Healthy Birth Initiative®

Reducing Primary Cesareans Collaborative
Our Team for Today’s Webinar

Leslie Cragin       Lisa Kane Low       Ana Delgado       Tami Michele       Kate Chenok
### Agenda for Reducing Primary Cesareans Webinar

**December 4, 2015**

1-3 p.m. Eastern (12 Central, 11 Mountain, 10 Pacific)

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<thead>
<tr>
<th>Topic</th>
<th>Time</th>
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<td>Introductions (roll call) and Ground Rules</td>
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<td>Leslie/Kate</td>
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<td>Project Overview</td>
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<td>Bundles Q&amp;A</td>
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<td>Helpful Communication Skills</td>
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<td>The Elephant</td>
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<td>Discussion 2015 Baseline Metrics</td>
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<td>Leslie</td>
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Ground rules for this call

• Start and end on time
• Answers to any questions we don’t have time for will be posted on the RPC page following the meeting.
• There are no “stupid” questions...if you are wondering about it so is someone else!
“Raise” your hand to ask a question, then type the question into the box.

Your name will be here.
Raise your hand by clicking on the hand next to your name.

Then click on the + next to the questions.
Write your question there.
Kate Chenok will monitor the questions and read them during the Q&A.
Project Aims

• Reduce primary cesarean births in low risk women through the support of physiologic labor and birth
• Increase skills in obstetric interdisciplinary QI processes at the local level
Project phases

• Preparation

• Learning collaborative
PRIMARY OUTCOME MEASURE

NTSV CESAREAN RATE

Nulliparous Term Singleton Vertex
NTSV: a national mandate

- NTSV C/S rate is a Joint Commission Perinatal Core Measure
- National Quality Forum endorsed measure (www.nqf.org)
Why NTSV?

• Cesareans pose greater risks than vaginal delivery for low risk women. (Clark, et al 2007)
• Primary cesarean accounts for much of the increase and leads to repeat cesareans (Barber, 2011)
• 15 fold variation exists across USA for NTSV cesareans (2.4% to 36.5%) (Kozhimannil et al 2013)
Why NTSV?

- Unwarranted variation: key QI opportunity
- Labor abnormalities and “non-reassuring” fetal heart rate tracings account for 60% of NTSV cesareans. (Barber, 2011)
Factors contributing to Primary Cesareans

- Nonreassuring fetal heart tracing (32%)
- Arrest of labor (18%)
- Macrosomia (10%)
- Preeclampsia (10%)
- Multiple gestation (16%)
- Elective (8%)
- Maternal-fetal (5%)
- Obstetric (1%)

Barber 2011
Supporting physiologic birth in order to contribute to the

REDUCTION OF NT hsv CESAREANS
Physiologic approach

- Fetal intolerance → decrease use of EFM*
- Arrest of labor → support normal progress**
  → increase care and coping***

* in low risk women following the evidence (Alfirevic et al. 2006; NICE 2007)
** (Romano AM & Lothian JA, 2008)
*** (Hodnett, 2011)
How do you support physiologic birth?

- Implement evidence-based care bundles
  - Intermittent auscultation
  - Promoting comfort in labor
  - Promoting spontaneous progress in labor

Two pages each, common thread of shared decision-making & patient autonomy

- Modeled on IHI bundles
  - http://www.ihi.org/resources/Pages/ImprovementStories/WhatIsaBundle.aspx
Key bundle elements

• Develop guidelines and policies in support of change
• Training for everyone who is part of the care team
• All needed resources are reliably available
• Shared decision making is a part each conversation about an intervention or procedure
• Data is gathered to support the QI process
Bundle format

• Readiness
  • Every unit:
  •
  • Risk and Appropriateness Assessment
    • Every patient:
    •
  • Reliable Delivery of Appropriate Care
  • Recognition and Response
    • Every patient for whom risk/appropriateness changes
    •
  • Reporting/Systems Learning
    • Every unit:
    •
• References
Intermittent auscultation (IA): Overview

• EFM is a poor quality screening tool for fetal compromise
• IA can reduce unnecessary cesareans done in response to cat II tracings
• IA allows for greater freedom movement which may promote progress in labor.
IA: Key bundle concepts

• Setting IA as the standard of care for all eligible women
  – Transition from IA to EFM and vice versa is based upon evidence

• Shared decision making with women and their families regarding fetal assessment options
  – Education about what that assessment means

• Evidence based policies for review of Cat II tracings
IA: Patient focus

• The woman, not the monitor is the most important thing in the room
  – Acknowledge woman’s options for fetal assessment
• Facilitates freedom of movement
• Reduces discomfort from constant presence of monitors on abdomen
IA: Potential Barriers

- Staffing concerns: how to support the 1:1 ratio
- Capacity building around the skills and documentation of IA
- Medico-legal concerns
- Culture change
Promoting spontaneous progress in labor: Overview

• Reduce C/S rate by limiting unnecessary interventions often associated with iatrogenic cesareans
  – Early admission
  – Misuse of Pitocin
  – Friedman curve
Promoting spontaneous progress in labor: Key bundle concepts

• Timing of admission
• Evidence based diagnosis of active labor, parameters for normal labor duration
• Educating staff and clients about changes the “norms” for labor
• Promoting comfort/support (see next bundle)
Promoting spontaneous progress in labor: Patient experience

• Early labor support at home and hospital
• Expectations for pain management and coping
• Improve education about normal labor progress
Promoting spontaneous progress in labor: Potential barriers

• Resources needed to delay admission
• Time needed for staff education
• Creation of patient education materials
• Putting shared decision making “into practice”
Promoting comfort in labor: Overview

• New evidence about length of labor and active phase of labor requires focus on support in labor
• Equivocal evidence about the effect of epidural on contractions, length of labor and second stage requires a cautious approach to this “silver bullet”
• Change unit culture focus from pain management to coping
Promoting comfort in labor: Key bundle concepts

- Coping versus pain
- Non-pharmacological options
- Continuous labor support
- Positioning, freedom of movement
- Shared decision making
Promoting comfort in labor: Patient focus

• Assisting women to have realistic expectations
• Individualized experience of pain
• Education about coping vs pain
• Active labor support
Promoting comfort in labor: Potential barriers

• Staffing for 1:1 support

• Creating a culture of trust rather than fear
  – Clients
  – Family
  – Doulas
  – Providers/nurses
BUNDLES Q & A

Lisa Kane Low
Data Driven Quality Improvement

• What are we trying to accomplish?
  – Reducing C/S rates for NTSV
• How will we know if a change is an improvement?
  – Data
• What changes can we make that will result in improvement?
  – Self-assessment, review of baseline data
  – Selection of bundles
    • http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
Plan

• AIM: Reduce NTSV cesarean section rate—include target amount and time frame
• Team: content experts, leaders
• Predictions: what drives your C/S rate?
• Data: what and how are you going to measure?
Do

• Bundle selection
• Implementation
  – Interdisciplinary
Study

• Data analysis
• Compare results to predictions
• What was learned?
Act

• How can you get closer to your goal?
• What changes can you make to be more successful?
TEAM BUILDING EXERCISE
Creating Your Team Name and Motto

• Audience: other participating teams and faculty who are not familiar with your site, your team, or the priorities of your team.
• Limit time on this- 30 min at most-keep it light, fun
• End product- 2 ppt slides
Storyboard

San Francisco General Hospital Medical Center
Level 1 Trauma Hospital, 1000 Births/year

The Quality Queens
• Keep calm and create change!
• Ana Delgado, CNM
• Juan Start, MD
• Reg Nurse, RN
• Rob Baron, RN, PhD

American College of Nurse-Midwives
With women, for a lifetime.
HELPFUL COMMUNICATIONS SKILLS
A Relationship-Based Approach

• Prepare
  – Relationship/rapport building
  – Process
  – Substance: your interests AND theirs
• Be transparent
• Use open-ended questions
  “Help me understand...”
• Assume good intent
• Explore different perspectives
ART

• Ask
  – Use open-ended questions
  – Elicit perspective/interests
  – Non-judgmental
• Respond with empathy
  – PEARLS
• Tell
  – Share your perspective, with permission
PEARLS

**Partnership:** “I’d like to work with you, not against you.”

**Empathy:** “You seem pretty frustrated.”

**Acknowledgement/apology:** “What I’m hearing is that you are finding it difficult to balance patient safety and choice.”

**Respect:** “I see how much thought and work you have put into this.”

**Legitimation:** “Most people I know would also feel troubled after an event like that.”

**Support:** “What can I do in the next meeting to support you?”
Tami Michele, DO, FACOOG
Obstetrician and Gynecologist
Spectrum Health Gerber Memorial OB/GYN
Medical Director and OB Dept. Chair

Michigan Health and Hospital Association Keystone OB Advisory Committee Member

PERSPECTIVES
What perspective do you bring to your team?
METRICS
Metrics

• Outcome Measure: NTSV cesarean rate
• Balancing Measure: Apgars less than 7 at 5 min.
• Variables for all NTSV patients: 13
• Variables per bundle: 4-7
ACNM Data Center

NTSV C-Section Rate

Measure Description: Measure explanation... (Lower rates are better). For additional information, please consult ACNM's Measure Collection Information.

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Directions: If there were no births in a particular category, please explicitly populate the field with a zero so the system can distinguish between a non-reported value and an actual zero.
Metrics and 2015 Baseline Metrics

• Deliverables- Measures of the work needed to implement the bundles.
  – Asked only twice
    • After Bundle selected, but before implementation started
    • After Dec. 31, 2016
Wrap Up

  - Team name and motto
    - Submit by Dec. 23 to leslie.cragin@gmail.com
  - Baseline data collection completed (except Dec.)
  - Analyze the most common reason for NTSV Cesareans in your setting
  - Visit http://www.birthtools.org/RPC-Collaborative-Participants-Member-Info