeks of pregnancy. The most common ways of starting contractions are by breaking your bag of water and use of medications.

There are a number of physical and social reasons that a patient and her clinician may choose elective induction. Patients should have a clear understanding of the pros and cons of inducing labor before considering labor induction.

**INDUCTION OF LABOR MAY:**
- Increase the duration of labor and hospital stay
- Increase the need for pain medication and/or epidural
- Decrease the patient’s ability to move about the labor room
- Increase the chance of cesarean delivery

For more information about induction please go to:

*Please understand that your scheduled time is a request*. You may not be able to come in on the day and time that you are scheduled if we have high patient volume and room is not available.

Call Labor and Delivery at 949/764-5789 before coming to the hospital to determine availability for induction. If there is no availability at that time, the charge nurse will provide you follow up instructions. You will be contacted by our Labor and Delivery staff regarding your delivery plans.

Continue your normal routine while waiting to be admitted to the hospital, to include eating and drinking as usual.

*I have read and understand the above information and have had the opportunity to ask questions.*

PATIENT SIGNATURE  PATIENT NAME  DATE
Education

Patients
- Prenatal Classes
- Educational Pieces
- Waiting for Baby Video on Website

Physicians
- Department Meetings/Physician Leaders
- Process Flow Charts – Education of Office Managers

Nursing Staff
- Staff Meetings
- Goal Alignment
- Research Project – “Move it Mama”
OB Transparency

CMQCC Data
CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE

Started with Blinded Data
NTSV C/S Rate by Provider

Cesareans among live births that are: 1) singleton; 2) vertex; 3) lacking "early onset delivery" ICD-9 code; 4) >=37 weeks GA; 5) to nulliparous women, CMQCC Data (March 2013 – February 2014)

Sum of NTSV C/S  Hoag Rate (31.10%)  CA Rate (27.60%)
Where Are We Now?

Full Data Transparency

Un-blinded Physician-specific data at Every OB/GYN Department Meeting

Continuous Process Improvement

Uptick in NTSV Rates

Renewed Efforts
Quality Improvement Collaborative to Support Vaginal Birth and Reduce Primary Cesareans

Kim Werkmeister, RN, CPHQ
Co-Lead, CMQCC Quality Improvement Collaborative
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Supporting Vaginal Birth Collaborative

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Transforming Maternity Care
Gather your Perinatal Quality Improvement Team

Primary Physician champion

Nursing – CNS, Manager, Bedside RN

Administration Quality Team Risk Mgr

Improved Maternity Care

Transforming Maternity Care
Take Action

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To join the Collaborative or for any questions contact:
Kim Werkmeister at kwerkmeister@cmqcc.org
or
Julie Vasher at jvasher@cmqcc.org

Transforming Maternity Care
Please raise your ‘hand’ icon and we will open up your line.

Be sure you have entered your pin #

-OR-

Type your question into the question pane and we will read it aloud.