THE AMERICAN COLLEGE OF NURSE-MIDWIVES HEALTHY BIRTH INITIATIVE™

Reducing Primary Cesareans

ACNM's Reducing Primary Cesareans Success Story
Winthrop Hospital
New York

Midwife Leader: Melanie Sumersille

Profile of Winthrop Hospital Ob/Gyn team:

- 20 Residents
- 3 Fellows
- 12 PAs
- 53 Voluntary OBs
- 7 Faculty OBs
- 7 MFM
- 3 Hospitalists
- *One midwife*
- 4,800 deliveries
- 70 % private insurance
- >75% Epidurals
- 41% overall cesarean rate in 2015
- 34.5% NTSV cesarean rate in 2015
- Baby Friendly 2015
- Magnet designation 2016

We recognized that our cesarean rate was too high, and wanted to change it. ACNM's Reducing Primary Cesarean Learning Collaborative (RPC) came at the perfect time – we wanted to change, but didn't have the tools to implement change. We chose the Progress in Labor change bundle to implement, and began working with RPC in 2016.

The Progress in Labor bundle was appropriate for us because 50 percent of our NTSV cesareans were for labor dystocia, and the bundle addresses that. The bundle is also patient-centered and consistent with our Baby Friendly and Magnet nursing goals.There were ACOG guidelines about safe reduction, but no specific suggestions as to how to reduce.

I am the only midwife at Winthrop, and I began to get buy in by meeting people on their own terms. I always stressed that our high rates were multi-factorial -- not as a result of one provider or practice, and that change requires everyone to participate.
For nurses, I got early and consistent support. With physicians, I began by working with the evidence, such as distributing the ACOG guidelines. A lot of what I accomplished was through one on one conversations, asking questions such as: "why do you think we have such a high section rate?" After listening to their answer, I was prepared to problem solve, and then always followed up by asking for their help and participation.

We rolled out the change by forming teams of two or three people. In forming the teams, I was careful not to select people who already understood physiologic birth – I wanted to get people involved in solving the problem who were contributing to the problem. I assigned each team a part of the bundle (following the stages of labor), and asked them to develop a plan. For example, one team designed a walking route for patients who presented early in labor; another team worked on developing a doula program to support women in labor; a third team worked to post dystocia criteria in the recovery room. Breaking up the tasks and assigning a team to work on each item was really key, because they direct assignments about what they were going to do between meetings. Another thing we found is that a lot of the nurses are required as a magnet hospital to have some project (e.g., to complete BSRN, needed an intern project) and the work of this project helped them to achieve that goal.

We worked hard to acknowledge the hard work that is involved in making change by publicly praising people, presenting at departmental meetings on a regular basis, and we even made buttons and handed them out to people. I do quarterly Grand Rounds presentations, and am constantly on the lookout for new evidence to distribute to clinicians.

This is a marathon process, not a sprint! It has taken time to get buy in and raise awareness. The nursing staff has had an enormous role – they share stories and problem solve on the floor. Now, we also get physicians who approach me and the nurses to problem solve and ask for help.

Winthrop's NTSV rate has not yet dropped, but we think that they will soon. We now have changes in place for each part of the process: from prenatal education, so that patients and physicians build a shared understanding of what's involved in labor; to the walking route mentioned earlier; to tools in place to promote comfort during labor; an active doula program that is available 24/7, and other polices to continually review our performance. This includes chart review for all NTSV cesareans that have a dystocia diagnosis. There is now peer review for each of these cases, and the department chair and vice chair review all providers' cesarean rates.

A learning for us was that we needed to change our culture before we could make policy and practice changes. It has taken longer than anticipated to achieve that, but we are seeing a lot of positive change. The other thing we didn't plan for was the amount of time it would take for hospital administrative approvals for some of our changes, such as implementing a walking route and creating new materials for patients. Going forward, we know to anticipate the and plan for a lengthy administrative approval process.

I think that the learnings from this project would support us in engaging in future quality improvement projects. Now that the fruits of our marathon are finally coming to life, we will be encouraged and excited to move forward.