



THE AMERICAN COLLEGE OF NURSE-MIDWIVES HEALTHY BIRTH INITIATIVE™

Reducing Primary Cesareans

ACNM's Reducing Primary Cesareans Success Story
Einstein Hospital
East Norriton, PA

Midwife Leader: Michelle Djevharian, CNM

Years of participation: 2016, 2017

Bundle: Promoting Spontaneous Progress in Labor

Key stats:

- 19.8% NTSV cesarean rate in 2015
- 16.1% NTSV cesarean rate 2016

Why we joined RPC: I read about ACNM's Reducing Primary Cesareans ("RPC") learning collaborative in an ACNM newsletter and asked my team whether they were interested. There was a lot of enthusiasm about the project. We thought it would help us to analyze our data and focus on areas in which we could be the best.

Change process: We set out to improve our NTSV cesarean rate, which was 19.8 percent in 2015. We had a lot of changes going on at the same time as the RPC learning collaborative, and I think they all worked together to create some big wins. We implemented the Promoting Progress in Labor change bundle.

Multidisciplinary team: I recruited people to be part of a team to work on this initiative. Prior to this initiative, we did have informal teams working together on various changes, but we made it more formal for this. We created a charter and agreed on goals.

I found that I could enlist the participation of several different types of people. One group was people who were in school and needed projects to focus on. For example, I needed references to include in a protocol about induction of labor, and a person on my team needed to do a research project, so she focused her research project on induction of labor. Another type of person I was able to recruit to help were people who felt that they were stuck in a routine and wanted some new energy in their professional lives. The idea of this new project was attractive to them, and they felt like they would be challenged. Finally, I found that people who were many years into their careers wanted to participate because they thought that this project could make a difference and contribute to society. Within the hospital, I also discovered that the Nurse Care Excellence team was a great source of support and volunteers for the project. I gave them a list of what was needed, and they helped to find people to work on the issues. Our overall staffing is:

- 13 Ob/gyns from 4 private practices

- 4 FTE equivalent midwives (11 midwives)
- 5 RNs

Making the case for change: It was very helpful that ACOG focused on the same issue around the same time. I was able to get physician attention on the issue, and use the evidence that was published and provided by ACOG in addition to the materials provided by ACNM.

Change process: One of our big issues was inductions, and another was patients who arrived in early labor. We developed several approaches to address these factors, all of which worked together to achieve a dramatic reduction in our NTSV cesarean rate, from 19.8 percent in 2015 to 16.1 percent in 2016.

Some of our highest impact changes were:

- A rule that providers could not order an induction, post-due-date, until 41 weeks, without filling out a sheet and having the patient sign it that said that an elective induction was being ordered. This worked wonders. Many patients were being induced at 40 weeks and 2 cms., and this simple change made providers focus on the issue and discuss it with patients.
- A change, that was already underway, to a model where the 13 physicians in 4 private practices cross-cover for each other. This created a “laborist” model where there was much less pressure to finish up a delivery within a certain period of time.
- Patient brochures and a handout that provide information about what to expect in labor – what’s normal, and what to expect. This handout is now provided to all 4 private practices to use in their offices, and is also included in discharge instructions for any patient who is sent home in early labor.
- Our episiotomy rate is now 4 percent. This came from a simple requirement that providers must include a reason for an episiotomy in the delivery notes. If they don’t include a reason and do an episiotomy, they receive an email asking them to explain.

Data Collection and Synthesis: We used our data to determine whether the changes worked, and we still are using it today. For example, we had a blip in our NTSV rates, and looked to see what was happening. We discuss the data at monthly department meetings and troubleshoot. For example, we recently noticed that our epidural rate had blipped up and were able to discuss that and its possible contribution to higher rates.

The biggest barrier to making change is finding the time! It takes time to organize the work to be done, recruit people to help, follow up with them, and troubleshoot when things don’t progress. We have ideas of other things we’d like to do, but it’s challenging to find the time.

Our advice: One key thing to remember is that there is usually “low hanging fruit,” and making simple changes can have a big and immediate impact.