Safety Action Series

Fostering Labor Support and Culture Change to Promote Vaginal Births

Thursday, May 12
2:00 p.m. Eastern
Dial In: 888.863.0985
Conference ID: 72813058
Speakers

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Lead Certified Nurse-Midwife, Lovelace Health System, New Mexico
Disclosures

- Abraham Lichtmacher, MD has no real or perceived conflicts of interest to disclose.

- Lowry Simpson, CNM has no real or perceived conflicts of interest to disclose.
Objectives

- Outline the importance of building a culture that supports and values women and their families throughout the labor process.
- Explore the characteristics of maternity care teams that successfully support and engage women and their families during labor.
- Describe provider education and training practices that enhance knowledge and improve skills on approaches to promote spontaneous onset and progress of labor and vaginal birth.
- Provide tips on how your institution can foster a unit culture that maximizes the likelihood of vaginal birth.
Why is vaginal birth better?

Financial Reasons

Patient Outcomes

When can I start exercising after pregnancy?

If you had a healthy pregnancy and a normal vaginal delivery, you should be able to start exercising again soon after the baby is born. Usually, it is safe to begin exercising a few days after giving birth—or as soon as you feel ready. If you had a cesarean delivery or other complications, ask your healthcare provider when it is safe to begin exercising again.

ACOG FAQ 131

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**TRUVEN HEALTH ANALYTICS MARKETSCAN® STUDY**

Childbirth Connection  
Catalyst for Payment Reform  
Center for Healthcare Quality and Payment Reform

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<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Vaginal Childbirth</th>
<th>Cesarean Childbirth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Charges</td>
<td>$24,921</td>
<td>$22,734</td>
<td>$32,062</td>
</tr>
<tr>
<td>Allowed Paid Amount</td>
<td>$13,494</td>
<td>$12,520</td>
<td>$16,673</td>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Charges</td>
<td>$24,227</td>
<td>$21,247</td>
<td>$31,259</td>
</tr>
<tr>
<td>Allowed Paid Amount</td>
<td>$6,673</td>
<td>$6,117</td>
<td>$7,983</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th></th>
<th>In two months after birth Base: all initial LTM III mothers</th>
<th>In two weeks prior to follow-up survey Base: all follow-up LTM III mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vaginal n=1556</td>
<td>Cesarean n=744</td>
</tr>
<tr>
<td>Extremely</td>
<td>3%</td>
<td>10%</td>
</tr>
<tr>
<td>Quite a bit</td>
<td>6%</td>
<td>16%</td>
</tr>
<tr>
<td>Moderately</td>
<td>21%</td>
<td>25%</td>
</tr>
<tr>
<td>A little bit</td>
<td>43%</td>
<td>36%</td>
</tr>
<tr>
<td>Not at all</td>
<td>27%</td>
<td>14%</td>
</tr>
</tbody>
</table>

p < .01 for differences in both time periods, by mode of birth
Why is vaginal birth better?

Longer Term Complications

Does an increased cesarean section rate improve neonatal outcome in term pregnancies?

- CONCLUSIONS:
  - Increasing cesarean section rate from a low to a moderate does not improve the short-term neonatal outcome in term singleton pregnancies. On the contrary, neonatal intensive care unit admissions increased with increasing caesarean section rate. Furthermore it is possible to achieve good neonatal outcome with a low cesarean section rate.


Arch Gynecol Obstet, 2015 Nov 16
What are the current regional or hospital experiences

We found wide variation even among hospitals in the same community. For example, 30 percent of low-risk deliveries at the University of Chicago Medical Center were by C-section, while at Northwestern Memorial Hospital, another teaching hospital just 10 miles away, only 17 percent were.
What are the current individual practice experiences?

– Time pressures
– Financial pressure
– Clinical skills
– Reduce liability risk
– Meeting patient needs
What are the patient needs?

- Patients are asking for elective delivery

reason for it. If you were pregnant in the future, had no medical reasons for a cesarean, and could decide for yourself, how likely would you be to want to have your next baby by cesarean section?

<table>
<thead>
<tr>
<th>Baseline: all follow-up LTM III mothers $n=1072$</th>
<th>Not likely at all</th>
<th>Not very likely</th>
<th>Somewhat likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mothers</td>
<td>53%</td>
<td>18%</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Most recent mode of birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal (not VBAC)</td>
<td>61%</td>
<td>19%</td>
<td>12%</td>
<td>8%</td>
</tr>
<tr>
<td>Repeat cesarean</td>
<td>42%</td>
<td>12%</td>
<td>15%</td>
<td>31%</td>
</tr>
<tr>
<td>Primary cesarean</td>
<td>37%</td>
<td>19%</td>
<td>24%</td>
<td>21%</td>
</tr>
<tr>
<td>Vaginal birth after cesarean (VBAC)</td>
<td>33%</td>
<td>36%</td>
<td>9%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Note: few respondents had vaginal birth after cesarean (VBAC)

- How are expectations set?

What are the patient perceptions?

- Want what is safer for baby
- Poor understanding of risk

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Not sure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newer maternity tests and treatments are generally improvements over older ones</td>
<td>29%</td>
<td>45%</td>
<td>15%</td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>Women can be confident that care recommendations from maternity care providers are based on up-to-date medical evidence about what works best</td>
<td>28%</td>
<td>54%</td>
<td>8%</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>In general, getting more maternity tests and treatments is better quality care than getting fewer tests and treatments</td>
<td>23%</td>
<td>40%</td>
<td>15%</td>
<td>18%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Interventions and their outcomes

Cascade of intervention in first-time mothers with term births who experienced labor

Base: first-time mothers with term births who experienced labor n=750

First-time mothers with term births (37-41 weeks’ gestation) who experienced labor

- Induction No 53%
  - Epidural No 39%
    - Cesarean Yes 5%
  - Epidural Yes 61%
    - Cesarean Yes 20%
- Induction Yes 47%
  - Epidural No 22%
    - Cesarean Yes 19%
  - Epidural Yes 78%
    - Cesarean Yes 31%

In this group, which included 85% of first-time mothers, the overall epidural rate was 69% and overall cesarean rate was 21%.

Who influences the patient perceptions/expectations?

How much do you agree or disagree with each of the following statements about your options for maternity care tests treatments, or procedures?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like my maternity care provider to tell me about the risks associated with each option so I know how each could affect me</td>
<td>36%</td>
<td>55%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>In deciding about care, I would like my maternity care provider to always discuss the option of choosing no test or treatment</td>
<td>26%</td>
<td>62%</td>
<td>9%</td>
<td>2%</td>
</tr>
<tr>
<td>I would like my maternity care provider to help me understand how much each option will cost me and my family</td>
<td>25%</td>
<td>61%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>I prefer to rely on my maternity care provider to make the best decisions for me</td>
<td>14%</td>
<td>51%</td>
<td>28%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Patient Expectation

Can be impacted from innocent comments made by:

• **Family** e.g. Your mom and all the women in the family have had C/Sections.

• **Providers** e.g. Your baby is very big.

• **Innuendos** that inadvertently sew seeds of doubt for successful birth outcomes
Patient Expectation

Can be Realized and Managed

• Prenatal Education
• Lamaze International
• Childbirth Connection
• Coalition for Improving Maternity Services
• The ACNM – The “Share With Women” series
• Penny Simkin “Birth Partner”
• Centering pregnancy
Strategies for Supporting Intended Vaginal Births

- Vaginal birth promoted as the 1st option
- Latent Phase versus Active Phase of labor
- Spontaneous onset vs Induction of labor
- Encouraging women to be active participants in their care
- Recognition of normal
- Decrease use of continuous fetal monitoring in low risk women
Philosophy of Midwifery Care

- Watchful waiting and non-intervention in normal processes
- Appropriate use of interventions and technology for current or potential health problems
- Consultation, collaboration and referral with other members of the health care team as needed to provide optimal health care
CNM Expectation

- Nutrition
- Mobility
- Empowerment of Patient: **Knowledge is Power**
  
  A patient centered maternity care culture:
  
  – Ensures cultural sensitivity, dignity and respects individual values, choices and cultural backgrounds.
  – Shared Decision making, data-driven quality improvement initiatives
Physician Experience

• My C/S rate is the same as everyone else in the hospital
• I know what ACOG (other professional organizations) recommend
  – But they don’t practice here, we are different here
  – Patient risks, distance from the hospital, high liability
• My patients are: “high risk”, “want a C/S”
  – “I do what they want”
• There is no down-side to higher C/S rates
What drives C/S?
(the opposite supports vaginal birth)

- Time pressures
- Financial incentives

COMMITTEE OPINION
Number 657 • February 2016

Committee on Patient Safety and Quality Improvement
Committee on Obstetric Practice

The Society for Maternal-Fetal Medicine and the Society of OB/GYN Hospitalists endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Patient Safety and Quality Improvement and the Committee on Obstetric Practice. Member contributors included Jeffrey Ecker, MD and John Keats, MD. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

The Obstetric and Gynecologic Hospitalist
What drives C/S?
(the opposite supports vaginal birth)

• There is no consequence for a high C/S rate
  – Professional standing, reputation, financial
  – Regulatory, payor
What drives C/S?
(the opposite supports vaginal birth)

- Lack of clinical training
  - Response to FHT, labor dystocia, malpresentation
Support in Labor

- Compared with women who had no continuous support, women with companions (such as a doula) who were neither on the hospital staff nor in the woman's social network were:
  - 28% less likely to have a cesarean section
  - 31% less likely to use synthetic oxytocin to speed up labor
  - 9% less likely to use any pain medication
  - 34% less likely to rate their childbirth experience negatively.

Support in Labor

“With appropriate Support and protection from external interference, childbearing women and their fetuses/newborns experience innate mutually regulating hormonally driven processes that have developed during human evolution. These processes facilitate the period from onset of labor through birth of the baby and placenta........”

Milbank: The Evidence Based Maternity Care Report. 2008 Buckley 2004; Winburg 2005; Childbirth Connection a program of the National Partnership for Women and Family
Support in Labor

- Studies of physiologic labor indicate that when fear and anxiety are reduced, normal hormonal processes (e.g. natural oxytocin release are protected. When this happens, beta-endorphin levels increase natural pain relief and reduce overall stress).

*CMQCC Toolkit to support Vaginal Birth and Reduce Primary C/Sections; 2016*
Birth

• Spontaneous Vaginal Birth
  – Resist unnecessary intervention
  – Effective communication
  – Coaching and encouragement

• Pushing in Labor: Performance not Endurance
  – Delayed Pushing, Passive Descent
  – Maternal exhaustion, fetal acidosis

• Positioning
  – Effects on expulsion efforts
  – Effects on internal rotation of presenting part
So how do we change?

- Change the expectations
  - Set expectations early (antepartum)
  - Reinforce expectations
  - Patient education

- Standardize care
  - Policies on IOL, TOLAC, oxytocin use

- Collaborative Team approach to patient care

- Monitor compliance with policies
Culture Change

• Change the incentives
• Change the expectations
• Change policies to force behavior
• Change must be desired
• Leadership
Leadership

• Do we have leaders?
• 42% of hospitals surveyed lack effective leadership.*
• Must be developed

Q&A Session
Press *1 to ask a question

You will enter the question queue
Your line will be unmuted by the operator for your turn

A recording of this presentation will be made available on our website:
www.safehealthcareforeverywoman.org
Next Safety Action Series

Successfully Implementing Quality Improvement Projects: Presentation of Resource Toolkit

Wednesday, June 1, 2016
11:00 am Eastern

Barbara O’Brien, MS, RN
Program Director, Office of Perinatal Quality Improvement, The University of Oklahoma Health Sciences Center

Sue Gullo, MS, BSN
Managing Director, Institute for Healthcare Improvement

Click Here to Register