Due to the high number of registrants for this session we ask that you please dial in 15 minutes prior to session start time to ensure a quick and efficient entry process.
Speakers

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Disclosures

- David Lagrew, MD, FACOG has no real or perceived conflicts of interest to disclose.

- Lisa Kane Low, PhD, CNM, FACNM, FAAN has no real or perceived conflicts of interest to disclose.
Objectives

- Describe the magnitude of the problem.
- Take a look at the processes, methods, and tools that were used to develop the bundle.
- Provide an overview of bundle components.
- Give suggestions for how to effectively implement and utilize the bundle within your organization.
- Identify resources to customize for use within your organization.
• Up to one-third of elective deliveries occur prior to documented fetal maturity.
• 53% of the disparity in cesarean section is related to labor induction and early admission.
• Patient centered care is talked about but rarely practiced.
• Communication errors are the leading primary cause of perinatal sentinel events.
• Up to 90% of birth trauma is preventable.
• Maternal Mortality in the US has increased at an annual rate of 2.1% for the last 20 years.

Cherouny, 2011 IHI
Even after adjusting for risk, variation in low risk C-section rates among hospitals and California regions is dramatic—ranging from 13% to 80%.

* Collected from calqualitycare.org and based 2012 hospital reported data
Quality Patient Care in Labor and Delivery: A Call to Action

Introduction
Pregnancy and birth are physiologic processes, unique for each woman, that usually proceed normally. Most women have normal conception, fetal growth, labor, and birth and require minimal-to-no intervention in the process. Women and their families hold different views about childbirth based on their knowledge, experiences, belief systems, culture, and social and family backgrounds.

As representatives of professional societies whose members care for pregnant and laboring women, we agree that patient-centered and safe care of the mother and child enhance quality and is our primary priority. Optimal maternal health outcomes can best be achieved in an atmosphere of effective communication, shared decision-making, and teamwork, and data-driven quality improvement initiatives.

“Patient-centered” means that health care providers, and the system they practice within, accept that the values, culture, choices, and preferences of a woman and her family are relevant within the context of promoting optimal health outcomes. The overarching principles involved include treating all childbearing women with kindness, respect, dignity, and cultural sensitivity. Throughout their maternity care experiences, patient-centered care is enhanced when women are provided supportive resources such as education and skilled attendants. Specifically, patient-centered care requires the balance between maternal-child safety and well-being with the woman’s needs and desires.

Communication
The childbirth experience is dynamic and includes not only the woman and her family, but a host of other members of the health care team. Effective communication between the caregiver and the laboring woman and her family, as well as among the members of the care team, is critical to ensuring safety. Each team member should possess the skills necessary to promote effective communication, and should be aware of the concepts and skills involved in leadership, situational awareness, and mutual support.
Current Commentary

The National Partnership for Maternal Safety

Mary E. D’Alton, MD, Elliott K. Main, MD, M. Kathryn Menard, MD, and Barbara S. Levy, MD

Recognition of the need to reduce maternal mortality and morbidity in the United States has led to the creation of the National Partnership for Maternal Safety. This collaborative, broad-based initiative will begin with three priority bundles for the most common preventable causes of maternal death and severe morbidity: obstetric hemorrhage, severe hypertension in pregnancy, and peripartum venous thromboembolism. In addition, three unit-improvement bundles for obstetric services were identified: a structured approach for the recognition of early warning signs and symptoms, structured internal case reviews to identify systems improvement opportunities, and support tools for patients, families, and staff that experience an adverse outcome. This article details the formation of the National Partnership for Maternal Safety and introduces the initial priorities.

(Obstet Gynecol 2014;123:973–7)
DOI: 10.1097/AOG.0000000000000219

issued a Sentinel Alert entitled “Preventing Maternal Death” and proposed various initiatives to decrease maternal mortality including case reporting and review, health care provider education, team training and drills, and thromboembolism prophylaxis.

During the past 2 years, several organizations—including the American College of Obstetricians and Gynecologists (the College), the Centers for Disease Control and Prevention, the Society for Maternal–Fetal Medicine, the Health Resources and Services Administration, the Association of Women’s Health, Obstetric, and Neonatal Nurses, and the American College of Nurse-Midwives—have collaborated to identify priorities for maternal safety. Universal recognition of the need for action to reduce U.S. maternal mortality and morbidity led to the creation of the National Partnership for Maternal Safety. This report outlines a national initiative for every birthing facility.
www.safehealthcareforeverywoman.org
Collaboration to reduce maternal morbidity and mortality

- **Professional Organizations**
  - ACNM, ACOG, AWHONN, SMFM

- **Policy Organizations**
  - Association of Maternal and Child Health Programs (AMCHP)
  - Association of State and Territorial Health Officials (ASTHO)
  - California Maternal Quality Care Collaborative (CMQCC)
  - Health Resources and Services Administration Maternal and Child Health Bureau (HRSA-MCHB)
AIM Bundles

- Obstetric Hemorrhage
- Severe Hypertension in Pregnancy
- Prevention of Venous Thromboembolism in Pregnancy
- **Safe Reduction of Primary Cesarean Births**
- Protocols and Resources to Support Patients, Families, and Staff
- Postpartum Care Basics for Maternal Safety
- Reduction of Peripartum Racial Disparities
- Patient, Family, and Staff Support after a Severe Maternal Event
Fig. 3. Indications for primary cesarean delivery. (Data from Barber EL, Lundsberg LS, Belanger K, Pettker CM, Funai EF, Illuzzi JL. Indications contributing to the increasing cesarean delivery rate. Obstet Gynecol 2011;118:29–38.) →

# Members of the Workgroup

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Bundle Components

- **Readiness** - Every Patient, Provider and Facility
- **Recognition and Prevention** - Every Patient
- **Response** - To Every Labor Challenge
- **Reporting/Systems Learning** - Every Birth Facility
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.
Culture of Supporting Intended Vaginal Delivery

To be successful, one must achieve development of a culture in which the clinical providers, administrative support and public: 1) appreciate the true value of achieving a vaginal delivery; 2) respectfully acknowledges the desires of the patient and 3) maintains educational processes, facilities, equipment and staff expertise which can maximize the chance of successfully obtaining vaginal delivery which is safe for mother and infant(s).
Readiness *Continued*

- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth
  - Assessment of labor
  - Methods to promote labor progress
  - Labor support
  - Pain management (both pharmacologic and non-pharmacologic)
  - Shared decision making
Definitions of Labor Progress per the ACOG/SMFM Consensus Statement

• Slow but progressive labor in the 1st stage should not be indication for c/s

• Cervical dilation of 6cm is threshold for active labor and standards of active labor progress should not be applied before then

• C/S for active phase arrest in 1st stage should be reserved for women
  – beyond 6cm with ROM who FTP despite 4 hours of adequate ctx
  – Or 6 hours of oxytocin administration.

ACOG/SMFM Consensus Statement
Second Stage Labor

• At least 2 hours for multiparous women
• At least 3 hours for nulliparous women
• Longer durations may be appropriate on an individualized basis...e.g. epidural, fetal malposition
Recognition and Prevention – Every patient

- Implement standardized admission criteria, triage management and 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.
Recognition and Prevention

continued

- 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 delivery.
Nulliparous Labor Curves from Dilatations often associated with Active Labor Onset

- 7.3 hrs (median)
- 13.7 hrs (90th %)
- 16.4 hrs (95th %)

Dilatations commonly associated with active labor onset

(Friedman, 1955, 1971, 1978)  
(Zhang, Troendle et al, 2002)  
(Zhang, Landy et al, 2010)
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.
Optimal Models of Care
Prospective cohort study of 3684 NTSV deliveries and 1375 with prior CD

“This research demonstrates that changing from the traditional model of obstetric care to one that expands access to midwives and to OB/GYN doctors whose schedule is structured to allow them dedicated time spent delivering babies, without having to come in from the office or from home, is an intervention that can successfully lower cesarean delivery rates and make childbirth safer.”

Maternity Care TEAM:
Roles in Safe Reduction of Primary Cesarean
and Promoting Healthy Births

Maternity Care TEAM:
Common Goal,
Collective Approach,
Experience working with each other

TEAM members:
Doulas,
Anesthesia,
Family and Friends
Response *continued*

- 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.
Response continued

• 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.
ACOG/SMFM Recommendations For Special Cases

• Before a vaginal breech birth is considered, women need to be informed that there is an increased risk of perinatal or neonatal mortality and morbidity and provide informed consent for the procedure.

• Perinatal outcomes for twin gestations in which the first twin is in cephalic presentation are not improved by cesarean delivery.

Joint Commission: Perinatal Care Core Measure Set

- **PC-01** Elective Delivery
- **PC-02** Cesarean Section
- **PC-03** Antenatal Steroids
- **PC-04** Health Care- Assoc.
  
  Bloodstream Infections in Newborns
- **PC-05** Exclusive Breast Milk Feeding

Opportunities for Improvement through Implementation of Bundle
Bundles which drill down on specific bundle elements

- Promoting Progress in Labor
- Supporting Comfort and Coping in Labor
- Intermittent Auscultation
Reporting/ Systems Learning – Every birth facility

• Track and report labor and cesarean measures in sufficient detail to:
  – Compare to similar institutions
  – Conduct case review and system analysis to drive care improvement
  – Assess individual provider performance
Background: Individual Provider Reports

Functionality allows:

* Individual Provider Displays

* Ability to customize reporting periods
Reporting/Systems Learning

• Track appropriate metrics and balancing measures which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety.
Possible Metrics

• Maternal: metrics such as rates of severe maternal mortality, transfusions, infection and readmissions along with findings of thoughtful case reviews

• Neonatal: metrics like rates of low Apgars/cord gases, admissions to NICU, neonatal sepsis, etc.

• Prior studies have been reassuring
Summary

- Lowering the primary cesarean section will increase maternal safety by decreasing morbidity from unnecessary surgeries and the consequences of prior cesarean delivery in future pregnancies.

- A number of previous studies have shown by focusing on a number of clinical changes, using a culture which values vaginal birth, significant improvements can be obtained.

- By utilizing prior techniques of obstetrical performance improvement, such as leadership, patient centered care, team work and education the efforts will improve women’s lives.
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

National Improvement Challenge on Obstetric Hemorrhage Winning Programs

Wednesday, October 28, 2015 | 11:00 a.m. ET

Moderated by Paul A. Gluck, MD, FACOG
Immediate Past Chair of the Council

Click Here to Register