Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

A Quality Improvement Toolkit
Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

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CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

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Executive Summary

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Introduction

Cesarean birth is a lifesaving procedure, with obvious benefits to mother and baby when vaginal birth is no longer safe. Nonetheless, the extraordinary rise and remarkable variation in rates of cesarean create concern for both the quality and cost of maternity care. In the ten-year period from 1998 to 2008, cesarean birth rates in the United States rose from 22% to 33% of all births, making it the nation’s most common hospital surgery. Having the largest population and the largest number of births of any state, birth trends in California mirror the increased cesarean rates nationwide, with cesarean birth accounting for approximately one-third of all births.

The most important group to focus on for both cesarean reduction and labor support is a population known as Nulliparous Term Singleton Vertex (NTSV). It is a standard population that presents the most favorable set of conditions for vaginal birth – women with a full-term, single baby in the head-down position (vertex), but is also the group that has the most labor complications – women having a first birth (nulliparous). It is also a population that can be compared between states, hospitals and even providers. Importantly, the NTSV population has been the largest contributor to the rise in cesarean rates, and exhibits the greatest variation for all sub-populations of cesarean births for both hospitals and providers.

The Toolkit to Support Vaginal Birth and Reduce Primary Cesareans is a collaborative effort by a diverse task force of over fifty experts, including obstetricians, anesthesiologists, midwives, labor nurses, doulas, patient advocates, childbirth education professionals, public health professionals, policymakers, and health care purchasers. It is a comprehensive, evidence-based, how-to guide to reduce avoidable cesarean births in the Nulliparous Term Singleton Vertex (NTSV) population. The primary goal of the toolkit is to facilitate the achievement of NTSV cesarean rates among California hospitals by 2018 to less than 23.9% (the Healthy People 2020 goal). Although the focus of the toolkit is on NTSV (or “first birth”) cesareans, the concepts can be generalized to most women giving birth.

Large Variation Exists Among California Hospitals

It is well-recognized that variation in care represents an opportunity for improvement in practice. There is considerable variation in NTSV cesarean rates across California hospitals. For example, in 2013, the Los Angeles region had the highest average NTSV cesarean rate of 33.1%, with a range of 49 percentage points separating the facilities with the highest and lowest cesarean rates. Women giving birth in the North Bay Region (Solano, Napa, and Sonoma counties), however, had a considerably lower average NTSV cesarean rate of 22.1% and experienced much less variation, with a difference of only 10 percentage points between facilities with the highest and lowest rates. Another way to conceptualize this variation is to say that women who gave birth in the Los Angeles region during that period were 50% more likely to deliver by cesarean than women in the North Bay region.

Variation in NTSV cesarean rates is not only regional. Large variation also exists between hospitals with similar mixes of private and public insurances, and between same “type” facilities, such as similar teaching hospitals, public hospitals and so forth. Furthermore, large variation in individual provider rates exists even within single facilities. These within-group variations indicate that the risk level or “type” of patient is not driving the high rates of NTSV cesarean within certain facilities, nor is maternal request. Rather, various
Quality Maternity Care is at Stake

For most low-risk NTSV women, cesarean birth creates more risk, including hemorrhage, uterine rupture, abnormal placentation, and cardiac events. The biggest risk of the first cesarean may very well be the next and subsequent cesareans. The risk of uterine rupture, uterine atony, placenta previa, placenta accreta, and surgical adhesions all increase with each cesarean. By the third cesarean, the risk of placenta previa nearly triples, and roughly 40% of women with placenta previa will also have placenta accreta. Studies are currently underway to further examine the psychological risks of cesarean. To date, psychological stress, anxiety, and post-traumatic stress disorder (PTSD) have been identified as potential risks of cesarean. Patients also suffer from less acute but nonetheless significant other consequences: longer hospital stays, increased pain and fatigue, slower return to normal activities and productivity, and delayed and difficult breastfeeding.

Risks of cesarean birth for neonates are equally concerning. With the exception of fetuses in breech presentation, neonates have reaped few benefits with the rising rate of cesarean birth. Cerebral palsy rates have remained unchanged in the past 15 years, and recent evidence indicates that significant health consequences, including higher rates of serious respiratory complications, higher rates of admission to the Neonatal Intensive Care Unit (NICU), and development of childhood asthma requiring hospitalization and inhaler use are more likely in babies born by cesarean. Furthermore, cesarean birth remains a barrier to early breastfeeding support, delays the first feeding, and delays or completely interferes with early skin-to-skin contact, all of which adversely affect the ability to exclusively breastfeed.

In 2009, a paper entitled 2020 Vision for a High-Quality, High-Value Maternity Care System was produced by Childbirth Connection in collaboration with a multidisciplinary, expert team of maternity care providers, payers, consumer advocates, and policymakers. This paper defined high-value, high-quality maternity care as “the consistent provision of woman-centered care grounded in the best available evidence of effectiveness with least risk of harm, and the best use of resources.” By this definition, the overuse of cesarean birth as currently employed by the majority of hospitals across the nation could quite possibly be the single, largest barrier to consistently providing high-value, high-quality maternity care.

Cesareans are Costly

In addition to the extensive health consequences noted above, the financial burden of cesarean extends well beyond the surgery itself. The costs are significant for insurers, employers, taxpayers, the government, and ultimately the consumer. Cesareans are costly for many reasons. First, the procedure itself is expensive. Studies of actual payments to hospitals and providers indicate that each cesarean costs $5,000 to $10,000 more than a vaginal birth. Secondly, most women will have more than one child. The vast majority of women with a previous cesarean will undergo a second or third surgery, so the actual cost of a primary cesarean should be doubled or even tripled to reflect the true direct cost per patient over time. The California Maternal Quality Care Collaborative (CMQCC), in collaboration with the Pacific Business Group on Health (PBGH), developed a high-level economic model of the financial burden of cesarean birth. Using this model, conservative estimates show a potential annual savings in California of $80 million to $440 million, depending on the rate of cesarean reduction.

The Goal for NTSV Cesareans

In response to the increasing rate of cesarean births and the resulting risks to mothers and babies, various stakeholders have mounted concerted efforts to reduce that rate and thereby to improve quality of care. In 1985, the World Health Organization proposed a target of 15% for the Total Cesarean rate, noting that there was no evidence that a higher rate benefited mothers and babies. In 2000, the American Congress of Obstetricians and Gynecologists (ACOG) published a report on the trend in cesarean births, including a discussion on measurement that focused on the NTSV rate, with a proposed national goal of 15.5%. Healthy People 2010, the federal Health and Human Services project that defines health goals for the entire country every 10 years, followed ACOG’s lead and focused on low-risk women (defined as nulliparous, term gestation, singleton fetus, vertex presentation), devising separate cesarean targets for low-risk women without a prior cesarean and low-risk women with a prior cesarean. The Healthy People 2010 cesarean target for low-risk women without a prior cesarean was set at 15%, but was not met nationally. With this in mind, 10 years later, the Healthy People 2020 target rate of 23.9% was created to reflect a more modest, attainable rate.
Summary of Toolkit Components

The toolkit is aligned with the *Safe Reduction of Primary Cesarean Births Bundle*¹ published in 2015 by the Alliance for Innovation on Maternal Health (AIM), a program of the National Partnership for Maternal Safety. Additionally, the toolkit draws heavily from the *Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery*² published in 2014 by the ACOG and the Society for Maternal-Fetal Medicine (SMFM). The contents of the toolkit are arranged to reflect the four major domains of the AIM bundle:

• **Readiness (Improving the Culture of Care, Awareness, and Education)**
• **Recognition and Prevention (Supporting Intended Vaginal Birth)**
• **Response (Managing Labor Abnormalities)**
• **Reporting (Using Data to Drive Improvement)**

As a keystone for QI implementation efforts, the toolkit offers a menu of various evidence-based strategies for the reduction of primary cesarean birth, corresponding tools that can be implemented within facilities, slide decks for professional education, and lessons learned from California hospitals that have achieved and sustained a low NTSV cesarean birth rate. While the majority of the toolkit is meant to guide individual hospital and provider-level change, it also includes guidance to inform state, county and hospital system-level change.

Understandably, quality improvement programs for cesarean reduction will differ between facilities. The expectation is not that each facility will implement every tool or concept introduced in the toolkit. Rather, each facility should implement and/or adapt the tools and concepts that will best improve NTSV cesarean rates according to the unique needs of the organization.

The tables on the following pages outline the key strategies to reduce avoidable cesarean births, arranged according to the major domains of the toolkit.

Conclusion

Multiple strategies are necessary to reduce cesarean rates statewide and nationally. Changes in clinical practice represent only one component. Other critical pressure points must come to bear, including (but not limited to) payment reform, consumer and employer knowledge and expectations, and transparency of hospital and provider level data (all of which are discussed in the toolkit). Just as the reduction of early elective deliveries before 39 weeks gestation recently became a significant national effort that resulted in extraordinary changes in routine obstetric practice, a similar national effort to reduce cesarean rates is currently mounting from many collective, cohesive fronts. Together, improvement is possible.
Key Strategies for Improving the Culture of Care, Awareness, and Education for Cesarean Reduction

1. **Improve Quality of and Access to Childbirth Education**
   - Align hospital practices and philosophies with evidence-based childbirth education
   - Collaborate to assess and mitigate barriers to childbirth education (including cost, time of day), and include flexible educational formats such as high quality web content or interactive web-based learning
   - Implement prenatal care models that efficiently integrate comprehensive pregnancy and childbirth education into routine visits, such as group prenatal care

2. **Improve Communication through Shared Decision Making at Critical Points in Care**
   - Train providers, nurses, and staff on the essential elements of effective communication and shared decision making
   - Design shared decision making discussions around the major decision points that impact the risk for cesarean, and effectively and routinely incorporate these discussions into regular prenatal visits
   - Improve the shared decision making process through the utilization of high-quality, evidence-based decision aids in consumer-preferred formats specific to the woman’s literacy level
   - Adapt the clinical environment in order to integrate patient engagement and shared decision making into routine care (such as adjusting workflows to allow ample time for questions and educational opportunities)
   - Respect and value differences in culture and religious beliefs

3. **Bridge the Provider Knowledge and Skills Gap**
   - Improve the content of professional education and continuing education to support a “wellness approach” to obstetric care for the majority of women giving birth, including a redesign of standard curriculum to include principles of physiologic childbearing and a greater focus on the reduction of routine interventions for low-risk women
   - Incorporate interprofessional training and mentorship of nursing and medical students, nurse-midwifery graduates, and medical residents to foster a generational change in how routine obstetric care is delivered
   - Ensure that all providers and nurses maintain the critical skills necessary to support vaginal birth
   - Create a culture of transparency for hospital and provider level data

4. **Improve Support from Senior Hospital Leadership and Harness the Power of Clinical Champions**
   - Utilize the power of hospital leadership at all levels (e.g. executive and departmental) to promote an environment of continuous quality improvement
   - Create, nurture, and sustain a core group of enthusiastic, clinical champions

5. **Transition from Paying for Volume to Paying for Value**
   - Implement alternative payment models (APMs) that reward quality, reduce incentives to perform cesarean deliveries, and focus on coordinated patient-centered care
Key Strategies for Supporting Intended Vaginal Birth

1. Implement Institutional Policies that Uphold Best Practices in Obstetrics, Safely Reduce Routine Interventions in Low-Risk Women, and Consistently Support Vaginal Birth

- Perform a comprehensive review of existing unit policies and edit such policies to provide a consistent focus on supporting vaginal birth

2. Implement Early Labor Supportive Care Policies and Establish Criteria for Active Labor Admission

- Implement policies that support the physiologic onset of active labor, reduce stress and anxiety for the woman and family, and improve coping and pain management
- Implement written policies that establish criteria for active labor admission, versus continued observation of labor status and/or discharge home
- Give adequate anticipatory guidance during the prenatal period about early labor expectations and the safety of completing early labor at home
- Educate women and families on supportive care practices and comfort measures to facilitate completion of early labor at home

3. Improve the Support Infrastructure and Supportive Care during Labor

- Improve nursing knowledge and skill in supportive care techniques that promote comfort and coping
- Improve unit infrastructure and availability of support tools
- Improve assessment of pain and coping
- Remove staffing and documentation barriers to supportive bedside care
- Educate and empower spouses, partners, and families to provide supportive care

4. Encourage the Use of Doulas and Work Collaboratively to Provide Labor Support

- Integrate doulas into the birth care team
- Improve teamwork, communication, and collegial rapport between nurses and doulas in order to promote safe, patient-centered care and continuous labor support
- Develop unit guidelines to foster the delineation of roles and expectations

5. Utilize Best Practice Recommendations for Laboring Women with Regional Anesthesia (Epidural, Spinal, and Combined Spinal Epidural)

- Do not avoid or delay placement of epidural anesthesia as a method of reducing risk for cesarean delivery
- There is no arbitrary cervical dilation that must be met in order to administer epidural anesthesia
- The woman should be assisted in changing position at least every 20 minutes to assist necessary fetal rotation
- Allow for longer durations of the second stage of labor for women with regional anesthesia (e.g. 4 hours in nulliparous women, 3 hours in multiparous women), as long as maternal and fetal statuses remain reassuring
- Allow for passive descent when there is no urge to push (delayed pushing until there is a stronger urge to push, generally 1-2 hours after complete dilation)
- Preserve as much motor function as possible by administering the lowest concentration of epidural local anesthetic necessary to provide adequate maternal pain relief
- Turning an epidural off during the second stage of labor likely has minimal beneficial effect on the length of the second stage
- Utilize patient-controlled epidural anesthesia (PCEA) with background maintenance infusion that is intermittent or continuous (for laboring women, this is superior to PCEA alone and continuous infusion epidural)

6. Implement Intermittent Monitoring Policies for Low-Risk Women

- Implement policies that include a risk assessment tool, or checklist with exclusion criteria, to assist in identifying patients for which intermittent auscultation or intermittent EFM is appropriate
- Modify standing admission orders to reflect the use of intermittent auscultation or EFM as the default mode of monitoring for women who do not meet exclusion criteria
- Implement initial and ongoing training and education of all nurses and providers on intermittent auscultation and/or intermittent EFM procedures
- Provide patient education for the use of intermittent methods of monitoring and engage in shared decision making in order to determine the most appropriate method for each patient
- Ensure appropriate nurse staffing to accommodate intermittent monitoring

7. Implement Current Treatment and Prevention Guidelines for Potentially Modifiable Conditions

- Assess fetal presentation by 36 weeks gestation and offer external cephalic version (ECV) to patients with a singleton breech fetus
- Ensure initial training and ongoing physician competency in ECV
- Offer oral suppressive therapy at 36 weeks gestation, or within 3-4 weeks of anticipated delivery, to all women with a history of genital herpes, including those without active lesions during the current pregnancy
- A cesarean delivery need not be performed on women with a history of genital herpes but no active genital lesions at the time of labor

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans
Key Strategies to Manage Labor Abnormalities and Safely Reduce Cesarean Births

1. **Create Highly Reliable Teams and Improve Interprofessional Communication at Critical Points in Care**
   - Develop protocols and institutional policies that promote and support teamwork and effective communication
   - Create a culture of collegiality and mutual respect
   - Implement formal programs for the development and ongoing evaluation of teamwork and communication (e.g., TeamSTEPPS®)
   - Promote standardized communication techniques to improve efficiency and clarity of communication (e.g., SBAR)
   - Promote situational awareness through impromptu huddles, team rounds, and debriefings
   - Develop Rapid Response Teams

2. **Implement Standard Diagnostic Criteria and Standard Responses to Labor Challenges and Fetal Heart Rate Abnormalities**
   - Utilize standard diagnostic criteria and algorithms to reduce and respond to labor dystocia
   - Implement policies for the safe use of oxytocin
   - Endorse NICHD categories and standardize responses to abnormal fetal heart rate patterns and uterine activity
   - Standardize induction of labor (e.g., patient selection, scheduling, and induction process)

3. **Utilize Operative Vaginal Delivery in Eligible Cases**
   - Ensure initial training and ongoing physician competency in forceps and vacuum extraction

4. **Identify Malposition and Implement Appropriate Interventions**
   - Identify malposition early (ideally by early second stage of labor), and employ the use of ultrasound if unable to clearly define the position of the vertex with digital exam and Leopold’s Maneuvers
   - Promote rotation of the vertex from an OP position with maternal positioning including during second stage, and manual or instrumented rotation by an experienced, well trained provider
   - As long as incremental descent is being made, and fetal and maternal statuses permit, allow for longer durations of the second stage (e.g., at least 4 hours for nulliparous women and at least 3 hours for multiparous women)

5. **Consider Alternative Coverage Programs (Laborist Models and MD/CNM Collaborative Practice Models)**
   - Laborist models of care promote on-site readiness, remove the time-based and economic incentives to perform cesareans, and lend to the retention of core knowledge and skills
   - Midwifery care has been identified as an underused maternity service, with the potential to curb costs, improve overall outcomes, and reduce rates of cesarean

6. **Develop Systems that Facilitate Safe, Patient-Centered Transfer of Care Between the Out-of-Hospital Birth Environment and the Hospital**
   - Develop relationships with local out of hospital providers in order to increase collaborative communication and facilitate safe and respectful transfer of care

7. **Reduce Liability-Driven Decision Making by Focusing on Quality and Safety**
   - Educate providers on the benefits of a well-designed quality improvement program to reduce cesarean
   - Specifically address the situations that contribute the most to obstetric liability claims
   - Well-chosen cesareans are sometimes necessary to prevent avoidable maternal and fetal harm. The goal of a quality improvement program to reduce cesarean is not to prevent cesarean birth “at all costs”
Key Strategies for Using Data to Drive Reduction in Cesareans

1 Strategies to Make Data Compelling to Providers

- Provide timely data to providers in a persuasive manner using display tools, background information, benchmarks, historical data, and broader outcome data (such as infant outcomes and maternal morbidity measures)
- Present comparative data in a manner that demonstrates a sense of urgency
- Present identical measures across multiple levels – MD / practice group / hospital / medical group / health plan / purchaser / region / state
- When presenting the data, include a goal that is attainable/achievable by showing that similar providers have already reached the goal
- *Package* the data for the audience – data can be supplemented by patient stories, not just graphs and figures

2 Strategies to Assist Organizations to Understand Data Associated with their Hospital, and Identify Steps to Improve Care

- Create meaningful sub-measures that indicate the drivers for the cesarean rate and benchmark these against other facilities
- For internal hospital use, create provider level rates to help utilize “peer pressure” and identify those who would benefit from specific educational programs including reviews of their processes of care
- Use rapid-cycle data (30-75 days old) to provide immediate feedback for QI projects including multiple peer comparisons
- Expand use of balancing measures to document lack of harm from interventions

3 Strategies to Assist Providers to Understand their Cesarean Rates and be Comfortable with the Quality of the Data

- Provider-level data is a very important tool for driving QI but opens new issues of attribution, especially in facilities that have midwives or family medicine physicians who perform vaginal births with covering obstetricians performing the cesarean deliveries
- Create data tools that allow practitioners to “roll-up” outcomes together (group statistics) or reassign attribution within the data set
- Create tools for sub-analysis of physician-level rates to help providers understand where improvement opportunities lie

4 Strategies to Engage Women, Employers, and the General Public in the Improvement Project

- Public release of selected hospital-level measures that have been well vetted
- Provide a lay explanation of the measures
- Widely distribute these measures through multiple media channels to capture the greatest attention
References


How To Use This Toolkit

The Toolkit to Support Vaginal Birth and Reduce Primary Cesareans is a collaborative effort by a diverse task force of over fifty experts, including obstetricians, anesthesiologists, midwives, labor nurses, doulas, patient advocates, childbirth education professionals, public health professionals, policymakers, and health care purchasers (hereafter, the “Task Force”). It is a comprehensive, evidence-based, how-to guide to reduce avoidable cesarean births in the Nulliparous Term Singleton Vertex (NTSV) population. The primary goal of the toolkit is to facilitate the achievement of NTSV cesarean rates among California hospitals by 2018 to less than 23.9% (the Healthy People 2020 goal). Currently, individual hospital NTSV cesarean rates in California range from 12% to 70%. This extraordinary range of variation cannot be explained by any clinical or demographic attributes, and indicates the need for performance improvement. Although the focus of the toolkit is on NTSV (or “first birth”) cesareans, the principles of labor support can be generalized to most women giving birth.

The content of this toolkit is in alignment with the Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery (Appendix A) published by the American Congress of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) in 2014. Additionally, the toolkit is modeled after the Safe Reduction of Primary Cesarean Births Bundle (Appendix B) published by the Alliance for Innovation on Maternal Health (AIM) in 2015. AIM is a program of the National Partnership for Maternal Safety, a multistakeholder organization that includes the ACOG, the American College of Nurse-Midwives (ACNM), the Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN), the American Academy of Family Physicians (AAFP) and many more organizations and key policy-making entities in women’s health care. The AIM safety bundles are evidence-based outlines of the most important implementation elements required for a given topic area. The contents of this toolkit are arranged to reflect the four major domains of the AIM bundle, and to expand the domains with examples and detail for immediate use:

- **Readiness (Improving the Culture of Care, Awareness, and Education)**
- **Recognition and Prevention (Supporting Intended Vaginal Birth)**
- **Response (Managing Labor Abnormalities)**
- **Reporting (Using Data to Drive Improvement)**

As a keystone for QI implementation efforts, this toolkit offers a menu of various evidence-based strategies for the reduction of primary cesarean birth that can be adapted to fit the circumstances and resources of each individual hospital. The toolkit includes a comprehensive discussion of strategies to reduce cesareans, corresponding tools that can be implemented within facilities, slide decks for professional education, and lessons learned from California hospitals that have achieved and sustained a low NTSV cesarean birth rate. While the majority of the toolkit is meant to guide individual hospital and provider-level change, it also includes guidance to inform state, county and hospital system-level change.

For purposes of this toolkit, the term “nurse” is used to refer to labor and delivery nurses while the collective term “providers” includes obstetricians, family medicine physicians, nurse-midwives, and other advanced practice obstetric clinicians.

Getting Started

Quality improvement programs for cesarean reduction will differ between facilities. The expectation is not that each facility will implement every tool or concept introduced in this toolkit. Rather, each facility should implement and/or adapt the tools and concepts that will best improve NTSV cesarean rates according to the unique needs of the organization.

For ease of navigation, each section of the toolkit includes a road map to guide the user through the content of that particular section and the available tools. Furthermore, all tools are arranged in order of toolkit section in Appendix C, and arranged by topic in Appendix D. For further guidance on implementation, visit the implementation guide located alongside this toolkit on the CMQCC website.
The Case for Improvement in Cesarean Birth Rates

Introduction

No one disputes that cesarean birth can be a lifesaving procedure, with obvious benefits to mother and baby when vaginal birth is no longer safe. Nonetheless, the extraordinary rise and remarkable variation in rates of cesarean birth create concern for both the quality and cost of maternity care.1-4 In addition, the Joint Commission (TJC) called the rise in cesarean an “epidemic” and noted “there are no data that higher rates improve any outcomes, yet the C-section rates continue to rise.”5 It is well-recognized that variation in care represents an opportunity for improvement in practice. Setting aside multiple gestations, breech presentations, and pregnancies complicated by prematurity, this toolkit will focus on the area with greatest variation and hence the greatest opportunity for impact—labor management of first births.
Current Landscape of Cesarean Birth in California and the United States

In the ten-year period from 1998 to 2008, cesarean birth rates in the United States rose 50%, from 22% to 33% of all births,\(^4\) making it the nation’s most common hospital surgery (Figure 1). Having the largest population and the largest number of births of any state, birth trends in California mirror the increased cesarean rates nationwide, with cesarean birth accounting for approximately one-third of all births.\( ^6 \)

The most important group to focus on for both cesarean reduction and labor support is a population known as Nulliparous Term Singleton Vertex (NTSV). It is a standard population that presents the most favorable set of conditions for vaginal birth – women with a full-term, single baby in the head-down position (vertex), but is also the group that has the most labor complications – women having a first birth (nulliparous). It is also a population that can be compared between states, hospitals and even providers. Importantly, the NTSV population has been the largest contributor to the rise in cesarean rates, and exhibits the greatest variation for all sub-populations of cesarean births for both hospitals and providers.\(^2,7\)

There is considerable variation in cesarean rates across California hospitals. For example, in 2013, the Los Angeles region had the highest average NTSV cesarean rate of 33.1%, with a range of 49 percentage points separating the facilities with the highest and lowest cesarean rates.\(^2\) Women giving birth in the North Bay Region (Solano, Napa, and Sonoma counties), however, had a considerably lower average NTSV cesarean rate of 22.1% and experienced much less variation, with a difference of only 10 percentage points between facilities with the highest and lowest rates. Another way to conceptualize this variation is to say that women who gave birth in the Los Angeles region during that period were 50% more likely to deliver by cesarean than women in the North Bay region.\(^2\)

Variation in NTSV cesarean rates is not only regional. Large variation also exists between hospitals with similar mixes of private and public insurances, and between same “type” facilities, such as similar teaching hospitals, public hospitals and so forth. These within-group variations indicate that the risk level or “type” of patient is not driving the high rates of NTSV cesarean within certain facilities, nor is maternal request. Rather, various cultural and clinical components are at play, including variations in practice style and clinical decision making.\(^7\)

The most recent data from the CMQCC Maternal Data Center show an average NTSV cesarean rate of 26.1% in California. Additionally, 60% of California hospitals have an NTSV cesarean rate above the national target of 23.9% (Figure 2).
Figure 2. Variation in NTSV Cesarean Rates among 251 California Hospitals

Variation of NTSV Cesarean Rate Among 251 California Hospitals: 2014

Range: 12%-70%
Median: 25.3%

First Time, Low Risk Cesarean Rate
251 California Hospitals Reporting Live Births

40% of CA hospitals MEET THE NATIONAL TARGET.

60% of CA hospitals NEED TO IMPROVE.

23.9% NATIONAL TARGET RATE
26.1% CALIFORNIA AVERAGE

Large Variation = Improvement Opportunity

SOURCE: CMQCC Maternal Data Center, 2014
Quality Maternity Care is at Stake

For most low-risk NTSV women, cesarean birth creates more risk – more hemorrhage, uterine rupture, abnormal placentation, and cardiac events (Figure 3). The biggest risk of the first cesarean may very well be the next and subsequent cesareans. The risk of uterine rupture, uterine atony, placenta previa, placenta accreta, and surgical adhesions all increase with each cesarean. By the third cesarean, the risk of placenta previa nearly triples, and roughly 40% of women with placenta previa will also have placenta accreta. Studies are currently underway to further examine the psychological risks of cesarean. To date, psychological stress, anxiety, and post-traumatic stress disorder (PTSD) have been identified as potential risks of cesarean. Women also suffer from less acute but nonetheless significant other consequences: longer hospital stays, increased pain and fatigue, slower return to normal activities and productivity, and delayed and difficult breastfeeding.

Risks of cesarean birth for neonates are equally

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**Figure 3.** Summary of Maternal Risks Associated with Cesarean Birth

**Maternal Risks of Cesarean Birth**

**Physiologic**

- **ACUTE**
  - Longer hospital stay
  - Increased pain and fatigue
  - Slower return to normal activities and productivity
  - Delayed and difficult breastfeeding
  - Anesthesia complications
  - Postpartum hemorrhage
  - Wound infection
  - Deep vein thrombosis
  - Maternal death

- **LONG TERM & SUBSEQUENT**
  - Subsequent cesarean births
  - Abnormal placentation (placenta previa and placenta accreta) resulting in increased risk of severe morbidity, life-threatening hemorrhage, and hysterectomy
  - Uterine rupture
  - Surgical adhesions
  - Bowel injury
  - Bowel obstruction
  - Delayed interval from incision to birth (neonatal risk)

**Psychological**

- **ACUTE**
  - Delayed and/or ineffective bonding with neonate
  - Maternal anxiety

- **LONG TERM & SUBSEQUENT PREGNANCIES**
  - Postpartum anxiety and depression
  - Post Traumatic Stress Disorder (PTSD)
In 2009, a paper entitled *2020 Vision for a High-Quality, High-Value Maternity Care System* was produced by Childbirth Connection in collaboration with a multidisciplinary, expert team of maternity care providers, payers, consumer advocates, and policymakers. This paper defined high-value, high-quality maternity care as “the consistent provision of woman-centered care grounded in the best available evidence of effectiveness with least risk of harm, and the best use of resources.”

### Reducing the Cost of Care

In addition to the extensive health consequences noted above, the financial burden of cesarean extends well beyond the surgery itself. Moreover, the costs are significant for insurers, employers, taxpayers, the government, and ultimately the consumer who shoulders the burden through deductibles and other out-of-pocket costs. Private insurance, mostly employer-based group plans, finances approximately 50% of all births. California taxpayers, in addition to paying a portion of their own insurance, also shoulder a significant burden of costs through public health care assistance programs, with roughly 48% of births financed by Medicaid.

Cesarean birth is costly for many reasons. First, the procedure itself is expensive. Studies of actual payments to hospitals and providers indicate that each cesarean costs $5,000 to $10,000 more than a vaginal birth. Secondly, most women will have more than one child. The vast majority of women with a previous cesarean will undergo a second or third surgery, so the actual cost of a primary cesarean should be doubled or even tripled to reflect the true direct cost per patient over time. The California Maternal Quality Care Collaborative (CMQCC), in collaboration with the Pacific Business Group on Health (PBGH), developed a high-level economic model of the financial burden of cesarean birth. Using this model, conservative estimates show a potential annual savings in California of $80 million to $440 million, depending on the rate of cesarean reduction.

The 2009 cesarean rates used for these calculations are considerably lower than current rates and the costs do not include those for hospital readmissions from complications directly resulting from surgery, nor the cost of NICU admissions directly related to cesarean birth. Even a modest reduction in the overall rate of cesareans will yield a significant annual savings in health care spending, while simultaneously reducing unnecessary risk to women and babies.

### Neonatal Risks of Scheduled Cesarean Birth

<table>
<thead>
<tr>
<th>Risk</th>
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<tbody>
<tr>
<td>Higher risk of respiratory morbidity (respiratory distress syndrome, transient tachypnea of the newborn, and infections)</td>
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<tr>
<td>Higher NICU admission rates</td>
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<tr>
<td>Prolonged length of stay in NICU</td>
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<tr>
<td>Increased risk of asthma requiring hospitalization and inhaler use in childhood</td>
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<tr>
<td>Difficulty with breastfeeding</td>
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Table 1. Summary of Neonatal Risks Associated with Scheduled Cesarean Birth

The overuse of cesarean birth as currently employed by the majority of hospitals across the nation could quite possibly be the single, largest barrier to consistently providing high-value, high-quality maternity care.

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CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans
In response to the increasing rate of cesarean births and the resulting risks to mothers and babies, various stakeholders have mounted concerted efforts to reduce that rate and thereby to improve quality of care. In 1985, the World Health Organization proposed a target of 15% for the Total Cesarean Rate, noting that there was no evidence that a higher rate benefited mothers and babies. In 2000, the ACOG published a report on the trend in cesarean births, including a discussion on measurement that focused on the NTSV rate, with a proposed national goal of 15.5%. Healthy People 2010, the federal Health and Human Services project that defines health goals for the entire country every 10 years, followed ACOG’s lead and focused on low-risk women (defined as term gestation, singleton fetus, vertex presentation), devising separate cesarean targets for low-risk women giving birth for the first time and low-risk women with a prior cesarean. The Healthy People 2010 cesarean target for low-risk women giving birth for the first time (NTSV) was set at 15%, but was not met nationally. With this in mind, 10 years later, the Healthy People 2020 NTSV target rate of 23.9% was created to reflect a more modest, attainable rate.

In 2011, CMQCC published a white paper, Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality. This paper outlined the use of the NTSV metric as the best measure for quality improvement. A focus on the NTSV population controls for risk factors and addresses the population that accounts for the most variation between hospitals. The National Quality Forum (NQF) endorsed the NTSV metric in 2008, followed by The Joint Commission (TJC) in 2010. The metric has since been widely adopted, including by the Leapfrog Group, Centers for Medicare and Medicaid Services, and several states as part of their Medicaid quality initiatives. In January 2016, TJC required all hospitals with 300 or more births per year to report the perinatal care (PC) core measure set including PC-02, NTSV cesareans. Nationally, this means that more than 80% of hospitals are now required to report on NTSV cesareans.

In 2014, ACOG and the SMFM published the Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery that outlined 18 clinical strategies to reduce unnecessary cesareans. In 2015, the Alliance for Innovation on Maternal Health (AIM), a national, multi-stakeholder program, released the Safe Reduction of Primary Cesarean Births Bundle. This bundle is meant to be a widely implemented, easily adopted set of strategies for the safe, evidence-based reduction of primary cesareans. Similarly, the ACNM is spearheading the Reducing Primary Cesareans project with associated bundles for reduction of cesarean births. Clearly, a national agenda for the reduction of cesarean is mounting from many collective, cohesive fronts.
Part I. Readiness: Improving the Culture of Care, Awareness, and Education

Recognizing the Value of Vaginal Birth

Unless the undeniable value of vaginal birth is recognized by all sectors of the health care delivery system and the public, any attempt to reduce current cesarean rates will likely be unsuccessful. The high rate of cesareans among low-risk nulliparous women means that more healthy women and newborns than necessary are exposed to potential harms with little or no benefit. Nonetheless, in recent years, convincing hospitals, health care providers, and the public of the value of vaginal birth has been difficult. The Task Force identified four major factors that contribute to this difficulty (Table 2).

Table 2. Readiness: Major Factors Influencing the Culture of Care and the Value of Vaginal Birth

<table>
<thead>
<tr>
<th>Readiness: Major Factors Influencing the Culture Of Care and the Value of Vaginal Birth</th>
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<tbody>
<tr>
<td>1. Casual acceptance of cesarean delivery (no public or institutional agenda for change)</td>
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<tr>
<td>2. Knowledge deficit among women, families, and providers of benefits of vaginal birth</td>
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<tr>
<td>3. A provider-centered maternity care culture that underappreciates women’s informed</td>
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<tr>
<td>choices, values, and preferences</td>
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<tr>
<td>4. Payment/reimbursement models that conflict with high-value, high-quality maternity</td>
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<td>care</td>
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Casual Acceptance of Cesarean Birth

Cultural influences on attitudes toward birth are powerful, and vary across time and place. Today’s childbearing women are more technology-driven than ever before. Moreover, providers and nurses newly entering the workforce are similarly familiar with, accepting of, and dependent on technology. It is therefore no surprise that both consumers and providers exhibit a pervasive tolerance for increasingly technological childbirth, including the casual acceptance of cesarean birth as a safe and easy way to give birth.

Knowledge Deficit Regarding Benefits of Vaginal Birth

Fewer women are utilizing established models of prenatal education such as childbirth education classes. The recent Listening to Mothers III survey indicates that only about half of all mothers participated in established, in-person childbirth
education classes. Instead, most women now rely on childbirth information from multiple — primarily electronic and digital — media sources, including the Internet, videos, reality TV, and social media, to educate themselves and support decision making. Research exploring electronic and digital media representations note that they are the dominant means of creating and sharing culture among women of childbearing age. This raises concerns about women’s exposure to poor quality and conflicting information, and about the negative impact of the prevailing media representations of childbirth, which emphasize the “pain, fear, and risks, associated with childbirth, coupled with a strong emphasis on medical technology and interventions for childbirth.” This perspective contributes to deficient, erroneous and fraught beliefs surrounding pregnancy and birth, and limits awareness of other ways of understanding birth.

Furthermore, the fear of childbirth that is deeply embedded in American birthing culture has a significant impact on the perceived value of vaginal birth and is a critical determinant of women’s birth choices and experiences. Research demonstrates that women with high levels of fear view birth as inherently risky and express preference for obstetric interventions. Cultural narratives perpetuated in the media portray pregnancy and labor in conflicting and polarizing ways. Labor pain is alternately characterized as excruciating or debilitating, which serves to confuse women and to increase their fears.

The current model of prenatal care may lead to missed opportunities for educating women about labor and birth. For example, most standard prenatal care visits are generally less than 10 minutes in length. Prenatal care providers are often challenged by the dual expectation to provide high quality care and simultaneous patient education. This puts significant restrictions on talking, teaching, and answering questions. The result is that many women will not think about certain care decisions until they are actually in labor, when they are so much more vulnerable to constraints of time, pain, and stress.

Many providers and nurses also exhibit a knowledge deficit about the benefits of vaginal birth. Whether nurses or providers view the current cesarean trend as a significant quality improvement issue depends on a convergence of factors, including training, experience, and current role. Data from California hospitals suggest that many providers may not find the current rate of cesarean birth to be problematic. Because a first cesarean is quite safe by today’s standards, the future risks of multiple repeat cesareans, such as the considerable step-wise increase in life-threatening hemorrhage, may not be fully appreciated or considered by all practicing obstetricians.

A Maternity Culture that Underappreciates Women's Informed Choices and Preferences

In general, today’s maternity care system is moving along with the rest of the health care system toward patient-centered care. A patient-centered maternity care culture:

- **Respects individual values, choices, preferences, and cultural backgrounds of all women and their families**
- **Ensures women are treated with dignity, respect, kindness, and cultural sensitivity throughout the course of pregnancy, labor and birth, and the postpartum period**
- **Promotes optimal health outcomes for women and newborns through “effective communication, shared decision making, teamwork, and data-driven quality improvement initiatives”**

Despite this overall trend, however, and the importance of educating and involving women as partners in care, decisions about pregnancy and birth are often made by providers rather than by women. Institutional practices and caregiver workflows, even as far as timing of birth, may take precedence over women’s informed choices. The Listening to Mothers II and Listening to Mothers III surveys, both with nationally representative samples, found that providers made decisions regarding cesarean birth more than twice as often as women did, under all conditions. Listening to Mothers III found that 13% of women felt pressure to have a cesarean; this rose to 28% among women with a primary cesarean. While a very small portion of women may desire a pre-labor cesarean, data from this survey do not support the suggestion that maternal requests for cesareans contribute significantly to the high cesarean rate. To the contrary, the evidence indicates that women prefer vaginal birth — less than 1% of women reported choosing a non-medically indicated cesarean for their first birth. The same survey revealed that women overwhelmingly perceive care providers to be “very trustworthy” or “completely trustworthy.” This puts providers in a unique position to promote vaginal birth as the optimal mode of delivery, and to create positive messaging surrounding its benefits.
Payment/Reimbursement Models that Conflict with High-value, High-quality Maternity Care

Maternity care is fertile ground for payment reform. Maternity and newborn care together represent the most costly category of hospital expenditures for all payers, including Medicaid. Payment reform is essential to delivering higher value care and improving the health of women, but within a multi-strategy approach to reducing primary cesareans, payment reform may be one of the most difficult elements to influence. Understanding the complexity of maternity care reimbursement is integral for change in this landscape, and ultimately for the success of overall health care reform.

Though payment schemes differ between Medicaid and private payers, under the current system both entities reimburse hospitals at a higher rate for cesarean than for vaginal birth. In California, the average cost of maternal care for women with commercial insurance, according to a 2010 analysis, was 40% higher for cesarean births than for vaginal births. Other analyses show average maternal care costs for cesarean births to be 50% higher than vaginal births. Facility (hospital) costs form the greatest part (upwards of 50%) of these costs, with provider fees making up about 20-25% of payments by private insurers and Medicaid. Higher reimbursement for cesarean births may lead to lack of incentive for a hospital to support change, specifically to invest in quality improvement projects to lower cesarean rates.

Though hospital reimbursement remains higher for cesarean births, many payers have attempted to curb provider incentives to perform cesarean by fixing rates of reimbursement regardless of mode of birth. For that reason, many providers nowadays bill under a “global obstetric fee” that bundles the reimbursement for routine prenatal care, labor and delivery, and postpartum care, a large portion of which is delivery-based. Unfortunately, having a payment method that is delivery-based but that offers no financial incentive for vaginal birth may indirectly result in a time-based incentive to prematurely end long labors with cesarean, or to induce labor while on-call in order to ensure one’s presence at the birth. This is especially true in the current environment, in which more than ever before providers must balance clinic obligations, personal life, and on-call time in the hospital.

Another important issue for consideration is that major payers do not routinely reimburse for high-value services that may directly affect rates of cesarean. These services include such things as the kind of time-consuming health education needed to promote shared decision making, childbirth education classes, and expanded preventive services for women with chronic conditions, all of which may increase the number of successful vaginal births. The current system also does not incentivize innovative methods of labor support (e.g. doula care), requiring that patients incur these costs or rely on the hospital or community programs to provide it as a free service. In a similar fashion, payers’ current method of bundling postpartum visits and not routinely paying for preconception care fails to give providers any incentive to educate women on the important choices which may influence outcomes and costs in the subsequent pregnancy. This includes important aspects of contraception, medical management of chronic diseases/obstetric complications, and planning for pregnancy after prior cesarean birth. For many providers it is simply not financially feasible to provide these high-value services without adequate reimbursement.
# Improvement Strategies

## Table 3. Key Strategies for Improving the Culture of Care, Awareness, and Education for Cesarean Reduction

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<table>
<thead>
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<tbody>
<tr>
<td><strong>1</strong></td>
<td><strong>Improve Quality of and Access to Childbirth Education</strong></td>
<td><strong>3</strong></td>
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<tr>
<td></td>
<td>• Align hospital practices and philosophies with evidence-based childbirth education</td>
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<td></td>
<td>• Collaborate to assess and mitigate barriers to childbirth education (including cost, time of day), and include flexible educational formats such as high quality web content or interactive web-based learning</td>
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<td></td>
<td>• Implement prenatal care models that efficiently integrate comprehensive pregnancy and childbirth education into routine visits, such as group prenatal care</td>
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<td><strong>2</strong></td>
<td><strong>Improve Communication through Shared Decision Making at Critical Points in Care</strong></td>
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<td></td>
<td>• Train providers, nurses, and staff on the essential elements of effective communication and shared decision making</td>
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<td>• Design shared decision making discussions around the major decision points that impact the risk for cesarean, and effectively and routinely incorporate these discussions into regular prenatal visits</td>
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<td></td>
<td>• Improve the shared decision making process through the utilization of high-quality, evidence-based decision aids in consumer-preferred formats specific to the woman’s literacy level</td>
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<td></td>
<td>• Adapt the clinical environment in order to integrate patient engagement and shared decision making into routine care (such as adjusting workflows to allow ample time for questions and educational opportunities)</td>
<td><strong>5</strong></td>
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<td></td>
<td>• Respect and value differences in culture and religious beliefs</td>
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1. Improve Quality of and Access to Childbirth Education

Improving Quality

One of the Healthy People 2020 goals is to “increase the proportion of women who attend prepared childbirth classes.” Women who are well-prepared for labor and birth are better situated to engage with providers in conversations about care, create realistic and informed plans, and to share in decision making at points in time when the greatest impact on maternal and infant outcomes is most likely.

Unfortunately, hospital philosophies and policies are not always congruent with evidence-based childbirth education. This disconnect often makes the information disseminated through formal classes irrelevant once the woman enters the birthing facility. Hospital providers and nurses may find themselves in a conflicted position where the patient believes a certain type of care will or should be given (e.g. less routine intervention) and feels confused as to why, for example, they are not allowed to walk, must have continuous monitoring, or are encouraged to use pitocin. Later sections of this toolkit will address the safe reduction of routine obstetric interventions, but suffice to say here that for most low-risk, nulliparous women, few interventions are needed for labor to progress safely and normally. It is thus incumbent upon hospitals, providers, and nurses to collaborate with childbirth educators to disseminate curriculum that is evidence-based, and that remains relevant to the patient upon entry to the labor and delivery unit.

Lamaze International, Childbirth Connection, and the Coalition for Improving Maternity Services are reputable sources that can guide facilities in the design of childbirth education material. The Lamaze website offers downloadable handouts, videos, and inexpensive online classes for parents, which promotes Lamaze’s vision of “knowledgeable parents making informed decisions.” Lamaze has passed high standards set forth by the National Commission for Certifying Agencies and holds professional status as an American Nurses Credentialing Center accredited provider. Lamaze also offers an App for smartphones that provides much of the information from the website.

Changing certain hospital policies, such as instituting a freedom of movement policy, intermittent monitoring for low-risk women, or offering a full array of nonpharmacologic methods to promote comfort and coping may be necessary in order to practice high-quality maternity care in alignment with evidence-based childbirth education.

Improving Maternity Services are programs that provide both comprehensive prenatal care and patient education. Creating standardized, pre-packaged patient education materials (such as “new patient packets” or packets distributed by trimester), or agreeing to distribute certain reputable web-based prenatal and childbirth education resources (such as from the organizations listed above) are an easy and efficient way for providers to engage in effective prenatal education.

Improving Access

Changing the way providers are faced with limited time to provide both comprehensive prenatal care and patient education. Creating standardized, pre-packaged patient education materials (such as “new patient packets” or packets distributed by trimester), or agreeing to distribute certain reputable web-based prenatal and childbirth education resources (such as from the organizations listed above) are an easy and efficient way for providers to engage in effective prenatal education.

The Coalition for Improving Maternity Services has done extensive work “encouraging and promoting evidence-based, Mother-and-Baby-Friendly maternity care” and is a valuable resource for designing and implementing mother-friendly policies that are in alignment with evidence-based childbirth education.

The ACNM, the professional association representing certified nurse-midwives and certified midwives in the United States, offers the Share With Women series. This series of consumer-oriented health care articles from the Journal of Midwifery & Women’s Health covers a variety of topics for prenatal care, labor, and birth that can be copied and distributed without permission.

As discussed previously, many providers are faced with limited time to provide both comprehensive prenatal care and patient education. Creating standardized, pre-packaged patient education materials (such as “new patient packets” or packets distributed by trimester), or agreeing to distribute certain reputable web-based prenatal and childbirth education resources (such as from the organizations listed above) are an easy and efficient way for providers to engage in effective prenatal education.

Improving Access

Improving access to childbirth education may require removing or decreasing barriers to attendance (such as cost), providing education in non-traditional formats that meet the needs and time-constraints of the patient (such as high quality web content or interactive web-based learning) and by providing incentives for attending classes.
Also, group prenatal care, such as that offered through the CenteringPregnancy® model, provides an extraordinary opportunity to improve the quality of childbirth education, increase efficiency of care, and improve overall outcomes.\textsuperscript{65,70} Education, patient engagement, and increased time with the provider are built into this care model. This type of group care has been shown to improve patient satisfaction and knowledge, and is associated with lower rates of cesarean birth as compared to the traditional, provider-centric prenatal care model.\textsuperscript{65,71}

2. Improve Communication through Shared Decision Making at Critical Points in Care

Informed consent has become a fundamental principle of health care, and requires that health professionals engage patients in a process to provide information on benefits, risks, and alternatives of a proposed treatment before the patient makes an informed decision to accept or refuse treatment.\textsuperscript{72} Providers must ensure that informed consent is “more than just signing the consent form.”\textsuperscript{73} Protection of patient autonomy, which is the primary purpose of informed consent, requires “open communication between provider and patient, and sharing of relevant information and adequate disclosure, to enable the patient to exercise personal choice.”\textsuperscript{74}

In recent years, out of concern for inadequacies of current legal concepts of informed consent, a growing number of health care leaders, policymakers and other stakeholders have called for revision of current methods in favor of shared decision making\textsuperscript{75} (Figure 4). Shared decision making is a collaborative process between the provider and patient that “takes into account the best available scientific evidence, as well as the individual’s values and preferences, to determine the right course of care.”\textsuperscript{76} Shared decision making helps “protect patient self-determination and balance patient autonomy with provider expertise and beneficence.”\textsuperscript{75} The ACOG Committee Opinion 492 Effective Patient-Physician Communication states that shared decision making promotes patient engagement, treatment adherence, and improved outcomes while reducing risk.\textsuperscript{74}

More specifically, by identifying the major decision points that most impact the risk for cesarean birth, providers can markedly improve the patient’s knowledge deficit and decision making (Table 4). Given that prenatal visits are often short and that nearly half of pregnant women do not participate in formal childbirth education classes,\textsuperscript{38} informed decision making at critical decision points should
utilize high-quality decision aids. Evidence-based decision aids improve the shared decision-making process by presenting various treatment options in an unbiased way, which facilitates an informed decision that aligns with the patient’s values and preferences. A systematic review of decision aids specific to maternity care has shown that they can improve knowledge and satisfaction while reducing anxiety and decisional conflict. For maximum effect, such decision aids should be available in consumer-preferred formats, including multi-media and print resources and should be appropriate for the patient’s literacy level. Interactive mobile tools, smart tools that incorporate patient health data, and social networks/social media tools are other promising innovations for shared decision making.

Table 4. Patient Decision Points that Impact Risk of Cesarean

<table>
<thead>
<tr>
<th>PATIENT DECISION POINTS THAT IMPACT RISK OF CESAREAN</th>
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<tbody>
<tr>
<td>Choice of provider and/or facility for prenatal care and care at time of birth</td>
</tr>
<tr>
<td>Timing of admission to hospital (admission to labor and delivery while still in the latent/early phase is associated with an increased risk of cesarean)</td>
</tr>
<tr>
<td>Choice of fetal monitoring method (continuous monitoring is associated with an increased risk of cesarean)</td>
</tr>
<tr>
<td>Whether to have continuous labor support by a trained caregiver like a doula (continuous labor support improves chances of having a vaginal birth)</td>
</tr>
<tr>
<td>Induction of labor without medical indication (depending on the provider and facility, induced labor may be associated with higher rates of cesarean)</td>
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</tbody>
</table>

Given that many of these major decision points will arise before labor begins and will be of concern throughout the period of care, women must be provided with regular opportunities for education and discussion. These opportunities may range from conversations with providers during prenatal visits, to the development of a collaborative birth plan, involvement in childbirth education classes, or enhanced prenatal care grounded in collaborative education and decision making. To incorporate patient engagement into routine care, the clinical environment may need to be adapted. For example, providers and staff should be trained on the essential elements of effective communication and shared decision making; workflows should be adjusted to provide ample time during prenatal visits for questions to be answered and preferences to be heard; and barriers to participation in childbirth education classes (such as time of day and cost) should be considered and mitigated. Also, cultural differences, belief systems, and literacy levels must be respected and valued.

“Both research and practice show that engagement leads to safer patient care by improving the outcomes of care, improving the experience of care for individual patients, improving the work experience of caregivers, and — by helping the organization change its processes—improving the outcomes for all patients”

— from Safety is Personal, a publication of the National Patient Safety Foundation’s Lucian Leape Institute.77

3. Bridge the Provider Knowledge and Skills Gap

Providers, hospitals, and policymakers have a responsibility to engage in practices that ultimately “reduce the burden of illness, injury, and disability, and to improve the health status and function of the people of the United States.”90 However, if providers and nurses perceive cesarean birth to be just as safe for low-risk women and/or do not have the skills necessary to support and protect the first vaginal birth, then reducing the burden of unnecessary interventions among this population will not be achieved. Strategies that serve to bridge the knowledge gap within the microsystems that provide direct care (nurses and providers) through the macrosystems that support this care (hospital systems, health care organizations, and national and/or regional organizations that support professional development) include:

• Improving the content of professional education and continuing education

• Incorporating interprofessional training and mentorship of nursing and medical students, nurse-midwifery graduates, and medical residents

• Ensuring that all providers and nurses maintain the critical skills necessary to support vaginal birth

• Creating a culture of transparency for hospital and provider level data

Professional education and continuing education programs can significantly influence the culture of care through widespread dissemination of the current cesarean trend as a major barrier to quality maternity care.37 Furthermore, improving the content of professional education for all maternity providers and nurses should include a redesign of curriculum to foster a greater focus on the “wellness model of care” for low-risk women and on principles of physiologic childbearing.91,92 Medical and nursing boards should contain questions relevant to these goals. Incorporating interprofessional training and mentorship of nursing students, medical students, new nurse-midwifery graduates, and medical residents is integral to fostering a generational change in how modern hospital-based maternity care is delivered.58,93,94

It is critical to ensure that all providers and nurses maintain the critical skills (the components of which are further explicated in this toolkit) necessary to support first and subsequent vaginal births and create awareness of the significance of provider decisions and nursing support in determining the outcome of vaginal birth.37,91

It is not uncommon to hear how a woman’s Birth Plan is a sure “ticket to the operating room.”89 On the contrary, Birth Plans offer a unique opportunity for providers to engage women in shared decision making early in the prenatal period and to discuss expectations, fears, gaps in knowledge, and specific decision points that may impact a woman’s risk of cesarean.

Consult Appendix E for the CMQCC Birth Preferences Guide, an adaptation of many well-written birth plans from various facilities.
Additionally, provider knowledge is enhanced through a culture of transparency of hospital and provider level data. Transparency clarifies a provider’s own cesarean rates, and potentially improves a provider’s valuation of vaginal birth. Furthermore, public reporting of this data improves consumer knowledge of quality providers, thus harnessing the power of consumer decision making to create a positive feedback cycle where quality is both created through transparency and sought out as a result of transparency (section IV will further outline public reporting).

4. Improve Support from Senior Hospital Leadership and Harness the Power of Clinical Champions

Improving perceptions about the value of vaginal birth from the institutional perspective is a major aim of this toolkit. First, the full support of senior leadership at the departmental and executive levels is a critical component of change in perinatal care. Executive and departmental leaders are positioned to positively frame the message for cesarean reduction, have various communication tools at their disposal, and have the financial resources to support quality improvement. The leadership also sets the mission and goals for the institution and has the ability to empower clinical champions to take action. Strong leadership, or the lack thereof, often determines the success or failure of a healthcare organization’s efforts to improve patient care.

Clinical champions are frontline physicians, midwives, nurses, and other integral staff who are familiar with the specific climate of care within their institution and who understand the specific message that must be tailored to the institution’s unique needs (Figure 5). This group, in the best of cases, should be interprofessional, highly visible, enthusiastically supportive of the project, consummate communicators, and well respected by colleagues. Harnessing the power of clinical champions who are empowered by senior leadership may be the single most effective organizational tool for mounting an institutional agenda for change. Many organizations that engage in patient-centered care or have an overall strong “culture of safety,” have successfully engaged clinical champions over multiple improvement projects. Additionally, these types of facilities utilize patient advisors, particularly, their own former patients, as effective champions for change.

Figure 5. Qualities of Successful Clinical Champions

- Well respected by colleagues and enthusiastically supportive of quality improvement projects
- Establishes effective dialogue with team members early in the process and ensures shared understanding of the desired outcome and the necessary processes to get there
- Improves care and teamwork in emergencies by thorough pre-planning of possible contingencies early in the care process
- Models effective communication and encourages the entire team to practice effective communication styles during drills, huddles, committee meetings, and case presentations
Indeed, garnering support for cesarean reduction requires leaders both inside and outside of the hospital walls. Clear delineation of each entity’s role is necessary to gain traction for change. To that end, the leadership roles for all stakeholders are outlined in Table 5. It is important to note the hierarchical model in this table, with the first level being that of the woman and her family. Patient experiences and expectations create a foundation for the redesign of care processes to support what is valued.101

**Table 5. Leadership Roles and Activities for Stakeholders in Perinatal Care**

<table>
<thead>
<tr>
<th>STAKEHOLDER GROUP</th>
<th>LEADERSHIP ROLES/ACTIVITIES</th>
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<tbody>
<tr>
<td>PATIENTS, FAMILIES, AND THE PUBLIC</td>
<td>Active participation in advisory councils to help providers redesign care which meets patients’ experience expectations; review publicly reported data and use to have meaningful discussions with providers about available choices in care; participate in the necessary childbirth education and other efforts to improve knowledge of the birth process; actively engage in shared decision making</td>
</tr>
<tr>
<td>PROVIDERS AND NURSES</td>
<td>Endorse the culture of “valuing vaginal birth;” develop clinical change and quality improvement leadership skills; actively participate in improving clinical skills and knowledge needed to achieve safe vaginal delivery; understand how to utilize metrics to improve care; participate in necessary care model development</td>
</tr>
<tr>
<td>MEDICAL GROUPS/HOSPITALS/ HOSPITAL ADMINISTRATION</td>
<td>Provide necessary financial and administrative support to help caregivers obtain the necessary skills and resources; hold managers and medical directors accountable for achieving success; endorsement and commitment from the “top” leaders of the organization to the culture of “valuing vaginal birth;” develop/maintain the infrastructure to provide meaningful metrics; ensure involvement of patients and families in solutions to ensure improved experiences and outcomes</td>
</tr>
<tr>
<td>PAYERS AND EMPLOYERS</td>
<td>Careful redesign of payment models which reward providers and enrollees for making the best long and short term decisions regarding birth; ensure the reimbursement models involve and reward team management; develop expert medical directors and staff who understand the process and metrics of providing obstetric care</td>
</tr>
<tr>
<td>NATIONAL AND REGIONAL PROFESSIONAL ORGANIZATIONS, REGULATORY AGENCIES, AND GOVERNMENT OFFICIALS</td>
<td>Review current regulations and standards to ensure that they are in alignment with goals to “value vaginal birth;” work with providers to choose meaningful metrics which can be used to evaluate public health; support providers to ensure that privacy/security and medical legal concerns are addressed</td>
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5. Transition from Paying for Volume to Paying for Value

With the development of the Patient Protection and Affordable Care Act, many health plans are moving to pay-for-performance programs (P4P). These programs create incentives to providers to reach performance and quality targets, thereby increasing quality of care and potentially reducing overall costs. In maternity care, specific quality measures could be easily linked to increased payments to providers, such as achieving target rates of NTSV cesarean, reducing elective births at less than 39 weeks, and improving rates of Vaginal Birth After Cesarean (VBAC).31 Nonetheless, there are currently only a few quality measures in maternity care that directly impact cesarean rates. New quality measures take time to be validated and established as national standards. Additionally, if P4P programs do not address or cannot solve the inherent problems in the underlying system, they will not fundamentally change how providers deliver care or incentivize providers to organize care more efficiently.32 To make a sustained impact on rates of cesarean, innovative payment models are needed, such as those often described as “transitional payment reforms,”
including physician-focused alternative payment models (APMs). These reforms are changes in reimbursement that allow providers to be accountable for aspects of spending, quality, and outcomes that they can actually control without requiring them to incur significant financial risk or accountability for outcomes and expenses they clearly cannot control.

There is no one-size-fits all APM, but many promising routes exist. The process of choosing a payment reform model should include consideration of the needs of all stakeholders:

- **Providers will desire a model that moderates significant financial risks**
- **Payers and purchasers will desire minimal changes in claims administration and will need to see rapid reductions in cost, or stabilization of costs**
- **Patients will require improvement in quality and/or affordability, such as expanded access to programs**

Innovative changes in payment require a certain amount of knowledge and sophistication on the part of both providers and payers. Converting to these innovative methods of reimbursement will require well-integrated teams. Appropriate oversight entities familiar with obstetric care will need to design and administrate the proper care, oversee cost and quality performance, and contract with payers. The digital tools required for quality and value reporting will demand related efficiencies. Data quality and governance will be critical in providing reliable feedback and fair payment. Transparency of data that is shared and trusted will be critical for consumer participation and the willingness of providers and payers to continue participation in new models of reimbursement (see Part IV for more on transparency and public reporting). In fact, innovative payment design is inherently connected to the future of patient-centered maternity care. When patients actively engage in decision making, are encouraged to seek out high-value care through publicly reported data and financial incentives, and demand more person-focused approaches to care delivery, the system will be required to coordinate care, focus on quality, and share risk. At present, it is unclear which particular payment model would contribute most to lowering cesarean birth and improving maternity care as a whole. Value-based care is currently evolving, and providers and payers must be willing to revise payment methods as necessary if, for example, cost and outcomes do not proceed as expected.

### Table 6. Examples of Alternative Payment Models and the Potential Impact on Cesarean Birth Rates

<table>
<thead>
<tr>
<th>Type of Alternative Payment Model</th>
<th>Description</th>
<th>Potential Impact on Cesarean Rates</th>
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<tbody>
<tr>
<td>Blended Facility Payments</td>
<td>A blended payment creates a single rate regardless of mode of birth, and is essentially a “blend” of the proportion of vaginal to cesarean births</td>
<td>Removes the significant reimbursement differential between cesarean births and vaginal births, potentially incentivizing a facility to engage in cesarean reduction efforts (helps to align provider and facility quality improvement efforts)</td>
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<tr>
<td>Bundled Payments (various types)</td>
<td>A hospital birth payment and the professional (provider) fee bundled into one prospectively set amount means one fee for labor and birth services is paid to cover hospital fees and all fees to providers</td>
<td>Encourages a coordinated team effort to improve quality and reduce overall cost (such as through a shared savings program) while still giving providers full responsibility for how to best manage care in alignment with shared outcome goals</td>
</tr>
<tr>
<td>Comprehensive Bundling of the “Maternity Care Episode”</td>
<td>A hospital birth payment bundled for both mother and infant means maternity expenses and NICU care of a normal term infant without preexisting conditions are bundled into one prospectively determined payment (NICU care for prematurity, intrauterine growth restriction, known congenital conditions, and other selected exclusions would be paid separately from the bundle)</td>
<td>Potentially reduces maternity care practices that increase the chances of a normal newborn needing NICU services (such as early elective delivery and other practices that may impact cesarean rates)</td>
</tr>
<tr>
<td>Warranted Payments</td>
<td>The upfront payment of an amount that is greater than the payment for labor and birth services alone incentivizes providers to control costs and engage in cesarean reduction efforts and other quality improvement programs to reduce adverse events</td>
<td>Theoremically leads to creative ways of controlling outpatient costs and more incentive to engage in quality improvement activities in order to reduce avoidable complications and cesarean birth</td>
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**CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans**

35
Example 1. Blended Facility Payments for Birth

Instead of paying a facility different rates based on type of care delivery, a blended payment creates a single rate regardless of mode of birth, and is essentially a “blend” of the proportion of vaginal to cesarean births.\(^\text{62}\) For example, if an uncomplicated vaginal birth costs $8,000 and a cesarean costs $11,000, and the facility’s rate of cesarean is 32%, then one way to calculate a blended rate would be as follows:

\[
\text{Blended rate} = (0.32 \times 11,000 + 0.68 \times 8,000) / (0.32 + 0.68) = \$8,960 
\]

There are various ways to create blended payments. Another example is to set the blend rate at what the proportion of vaginal to cesarean births ought to be,\(^\text{31}\) as determined by the institution. For example, the blend rate could be set at a reasonable target of 25% for cesarean births, potentially lower than the facilities’ current rate, but one that provides a reachable target and reasonable payment and that acts to create incentive to lower the facility’s rate.

Adjusting for risk level of the patient population could further refine blended payments. One example, implemented by the Washington State Medicaid program, includes blending the rates for vaginal birth with complications, vaginal birth without complications, and cesarean birth without complications into a single payment rate while leaving cesarean birth with complications as a separate fee.\(^\text{31}\)

Blended payments can be quite flexible. They can be applied to the current model of reimbursement or used in conjunction with other alternative models noted below.\(^\text{62}\) However, challenges do exist. Defining the optimal payment amount is critical. The point of blended payments is to remove the significant price differential between cesarean births and vaginal births. If set too low or too high, there may be no incentive for the facility and associated providers to engage in cesarean quality improvement efforts. This will likely require further demonstration projects, such as the recent CMQCC and PBGH pilot project to reduce NTSV cesareans in three Southern California hospitals (see Part V). This project, funded by the Robert Wood Johnson Foundation, involved specific cesarean reduction efforts within each hospital, data measurement and analysis, and the creation of a blended, flat case rate implemented by several selected health plan partners.\(^\text{105}\) While this project was time-intensive (especially the negotiations with health plan partners to design the blended case rate), and “growing pains” were inevitable to such a fundamental change in payment structure, the project proved that successful payment reform between major payers, hospitals, and providers is possible and replicable. Furthermore, the project demonstrated that while payment reform serves as only one of many incentives to improve NTSV cesarean rates, it is a strategy that may serve as a critical motivator when further alignment of hospital goals with target NTSV cesarean rates is necessary.

Example 2. Bundled Payments

Many options exist for the bundling of payments for maternity care, with each option having its own advantages and disadvantages. Bundling payments essentially creates a type of “accountable care” that returns care management decisions back to providers\(^\text{31}\) and incentivizes quality rather than reimbursing for individual units of service.\(^\text{62}\) Challenges to bundled payment methods include calculating fair payment rates, identifying standard exclusions to the bundles (i.e. certain conditions that would require supplemental payments), creating risk-adjusted bundles in certain circumstances, and implementing changes to the reimbursement structure in order to accommodate a new way of billing and dividing payment.

1. Hospital Birth Payment and the Professional (Provider) Fee Bundled into One Prospectively Set Amount

In this particular model, one fee would be paid to cover hospital fees and all fees to providers for labor and birth services. This type of payment structure encourages a coordinated team effort to improve quality and reduce overall cost while still giving providers full responsibility for how to best manage care in alignment with shared outcome goals.\(^\text{62,102}\)

2. Hospital Birth Payment Bundled for Both Mother and Infant

In this model, maternity expenses and infant care immediately after birth are bundled into one payment. NICU care of a normal, term infant without preexisting conditions is included in this bundle, potentially reducing maternity care practices (such as early elective delivery) that increase the chances of a normal newborn needing NICU services.\(^\text{31,69}\) NICU care for prematurity, intrauterine growth restriction (IUGR), known congenital conditions, and other selected exclusions would be paid separately from the bundle.

3. Entiety of the “Maternity Care Episode” Bundled into a Single Payment

This sort of bundling is the most comprehensive model and includes a risk-adjusted bundled payment for all prenatal care, lab work and ultrasounds, and labor and delivery fees.\(^\text{62}\) Execution of this “total cost of pregnancy” model theoretically leads to creative ways of controlling outpatient costs and more
incentive to provide stronger patient education and shared decision making during prenatal care, particularly at critical decision points that influence risk of cesarean birth. One example of this method currently being tested in sites around the nation is the PROMETHEUS Payment® approach. Developed by the Health Care Incentives Improvement Institute (HCII), this payment method establishes a “Pregnancy and Delivery Evidence-Informed Case Rate,” which is a patient-specific budget that is adjusted for the complexity of any given patient. Because the rate is paid for an entire episode of care (comprehensive bundling of pregnancy and birth), providers and hospitals are incentivized toward creative ways to reduce avoidable complications, which potentially includes engagement in cesarean birth quality improvement activities.

Example 3. Warrantied Payments

Warrantied payments are single payments that cover the normal cost of provider services, such as the cost of labor and birth, plus the cost of potentially avoidable complications or adverse events. Because a certain minimal number of complications are expected to occur, the increased cost of treating adverse events is built into the amount of the warrantied payment. The upfront payment of an amount that is greater than the payment for labor and birth services alone allows providers to flexibly redesign care in a way that reduces adverse events while simultaneously being rewarded with a built-in bonus if complications are significantly reduced. If the patient faces complications that arise from the initial service, the provider does not receive additional reimbursement. This model incentivizes providers toward quality improvement in all aspects of maternity care in order to reduce unexpected adverse events. Cesarean birth carries more risk of complications than vaginal birth, including readmission to the hospital. Thus, warrantied payments may provide an effective option to safely reduce cesareans.

Though the term “warranty” is generally thought of as a consumer protection, warrantied payments should not be confused with “outcome guarantee.” Rather, under warrantied payment methods, payers and providers merely agree on the situations that qualify as potentially avoidable complications. Standardized national quality measures should be used to set the warrantied payments, when possible. For patients to fully understand the warranty and thereby enhance consumer decision making, rates of avoidable complications should be publicly reported and easily accessed by the consumer.
In 1954, Dr. Emanuel Friedman and colleagues published the first in a series of reports on normal labor. His initial work looked at 100 term primigravidas who presented in labor early enough to allow for study of the full length of labor. Following this initial investigation, a larger study was conducted with 4,175 women. Cervical dilation over time was plotted and the resulting shape became universally known as Friedman’s Curve — the “normal” parameters of which are ubiquitous in modern obstetric care. More than 60 years and 200 million laboring women later, a new labor curve has emerged. Zhang et al. and the Consortium for Safe Labor published an influential document in 2010 that included 62,415 labors. This nationally representative, multi-center study of term patients with a singleton fetus in vertex presentation included women who underwent spontaneous onset of labor resulting in vaginal delivery with normal perinatal outcomes. Whereas a cervical dilation of 4 centimeters (cm) was previously used to diagnose the onset of active labor, Zhang’s work overwhelmingly reflected that the steepest part of the labor curve – in other words, when the fastest rate of cervical dilation begins – occurs at 6 cm. Furthermore, nulliparous and multiparous women had similar rates of cervical change until 6 cm, at which time multiparous labors progressed much more rapidly. Also, the length of time needed to progress from 4 cm to 6 cm was slower than earlier reported, with the Zhang study noting that it may take “more than 6 hours to progress from 4 to 5 cm and more than 3 hours to progress from 5 to 6 cm of dilation.” Data from other studies indicate that even more patience is necessary for certain patient populations shown to have longer labors, including women older than 35, induced labors, and obese women. Despite this convincing evidence that parameters for length of labor in previous decades were far too stringent, universal acceptance of these new standards for identifying the onset of active labor has not occurred. For that reason, clinical patience is the focus of many of the recommendations in the ACOG/SMFM Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery. Understanding what is “normal” is fundamental to the judicious use of interventions during labor and birth. The recent information, from the studies described above, creates the backdrop that should inform how providers and nurses define what is normal in day-to-day clinical decision making. Nonetheless, current obstetric care in the United States remains distinctly different from the rest of the world, applying a high-risk model to all
women and overusing costly procedures that increase risk. At the same time, current care underutilizes beneficial, low-cost interventions that are readily available, easy to implement, and well suited for low-risk women.55,91

The Task Force identified six barriers to supporting intended vaginal birth (Table 7).

### Table 7. Barriers to Supporting Intended Vaginal Birth

<table>
<thead>
<tr>
<th>Recognition and Prevention: Barriers to Supporting Intended Vaginal Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lack of institutional support for the safe reduction of routine obstetric interventions</td>
</tr>
<tr>
<td>2. Admission in latent (early) labor without a medical indication</td>
</tr>
<tr>
<td>3. Inadequate labor support</td>
</tr>
<tr>
<td>4. Few choices to manage pain and improve coping during labor</td>
</tr>
<tr>
<td>5. Overuse of continuous fetal monitoring in low-risk women</td>
</tr>
<tr>
<td>6. Underutilization of the current treatment and prevention guidelines for potentially modifiable conditions (e.g. breech presentation and recurrent genital herpes simplex virus)</td>
</tr>
</tbody>
</table>

### Lack of Institutional Support for the Safe Reduction of Routine Obstetric Interventions

A joint statement from ACOG, AWHONN, ACNM, AAFP, SMFM and others titled Quality Patient Care in Labor and Delivery: A Call to Action succinctly states, “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.”66 Despite the fact that most women are at low-risk for complications, the vast majority of women who deliver in hospitals are faced with liberal use of common obstetric interventions and procedures. These include routine use of pitocin, continuous fetal monitoring, and induction of labor. This suggests that many providers may not fully appreciate their role in the prevention of iatrogenesis through more judicious use of interventions.55

### Admission in latent (early labor without a medical indication)

The work by Zhang and colleagues in 2002 showed that half of patients entered the active phase of labor by 4 cm, three-quarters entered active phase by 5 cm, and nearly all by 6 cm.109 Zhang’s criteria reinforce something providers fully understand — that there is more to diagnosing active phase of labor than cervical dilation alone and that often it is a diagnosis that can only be made retrospectively.111 The decision to admit is further complicated by the patient’s level of discomfort and the expectation by some patients to be admitted upon arrival.112

Despite these difficulties, thoughtful management at the point of admission is likely the first decision a provider will make in supporting vaginal birth.107 The evidence is clear: latent phase admission is associated with higher rates of cesarean delivery 86,113,114 and more interventions throughout the course of labor,113-115 including a “two-fold increased use of oxytocin.”107 In a recent study of 20 hospital systems, NTSV cesarean rates were strongly correlated to specific modifiable hospital practices, including early labor admission rates.86 Nonetheless, many patients are admitted to the labor and delivery suite while still in latent labor111 and, in many cases, with only a presumptive diagnosis of active labor based solely on a cervical dilation of 3.5 to 4 cm.

### Inadequate Labor Support

Historically, before the rise of hospital birth, labor and birth took place in a family’s home, with the laboring woman supported and cared for by her midwife, other experienced women, and her family. Though much has changed with modern birth, women’s need for such physiological and psychological support has not. This support includes providing information, emotional support, and physical comfort to a laboring woman, as well as advocating for her wants and needs.82 Labor support reduces the need for analgesia, operative vaginal delivery, potentially shortens labor, and is associated with a significant reduction in cesarean delivery.82,116-118 Additionally, women report that emotional support during labor is more meaningful to them than pain medication and physical support.119

### Table 8. Benefits of Continuous Labor Support82

<table>
<thead>
<tr>
<th>Benefits of Continuous Labor Support</th>
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</thead>
<tbody>
<tr>
<td>Less likely to have a cesarean birth</td>
</tr>
<tr>
<td>Slightly shorter labor</td>
</tr>
<tr>
<td>More likely to report satisfaction with birth experience</td>
</tr>
<tr>
<td>Less likely to need the assistance of vacuum or forceps</td>
</tr>
<tr>
<td>Less likely to need pain medications</td>
</tr>
<tr>
<td>Babies less likely to have low 5-minute Apgar scores</td>
</tr>
</tbody>
</table>
Supportive Care from Spouses, Partners, and Family Members

Labor support is not only the purview of the labor and delivery nurse. Nearly three-quarters of women rely on their partner as a source of supportive care, and one-third rely on another family member or friend at some point during labor.\textsuperscript{38,126} Nonetheless, partners and family members may be minimally prepared in how to support a woman in labor.\textsuperscript{127} This is especially true if the patient chooses non-pharmacologic or minimal pharmacologic methods of pain relief, and therefore is in greater need of assistance with physical comfort.

Supportive Care from Doulas

A birth doula is a trained professional who continuously supports the physical and emotional needs of the patient during labor.\textsuperscript{128,129} Continuous labor support is associated with a significant reduction in cesarean delivery, operative vaginal delivery, and use of oxytocin.\textsuperscript{82,126,129,130} The ACOG/SMFM consensus statement states: “Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula…Given that there are no associated measurable harms, this resource is probably underutilized.”\textsuperscript{3}

\textbf{"Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula...Given that there are no associated measurable harms, this resource is probably underutilized."}

\textsuperscript{ACOG/SMFM Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery (2014).}\textsuperscript{3}

Reasons for underutilization are varied but include knowledge deficit about what a doula is/does, objections from partners, geographic lack of access to a doula, and cost.\textsuperscript{130} Also, while some nurses and providers fully understand a doula’s multi-faceted role and see them as an experienced and valuable team member, others see doulas as an obstacle to care and may have an antagonistic or adversarial view of them.\textsuperscript{131}

Supportive Care from Nurses

Labor and delivery nurses report increased feelings of job satisfaction when able to provide support to laboring women, rather than solely tending to the technical aspects of a birth.\textsuperscript{120} AWHONN identifies labor support as fundamental and intrinsic to the role of the labor and delivery nurse.\textsuperscript{131} Despite this, there are many barriers to nurses providing adequate labor support to patients. These include burdensome and time-consuming nursing documentation and other time constraints, a deficiency in knowledge of hands-on labor support techniques, and a hospital unit culture that does not value labor support as a primary responsibility of the nurse.\textsuperscript{45,122,124} The demands of busy labor and delivery units often leave nurses to care for more than one patient at a time in active labor. High rates of epidural use by laboring women may contribute to a perceived need for less support,\textsuperscript{122} and consequently to an erosion of labor support skills. The advent of centralized monitoring has further facilitated moving the nurse away from the bedside where hands-on labor support could be provided.\textsuperscript{45}

Limited Choices to Manage Pain and Improve Coping During Labor

Pain is more than simply the response of sensory neurons to injury or pain stimuli, but also depends in large part on psychological, emotional, social, cultural, and environmental factors.\textsuperscript{132} Labor pain is equally multifactorial but is unique in that, unlike the pain of injury, labor pain is “normal” and non-pathologic.\textsuperscript{133} Furthermore, women’s experiences of labor pain are highly individual, which creates difficulty in describing, assessing, and/or categorizing according to discrete definitions of pain.\textsuperscript{134} Despite these differences from pathologic pain, and the fact that TJC does not mandate the use of a Numeric Pain Scale (NRS) for all patient populations, most hospitals continue to use this standard numeric scale for women in labor, in order to meet TJC’s standards for pain assessment.\textsuperscript{134} Often, a variety of pain management methods, both pharmacologic and non-pharmacologic, are necessary to meet the unique needs of each laboring woman. But reliance on the numeric pain scale, added to the human desire to eliminate pain in patients and loved ones, has contributed to a singular focus on pharmacologic methods of pain relief in most maternity care centers and an underutilization of non-pharmacologic methods that promote coping. These non-pharmacologic methods, such as breathing and relaxation techniques, hydrotherapy, and touch techniques, are usually but inaccurately associated only with patients who desire a “natural” 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. However, excessive pain and suffering may inhibit oxytocin production and labor progress.\textsuperscript{31}
The ability to improve comfort and decrease anxiety according to each woman’s distinct preference is fundamental to promoting labor progress and preventing dysfunctional labor.

Overuse of Continuous Fetal Monitoring in Low-Risk Women

The development of electronic fetal monitoring (EFM) and continuous monitoring of the fetus during labor was intended to improve neonatal outcomes. The reality of continuous monitoring, however, has turned out to be quite different than expected. A recent systematic review revealed that the use of continuous EFM has reduced the rates of neonatal seizures, but has not reduced the rate of cerebral palsy, infant mortality, or the rate of admission to the neonatal intensive care unit (NICU). This same review further outlined that routine use of continuous monitoring, as compared to intermittent auscultation, increases the likelihood of cesarean delivery. Simply put, continuous monitoring of the low-risk patient offers almost no benefit to the fetus while simultaneously increasing the risk of cesarean delivery. Moreover, unless continuous fetal monitoring by telemetry unit is utilized, continuous monitoring adversely affects patient mobility and limits choice of alternative pain relief methods, such as walking, showering or change of position. Additionally, continuous EFM via centralized monitoring may decrease face-to-face time with the nurse, thereby reducing overall supportive care. Intermittent auscultation for low-risk women is supported by the ACOG and noted by the ACNM to be the preferred method of monitoring for low-risk women. Nonetheless, continuous EFM is still the standard of practice for low-risk women in most settings.

Underutilization of Current Treatment and Prevention Guidelines for Potentially Modifiable Conditions

Breech Presentation and Use of External Cephalic Version (ECV)

Current data suggests that breech presentation at 37 weeks of gestation complicates up to 4% of pregnancies. The vast majority (over 85%) of these cases are delivered by cesarean. Despite the ACOG/SMFM consensus statement that “obstetricians should offer and perform external cephalic version (ECV) whenever possible,” and the fact that most patients who undergo ECV will have a successful vaginal birth, this intervention remains underutilized.

Prevention of Recurrent Genital Herpes Simplex Virus (HSV) during Pregnancy

Genital HSV continues to be a major medical concern requiring ongoing surveillance and prevention during pregnancy. Recent assessments of the disease show that nearly 50 million people are infected nationwide. Between 5% and 10% of pregnant women will have a clinical recurrence of the disease during pregnancy, and up to a quarter of these women will have an outbreak in the last month. Neonatal herpes simplex virus, the major complication of genital herpes, is a serious disease of the newborn. The vast majority of these infections are a result of vertical transmission during delivery. More than half of newborns with disseminated disease will die, and a large portion of survivors will suffer significant neurologic impairment. Thus, in order to prevent neonatal herpes, cesarean birth remains the recommended route of delivery for women who present with active genital lesions during labor. Prevention of recurrence during pregnancy, especially at time of labor, is important to cesarean reduction efforts.

Improvement Strategies

1. Implement Institutional Policies that Uphold Best Practices in Obstetrics, Safely Reduce Routine Interventions in Low-Risk Patients, and Consistently Support Intended Vaginal Birth

A key component of consistently providing safe, high quality care is the consistent use of evidence-based practice to inform care decisions. Ample evidence exists to identify maternal care practices that reduce risk and improve outcomes, and policies that incorporate these practices are easily obtainable. The first step is to perform a comprehensive review of existing unit policies and edit such policies to provide a consistent focus on supporting vaginal birth. A robust set of institutional infrastructure documents that support vaginal birth and safely reduce primary cesareans are included in this toolkit and include model policies and procedures, standardized algorithms, and best practice guidelines (see Appendices).
Table 9. Key Strategies for Supporting Intended Vaginal Birth


   • Perform a comprehensive review of existing unit policies and edit such policies to provide a consistent focus on supporting vaginal birth

2. **Implement Early Labor Supportive Care Policies and Establish Criteria for Active Labor Admission**

   • Implement policies that support the physiologic onset of active labor, reduce stress and anxiety for the woman and family, and improve coping and pain management
   
   • Implement written polices that establish criteria for active labor admission, versus continued observation of labor status and/or discharge home
   
   • Give adequate anticipatory guidance during the prenatal period about early labor expectations and the safety of completing early labor at home
   
   • Educate women and families on supportive care practices and comfort measures to facilitate completion of early labor at home

3. **Improve the Support Infrastructure and Supportive Care during Labor**

   • Improve nursing knowledge and skill in supportive care techniques that promote comfort and coping
   
   • Improve unit infrastructure and availability of support tools
   
   • Improve assessment of pain and coping
   
   • Remove staffing and documentation barriers to supportive bedside care
   
   • Educate and empower spouses, partners, and families to provide supportive care

4. **Encourage the Use of Doulas and Work Collaboratively to Provide Labor Support**

   • Integrate doulas into the birth care team
   
   • Improve teamwork, communication, and collegial rapport between nurses and doulas in order to promote safe, patient-centered care and continuous labor support
   
   • Develop unit guidelines to foster the delineation of roles and expectations

5. **Utilize Best Practice Recommendations for Laboring Women with Regional Anesthesia (Epidural, Spinal, and Combined Spinal Epidural)**

   • Do not avoid or delay placement of epidural anesthesia as a method of reducing risk for cesarean delivery
   
   • There is no arbitrary cervical dilation that must be met in order to administer epidural anesthesia
   
   • The patient should be assisted in changing position at least every 20 minutes to assist necessary fetal rotation
   
   • Allow for longer durations of the second stage of labor for women with regional anesthesia (e.g. 4 hours in nulliparous women, 3 hours in multiparous women), as long as maternal and fetal statuses remain reassuring
   
   • Allow for passive descent when there is no urge to push (delayed pushing until there is a stronger urge to push, generally 1-2 hours after complete dilation)
   
   • Preserve as much motor function as possible by administering the lowest concentration of epidural local anesthetic necessary to provide adequate maternal pain relief
   
   • Turning an epidural off during the second stage of labor likely has minimal beneficial effect on the length of the second stage
   
   • Utilize patient-controlled epidural anesthesia (PCEA) with background maintenance infusion that is intermittent or continuous (for laboring women, this is superior to PCEA alone and continuous infusion epidural)

6. **Implement Intermittent Monitoring Policies for Low-Risk Women**

   • Implement policies that include a risk assessment tool, or checklist with exclusion criteria, to assist in identifying patients for which intermittent auscultation or intermittent EFM is appropriate
   
   • Modify standing admission orders to reflect the use of intermittent auscultation or EFM as the default mode of monitoring for women who do not meet exclusion criteria
   
   • Implement initial and ongoing training and education of all nurses and providers on intermittent auscultation and/or intermittent EFM procedures
   
   • Provide patient education for the use of intermittent methods of monitoring and engage in shared decision making in order to determine the most appropriate method for each patient
   
   • Ensure appropriate nurse staffing to accommodate intermittent monitoring

7. **Implement Current Treatment and Prevention Guidelines for Potentially Modifiable Conditions**

   • Assess fetal presentation by 36 weeks gestation and offer external cephalic version (ECV) to patients with a singleton breech fetus
   
   • Ensure initial training and ongoing physician competency in ECV
   
   • Offer oral suppressive therapy at 36 weeks gestation, or within 3-4 weeks of anticipated delivery, to all women with a history of genital herpes, including those without active lesions during the current pregnancy
   
   • A cesarean delivery need not be performed on women with a history of genital herpes but no active genital lesions at the time of labor
2. Implement Latent (Early) Labor Supportive Care Policies and Establish Criteria for Active Labor Admission

Nothing may be as important in determining the course of labor and mode of delivery as the admission decision. Strategies to avoid admission during the latent phase of labor include implementing policies that reduce stress and anxiety for the woman, improve coping and manage pain, promote supportive care in the home environment, and support the physiologic onset of active labor. Supportive policies and related documents include:

- Admission policy or checklist for spontaneous labor
- Latent labor support and therapeutic rest policies
- Patient education material to explain rationale for delayed admission, reduce anxiety, and provide guidance on when to return to the labor and delivery unit
- Material with specific guidance for partners and family members as to how to best support the woman in early labor

While each situation must be managed individually, and decisions about intervention must consider all neonatal and maternal factors, current consensus on contemporary labor patterns suggests it is reasonable to admit the low-risk nulliparous woman when all of the following are present:

- Significant, painful contractions
- 4 or 5 cm dilation with documented cervical change over time determined by comparative cervical examination within the immediate few hours
- 43

The nursing interaction in the triage suite is a critical component of a woman's ability to successfully manage latent labor in the home setting. Fear and anxiety will be reduced only if the woman feels supported and cared for. “The influences of pain, pain relief, and intrapartum medical interventions on subsequent satisfaction are neither as obvious, as direct, nor as powerful as the influences of the attitudes and behaviors of caregivers.” In some cases, it may take some time of walking or observation before the woman is ready to return home.

Equally important is the anticipatory guidance given to the woman during the prenatal period about what to expect during latent labor and how to adequately promote comfort and coping during this time. Having prenatal discussions about preferences and coping mechanisms that match the woman’s individual strengths, and making specific shared decisions for her birth plan, will make it more likely that she will be able to manage early labor at home. Anticipatory guidance and continued reiteration during the latent labor period will serve to align expectations and decrease fear and anxiety.
3. Improve the Support Infrastructure and Supportive Care during Labor

Improve Knowledge and Skill in Supportive Care Techniques

Nurses can have a significant influence on women’s mode of delivery and a nurse’s awareness of this can be a factor in her/his efforts to prevent cesarean birth. Neither nurses nor providers are routinely trained in labor support techniques as part of their formal education, nor in the reduction of cesarean birth through the support of physiologic processes. Because of this lack of training, knowledge of specific non-pharmacologic coping methods is inconsistent among clinicians and is not the cultural norm in many hospital settings. Education on non-pharmacologic methods until well into active labor, and women in facilities who are unable to reach an effective level of relief, women who desire to avoid pharmacologic methods, may take several combined approaches. Nonpharmacologic approaches are “relevant to virtually every childbearing woman.”

Changing the culture of supportive care within a facility, to increase the use of non-pharmacologic coping methods, may take several combined approaches. Nonetheless, feasible strategies can be implemented even in busy environments when patient census is high (Table 10). The tools provided in this toolkit can assist in developing these skills and in providing care that supports intended vaginal birth, safely reduces routine intervention, and provides a satisfying patient experience.

- Continuous labor support
- Breathing and relaxation techniques
- Touch techniques and massage
- Positions to promote comfort
- Heat and cold therapy
- Hydrotherapy
- Sterile water injections
- Transcutaneous electrical nerve stimulation (TENS)
- Freedom of movement in labor
- Upright and ambulatory positioning
- Techniques and tools (such as the peanut ball) that facilitate fetal rotation, flexion, and descent for women with epidural anesthesia
- Maternal exercises and positioning that facilitate fetal rotation in women with and without epidural anesthesia
- Maternal exercises and positioning that facilitate fetal rotation in women with and without epidural anesthesia

While nonpharmacologic methods have been traditionally associated only with women who desire a “natural” labor, such methods can improve coping for all women, especially those with regional analgesia (epidural) or narcotics who are unable to reach an effective level of relief, women who desire to avoid pharmacologic methods until well into active labor, and women in facilities where 24-hour in-house anesthesia coverage is not available. Nonpharmacologic approaches are therefore “relevant to virtually every childbearing woman.”

Nonpharmacologic approaches are “relevant to virtually every childbearing woman.”

Table 10. Support of Coping and Labor Progress

<table>
<thead>
<tr>
<th>Support of Coping and Labor Progress</th>
<th>Support progress through:</th>
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</thead>
<tbody>
<tr>
<td>Breathing and relaxation techniques</td>
<td>Freedom of movement in labor</td>
</tr>
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<td>Touch techniques and massage</td>
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</tr>
<tr>
<td>Heat and cold therapy</td>
<td>Maternal exercises and positioning that facilitate fetal rotation in women with and without epidural anesthesia</td>
</tr>
<tr>
<td>Hydrotherapy (shower, tub)</td>
<td></td>
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<tr>
<td>Sterile water injections for back labor</td>
<td></td>
</tr>
<tr>
<td>Use of Transcutaneous Electrical Nerve Stimulation</td>
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</table>
The physiologic process of labor and birth is mediated by hormones, and the hormonal responses can be easily disrupted. Natural increases in epinephrine, norepinephrine, cortisol, and oxytocin occur in labor, some of which is mediated by the physical environment, stress, and fear. Efforts should be made to provide a safe, calm physical environment that engages a parasympathetic response and thereby promotes normal physiologic processes during labor and birth.\textsuperscript{91,136}

The design of existing labor and delivery units should be assessed to identify barriers to supporting intended vaginal birth, and practical changes should be implemented as needed. The infrastructure of these units also includes department policies and procedures that support intended vaginal birth. In particular, freedom of movement in labor is a significant factor in a woman’s ability to cope,\textsuperscript{101} and position changes for the immobilized patient are important to facilitate flexion, rotation and descent.\textsuperscript{157} Ambulatory positions and freedom of movement have not been shown to increase risk to either the mother or fetus.\textsuperscript{192,195} Table 11 outlines the necessary components of a supportive infrastructure.

### Table 11. Key Components of a Supportive Unit Infrastructure\textsuperscript{91,153,154,157}

<table>
<thead>
<tr>
<th>Key Components of a Supportive Unit Infrastructure</th>
<th>Policies should:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low lighting and privacy</td>
<td>Encourage movement, standing, walking, and frequent position changes at one’s own discretion (for women without an epidural)</td>
</tr>
<tr>
<td>Comfortable space with adequate room for movement and walking</td>
<td>Support upright positioning, frequent position changes, and tools/techniques that promote optimal fetal positioning (such as peanut balls) for women with epidurals</td>
</tr>
<tr>
<td>Adequate availability of non-pharmacologic coping tools such as tubs or showers, rocking chairs, birthing balls, squat bars, and peanut balls</td>
<td>Encourage intermittent monitoring for eligible patients, or use of telemetry for women who must be continuously monitored and desire to be mobile</td>
</tr>
<tr>
<td>Freely available snacks with high nutritional value</td>
<td></td>
</tr>
</tbody>
</table>

**Improve Infrastructure and Availability of Support Tools**

Unit processes and expectations, such as those related to charting and staffing, can either inhibit or streamline a nurse’s ability to support vaginal birth in a meaningful way. Documentation demands, too, can become a barrier to providing care. Despite the known benefits of electronic health records (EHR), evidence suggests that the amount of time that nurses spend charting has increased in the last decade.\textsuperscript{124} The use of EHR should be designed to support nurses, minimize cumbersome and redundant documentation, and streamline data collection.

Documentation of electronic fetal monitoring (EFM) is another area where improvement is necessary. The frequency of EFM documentation is individually determined by institutions and should differ in frequency from the ACOG-recommended EFM assessments. However, some institutions’ EFM policies require documentation at every assessment interval, which causes an unnecessary documentation burden on the nurse.\textsuperscript{138} Changes in these areas may increase nurse availability for bedside care and labor support.\textsuperscript{159}

Noting that labor support is integral to nursing care of the laboring woman, AWHONN’s 2010 nurse staffing guidelines recommend 1:1 care for women “choosing to labor with minimal to no pharmacologic pain relief or medical interventions.”\textsuperscript{162} Staffing in accordance with this recommendation should theoretically allow for optimal labor support while simultaneously preventing nurse burnout.\textsuperscript{112} Interestingly, some studies have demonstrated that even when nursing ratios allowed for 1:1 care, the amount of labor support did not increase.\textsuperscript{161} This may be due to the fact that the strongest predictor of a nurse’s intention to provide labor support is the expectation of others.\textsuperscript{119} Thus, the expectation to provide excellent supportive care as the cultural norm, paired with 1:1 staffing ratios, may be the most effective solution to increasing the amount and quality of nursing labor support.

### Improve Assessment of Pain and Coping

The use of a standard numeric pain scale, used by most labor and delivery units, may actually inhibit coping and disrupt labor progress by emphasizing the need to eliminate pain completely.\textsuperscript{134} The Coping with Labor Algorithm (Appendix F) offers a simple alternative better attuned to women in labor. This algorithm is a validated tool that meets TJC’s requirements for pain assessment and is recommended by the Task Force as a replacement for the standard numeric pain scale. Furthermore, the Coping with Labor Algorithm is easy to use, specifically defines how to assess “coping” and “not coping,” gives nursing guidance on various methods that may promote comfort, and allows for a choice of pharmacologic and non-pharmacologic options of pain relief.
4. Encourage the Use of Doulas and Work Collaboratively to Provide Labor Support

Data consistently show that continuous labor support reduces the risk of cesarean delivery.\textsuperscript{162} Recent studies have replicated this finding specific to continuous labor support by doulas.\textsuperscript{130,162} Despite wanting to give more robust labor support, many nurses realize that continuous labor support is unrealistic given the many nursing obligations of a busy labor and delivery unit.\textsuperscript{163} Doulas offer a unique skill and can play a key role in the woman’s satisfaction of her birth experience.\textsuperscript{117,126} When doulas are utilized in a way that allows them to function appropriately in their unique and integral role, they can simultaneously advocate for women and act as helpful allies to nurses and providers.\textsuperscript{163} Although doula care is rising in the United States, it has not been fully accepted in the hospital setting. There are still many misconceptions about doula care and often there is a stigma surrounding the “type” of woman who has a doula.

Doulas should be considered an integral part of the birth team.\textsuperscript{127} The following are recommendations to improve teamwork between nurses and doulas and promote safe, patient-centered care:\textsuperscript{162}:

- **Open communication between the doula and the nurse and a “mutual understanding of roles.”** Unit guidelines may need to be developed to foster delineation of roles and expectations. Posting these guidelines at the bedside may be useful.

- **Collegial rapport and joint understanding that the doula’s professional knowledge of labor support techniques complements the nurse’s extensive technical and medical skillset.**

- **Two-way teaching.** Doulas appreciate thoughtful and respectful guidance and feedback, especially those training for future medical or nursing professions. Likewise, nurses and nursing students can learn extensive labor support skills from doulas if willing to do so.

There are various models of doula care in the United States. These models include hospital-based programs, community-based programs, and private practice.\textsuperscript{162} Hospital-based programs, such as those at UC San Diego Medical Center and Zuckerberg San Francisco General Hospital, are generally grant-funded and volunteer-based. Community-based programs, such as those provided through social service agencies or Federally Qualified Health Centers, provide doulas who are community health workers from the patient’s own community. This is particularly important in diverse, low-income areas where culturally sensitive and language-appropriate doula care is needed.\textsuperscript{130,164} This type of community doula program is growing, with many grantee project sites across the United States funded by the Department of Health and Human Services Health Resources and Services Administration (HRSA).\textsuperscript{164,166} Doulas also exist in private practice, and can be independently hired by women and families to assist during labor and the postpartum period. The client pays private practice doulas primarily out-of-pocket. However some states are implementing innovative strategies to pay for doula care, such as Medicaid coverage of doula services in Oregon and Minnesota.\textsuperscript{166}

Hospitals can benefit by incorporating innovative strategies to support the use of doulas within the facility, such as:

- **Working with a local doula organization to provide information, support, and resources to families.**

- **Connecting with community-based doula programs.**

- **Considering the implementation of a hospital-based program.**
5. Utilize Best Practice Recommendations for Laboring Women with Regional Anesthesia (Epidural, Spinal, and Combined Spinal Epidural)

There continues to be significant debate within the birth community about the correct timing for placement of epidural anesthesia in laboring women, the effect epidural anesthesia may have on the length of labor, and the risk of operative vaginal birth and cesarean birth for women who choose to have epidural anesthesia during labor. Hospitals and anesthesiologists often have differing opinions on the best type, modality, and dosing for regional anesthesia. Examples include “walking epidural,” combined spinal epidural (CSE), patient controlled epidural anesthesia (PCEA), continuous infusion epidural (CIE), and programmed intermittent epidural boluses (PIEB). The following recommendations by the Task Force (Table 12) are based upon the best available evidence, and in accordance with the ACOG/SMFM Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery.3

Table 12. Best Practice Recommendations for Regional Anesthesia2,167,175

<table>
<thead>
<tr>
<th>Best Practice Recommendations for Regional Anesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not avoid or delay epidural anesthesia as a method of reducing risk for cesarean delivery</td>
</tr>
<tr>
<td>In the absence of a medical contraindication, if a woman specifically requests pain relief by epidural anesthesia, there is no need to wait for a minimum or arbitrary cervical dilation before administering (maternal request is a sufficient indication to provide pain relief through regional anesthesia)</td>
</tr>
<tr>
<td>The woman should be assisted in changing position at least every 20 minutes to assist necessary fetal movement</td>
</tr>
<tr>
<td>Allow for longer durations of the second stage for women with regional anesthesia (e.g. at least 4 hours in nulliparous women, at least 3 hours in multiparous women), as long as maternal and fetal statuses remain reassuring</td>
</tr>
<tr>
<td>Allow for passive descent when there is no urge to push (delayed pushing until there is a stronger urge to push, generally 1-2 hours after complete dilation). Passive descent is correlated with shorter overall pushing time and greater chance of spontaneous vaginal birth</td>
</tr>
<tr>
<td>Preserve as much motor function as possible by administering the lowest concentration of epidural local anesthetic necessary to provide adequate maternal pain relief. Epidural solutions containing opioids allow less local anesthetic use without compromising labor analgesia</td>
</tr>
<tr>
<td>Turning an epidural off during the second stage of labor to improve pushing efforts is rarely necessary and likely has minimal beneficial effect on the length of the second stage</td>
</tr>
<tr>
<td>Utilize patient-controlled epidural anesthesia (PCEA) with background maintenance infusion that is intermittent or continuous (for laboring women, this is superior to PCEA alone and continuous infusion epidural)</td>
</tr>
</tbody>
</table>

Relationship of Epidural Anesthesia to Risk of Cesarean Delivery

Although some studies show epidural anesthesia to be associated with an increased risk of operative vaginal delivery,176 numerous other studies show no significant causal relationship between epidural anesthesia and the rate of cesarean birth.175,177

Timing of Epidural Placement

The evidence indicates there is no difference in rate of cesarean birth based upon “early” placement of epidural (e.g. less than 4 cm dilation) versus placement in active labor.175,177 Similarly, Wong and colleagues179 demonstrated no significant difference in cesarean birth for women undergoing induction of labor and randomized to receive either early or late epidural placement.

A joint statement by the American Congress of Obstetricians and Gynecologists and the American Society of Anesthesiologists states, “There is no other circumstance where it is considered acceptable for an individual to experience untreated severe pain amenable to safe intervention, while under a physician’s care. In the absence of a medical contraindication, maternal request is a sufficient medical indication for pain relief during labor. Pain management should be provided whenever medically indicated.”183

Regarding the timing of epidural and malposition of the fetus, it is not clear if epidural anesthesia predisposes to persistent malposition, or if an already malpositioned fetus increases the need for pain relief. While there is no evidence to suggest that epidurals cause malposition of the fetus, the preponderance of evidence suggests that those women who request and receive epidurals are up to four times as likely to have an occiput posterior fetus than women without epidurals.180,181 Evidence also suggests that placing an epidural later in labor (greater than or equal to 5 cm dilation, or greater than or equal to 0 station) is associated with fewer persistent malpositions.181,182
Relationship of Epidural to Overall Length of Labor and Duration of the Second Stage

The vast majority of studies indicate that labor is lengthened in women with epidural anesthesia. A retrospective analysis of 42,000 women demonstrated that epidural use is associated with a larger effect on the second stage of labor than previously suspected. The amount of anesthetic administered may also play a role. A 2011 meta-analysis of epidural anesthetic concentrations revealed that low concentrations (less than or equal to 0.1% epidural bupivacaine or less than or equal to 0.17% ropivacaine) were associated with fewer operative vaginal deliveries and a shorter second stage.

Recent studies comparing programmed intermittent epidural bolus (PIEB) to CIE show that PIEB improves satisfaction, results in less anesthetic consumption while maintaining analgesia, and may decrease motor block, an essential goal for obstetric anesthesia.

6. Implement Intermittent Fetal Monitoring Policies for Low-Risk Women

The type of fetal monitoring, like other interventions, should be based upon the risk profile and needs of the woman. The vast majority of the low-risk NTSV population are candidates for intermittent auscultation or intermittent EFM, and the use of intermittent methods is supported by the AWHONN and the ACOG. The ACNM endorses intermittent auscultation as the preferred method for low-risk women. Table 13 outlines the requirements for intermittent EFM or intermittent auscultation as the default method of monitoring.

Table 13. Components of Successful Implementation of Intermittent Fetal Monitoring

<table>
<thead>
<tr>
<th>Components of Successful Implementation of Intermittent Fetal Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies should include a risk assessment tool or checklist with exclusion criteria to assist in identifying women for which intermittent auscultation or intermittent EFM is appropriate.</td>
</tr>
<tr>
<td>Provide patient education for the use of intermittent methods of monitoring, including the risks and benefits of intermittent versus continuous methods, and engage in shared decision making in order to determine most appropriate method for each woman.</td>
</tr>
<tr>
<td>Provide on-going assessments of women to determine appropriateness of continued intermittent methods versus conversion to continuous EFM.</td>
</tr>
<tr>
<td>Engage in initial and ongoing training and education of all nurses and providers on intermittent auscultation or intermittent EFM procedures.</td>
</tr>
<tr>
<td>Provide appropriate staffing, e.g. 1:1 nursing care as recommended by AWHONN for intermittent auscultation in low-risk women.</td>
</tr>
<tr>
<td>Work with necessary committees and Information Technology (IT) to modify admission orders to reflect the use of intermittent EFM or auscultation as the default mode of monitoring for women who do not meet the exclusion criteria.</td>
</tr>
<tr>
<td>Ensure that the appropriate equipment, such as Dopplers, are readily available in sufficient numbers.</td>
</tr>
<tr>
<td>Develop a competency tool for evaluating knowledge of procedures and use of equipment.</td>
</tr>
</tbody>
</table>

A statement by the American Congress of Obstetricians and Gynecologists and the American Society of Anesthesiologists states, “There is no other circumstance where it is considered acceptable for an individual to experience untreated severe pain amenable to safe intervention, while under a physician’s care. In the absence of a medical contraindication, maternal request is a sufficient medical indication for pain relief during labor. Pain management should be provided whenever medically indicated.”

Innovations in Obstetric Anesthesia

In recent years, there have been many innovations in obstetric anesthesia including drug combinations, dosing, and delivery systems. At the forefront of these advances is the goal of improving patient satisfaction while simultaneously reducing the overall consumption of local anesthetic and subsequent need for anesthetic intervention. For laboring women, studies have shown that patient-controlled epidural anesthesia (PCEA) is superior to fixed dose continuous infusion epidural (CIE). In comparison to CIE, PCEA offers less analgesic consumption and need for anesthetic intervention. PCEA with background maintenance infusion improves overall pain control and decreases the need for unscheduled rescue boluses as compared to PCEA alone.
Many providers and nurses currently have no experience with intermittent methods of monitoring. Implementing intermittent monitoring as the default method for low-risk women will require “tapping into” a unit culture that prioritizes supportive, appropriate, evidence-based care. Intermittent monitoring should not be undertaken until providers and nurses have been adequately trained. Furthermore, women must be made aware of the risks and benefits of intermittent versus continuous methods. Shared decision making is critical.

7. Implement Current Treatment and Prevention Guidelines for Potentially Modifiable Conditions

Assessment of Fetal Presentation and External Cephalic Version (ECV)

Fetal presentation should be assessed by 36 weeks gestation and external cephalic version should be offered to women with a singleton breech fetus. It is incumbent upon physicians to engage in initial training for ECV and maintain competency. Regional anesthesia can be utilized to increase likelihood of successful ECV. If ECV is unsuccessful, cesarean delivery is the preferred mode of delivery. Alternatively, vaginal breech delivery is an option with a skilled provider who has significant experience in such cases, but should be undertaken with an abundance of caution. The woman should be informed that higher risk to the neonate may exist for vaginal breech deliveries than for planned cesarean of the breech fetus.

HSV Prophylaxis

Administration of acyclovir for viral suppression and prevention of outbreaks during pregnancy has been shown to be highly effective and remains the most important strategy to reduce active genital lesions at the time of labor. All women with a history of genital herpes, including those without active lesions during the current pregnancy, should be offered oral suppressive therapy at 36 weeks gestation, or within 3-4 weeks of anticipated delivery. A cesarean need not be performed on women with a history of genital herpes but no active genital lesions at the time of labor.
Part III. Response: Management of Labor Abnormalities

Standardization Matters

The past decade has seen many publications that address why and how medicine should focus on reducing variation in health care practices to improve outcomes across all specialties. Among the responses was the Surgical Safety Checklist, developed by Atul Gawande and colleagues. For nearly 4,000 patients from both high- and low-resource countries, the rate of surgical complications (including death, infection, and reoperation) was reduced from 11% pre-checklist to 7% after instituting the checklist. Furthermore, the Institute of Medicine’s publication Crossing the Quality Chasm: A New Health System for the 21st Century pleads for health care leaders and consumer representatives to support the development of best practices in order to achieve the highest quality of care.

Maternity care is no exception to this broad transformation in care. The ACOG published Quality and Safety in Women’s Health Care in 2010, and a Committee Opinion in 2012, updated in 2015, titled Clinical Guidelines and Standardization of Practice to Improve Outcomes. The latter document highlights a reduction in obstetric anesthetic complications, medication errors, and neonatal group B strep infections because of collaboratively created protocols and checklists which are now standardized approaches to care. The surgical safety checklist is another tool that has become embedded in the operating room processes of many obstetric units across the United States.

Many examples of interprofessional collaborative work to improve quality and safety in maternity care now exist. The Institute for Healthcare Improvement’s Perinatal Improvement Community has worked on a variety of obstetric topics over the past decade. Individual hospitals and hospital systems have contributed perinatal work processes to the literature showing how improving obstetric outcomes takes concerted teamwork and standardization. Reduction of early elective deliveries has been very successful in states where this work has been done. CMQCC and other state and national perinatal collaboratives, such as the Council on Patient Safety in Women’s Health Care, are examples of how health care providers and other experts can collaboratively provide education, process suggestions, and implement tools to improve outcomes. Previous...
toolkits by CMQCC, such as Response to OB Hemorrhage and Response to Preeclampsia, were initially meant to improve outcomes in California, but with open-sharing have had a significant impact nationally. The toolkit method, with its step-by-step approach, holds great potential to improve maternal and neonatal outcomes associated with all modes of birth.

Recent studies reveal that indicators that rely on provider discretion (such as failure to progress and fetal intolerance of labor) are contributing to the overall increase in primary cesareans more than objective indications such as breech or other obstetric conditions. From 2003 to 2009, a study at Yale University analyzed data from over 32,000 live births. Of these births, 50% of the overall increase in cesarean sections was attributable to an increase in primary cesareans. Half of the increase in primary cesareans was attributable to nonreassuring fetal heart rate (32%) and arrest of labor (18%). The data showed that primary cesareans for arrest of descent remained stable, revealing that “arrest of labor” diagnoses were really arrest of dilation. Similarly, Kaiser Permanente Southern California examined the rise in cesarean births among primary singleton births from 1991 to 2008, which included roughly 48,000 births per year. Of the primary singleton cesarean births, 24% of the increase, and other provider-dependent indicators such as failure to progress, cephalopelvic disproportion (CPD), and macrosomia accounted for 38% of the increase.

Given this information, the Task Force supports the standardization of definitions to guide care during labor and birth, thereby improving response to labor abnormalities and safely reducing primary cesarean births. Care during labor and birth requires simultaneous personalization of care for both the woman and the fetus under conditions that are often unpredictable. For this reason, perfect standardization of response is not realistic, nor acceptable. However, standardizing certain definitions within labor and birth (e.g., the NICHD categories for electronic fetal monitoring and the ACOG/SMFM criteria for labor dystocia) will serve to improve decision making, while still leaving room for compassionate, individualized care.

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Although a lack of standard definitions has been identified as a key barrier to reducing cesarean births, it is not the only major barrier. Efficient teamwork and effective communication, for example, form the foundation for quality improvement efforts.

Based on the findings discussed above, the Task Force has identified five core barriers to responding quickly and appropriately to labor abnormalities (Table 14).

### Table 14. Barriers to Appropriately Managing Labor Abnormalities

<table>
<thead>
<tr>
<th>Barrier to Appropriately Managing Labor Abnormalities</th>
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</thead>
<tbody>
<tr>
<td>1. Poor professional communication and lack of teamwork</td>
</tr>
<tr>
<td>2. Lack of standard diagnostic criteria and/or standard response to labor challenges and fetal heart rate abnormalities</td>
</tr>
<tr>
<td>3. Failure to identify and intervene for the persistently OP/OT fetus</td>
</tr>
<tr>
<td>4. Professional challenges in work-life balance (e.g., clinic, surgical, and family obligations) that create limited availability of the provider on the labor and delivery unit</td>
</tr>
<tr>
<td>5. Liability-driven decision making</td>
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</tbody>
</table>

### Poor Professional Communication and Lack of Teamwork

Teamwork and effective communication form the foundation of safe response to obstetric emergencies and labor abnormalities. Breakdown in communication is consistently identified as a leading factor contributing to failures in the delivery of safe patient care. It is widely accepted that having a high-functioning, reliable team on the perinatal unit is essential for promoting safe, patient-centered care with quality outcomes.

TJC makes the following strong recommendation: “Since the majority of perinatal death and injury cases reported root causes related to problems with organizational culture and with communication among caregivers, it is recommended that organizations conduct team training in perinatal areas to teach staff to work together and communicate..."
“Since the majority of perinatal death and injury cases reported root causes related to problems with organizational culture and with communication among caregivers, it is recommended that organizations conduct team training in perinatal areas to teach staff to work together and communicate more effectively.”

- The Joint Commission

more effectively.” Shared recognition by a perinatal care team that performing a potentially unnecessary cesarean can result in injury to both mother and baby is the underpinning for preventing this potential adverse event. But the labor process is dynamic, and changes in maternal and fetal status can occur rapidly. Management of labor requires continuous assessment and evaluation of both the mother and the fetus. Labor abnormalities as a whole (fetal intolerance of labor, arrest of labor, failure to progress) comprise the largest indicator for primary cesarean birth. While decision making is fairly straightforward when the fetus or labor process declares a significant abnormality, the decision to perform a cesarean under typical circumstances is often less certain. It is a decision based upon multiple factors occurring over time, and one that may by hampered by the stress of the moment, lack of information, irrelevant external factors, and poor situational awareness. Therefore, for both “normal” labors and “abnormal” labors, it is essential that the entire perinatal care team have the ability to work effectively and fluidly, and continuously communicate with skill. Many labor and delivery units already function with highly efficient and effective teams, while others may need to concentrate on this issue more closely before moving on to any of the other quality improvement activities noted in this section. Features of effective teamwork and skilled communication are listed in Table 15.

Table 15. Features of Effective Teamwork and Skilled Communication

<table>
<thead>
<tr>
<th>Features of Effective Teamwork and Skilled Communication</th>
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<tbody>
<tr>
<td>Respect for all members of the team</td>
</tr>
<tr>
<td>Trust in one another</td>
</tr>
<tr>
<td>Ability to rely on the information and actions of one another</td>
</tr>
<tr>
<td>Ability to resolve conflict</td>
</tr>
<tr>
<td>Ability to manage disruptive behavior</td>
</tr>
</tbody>
</table>

Lack of Standard Diagnostic Criteria and/ or Standard Responses to Labor Challenges and Fetal Heart Rate Abnormalities

The Task Force identified four specific areas where standardization could significantly improve safety and quality, guide decision making for appropriate use of cesarean birth, and promote patience and vigilance when indications for cesarean are not present:

- **Diagnosis of labor dystocia**
- **Use of oxytocin**
- **Response to abnormal fetal heart rate patterns**
- **Induction of labor**

Diagnosis of Labor Dystocia

As previously noted in Part II of this toolkit, a contemporary labor pattern has emerged that is quite different than reported by Friedman in his groundbreaking early studies. Zhang and colleagues noted that the fastest rate of cervical dilation begins at 6 cm, and that women laboring at the slowest “normal” rate may take “more than 6 hours to progress from 4 to 5 cm and more than 3 hours to progress from 5 to 6 cm of dilation.” Despite these findings and recommendations by the Consortium on Safe Labor, general institutional acceptance of this new labor curve has been slow. Many factors may contribute to this, including that the definition of prolonged latent phase by Friedman is still widely accepted, many women are admitted to the hospital before active labor has truly begun, and many providers still adhere to a frequent cervical examination schedule of every two hours even before commencement of active labor. All of these things combined may lead to an overall culture of care that diagnoses labor dystocia far too early. Furthermore, appropriate diagnosis of labor dystocia is critical to the judicious and appropriate use of oxytocin (see next section).

Use of Oxytocin

Intravenous oxytocin is the main pharmacologic agent for induction and augmentation of labor. It is an effective medication but also a “high-alert” medication due to its association with adverse maternal and fetal outcomes.
Over the past 50 years, both clinical researchers and providers have struggled with identifying the ideal dosing and minimizing potential complications associated with intrapartum oxytocin administration. Pharmacokinetics for oxytocin in pregnant women were clarified in the mid-1980s, showing quick initial onset of one to five minutes, but a slowly achieved steady-state of approximately 40 minutes. Since most complications are associated with uterine activity and are dose-related, recent quality improvement efforts to reduce adverse events related to oxytocin have focused on using lower initial dosing and increasing more slowly until the lowest effective dose has been achieved. Nonetheless, wide variation in oxytocin protocols and administration persists.

Response to Abnormal Fetal Heart Rate Patterns

Electronic fetal monitoring (EFM) was introduced in 1958 by Edward Hon at Yale University. It seemed to improve outcomes for preterm births and rapidly became the default method of intrapartum fetal surveillance. Unfortunately, EFM was brought into use before extensive testing and before basic understanding of the relationship between specific fetal heart rate (FHR) patterns and fetal metabolic acidemia. As the use of EFM increased, so did the rate of cesarean birth, but without a concomitant decrease in adverse fetal outcomes or mortality. Since the evidence regarding clinical benefit of EFM is often conflicting, the relationship of FHR patterns to the increase in cesarean birth is clear. Barber and colleagues noted that non reassuring FHR tracings contributed the greatest proportion of the overall increase in cesarean births in a single institution between 2003 and 2009.

Induction of Labor

In the U.S., approximately 23% of births are induced. According to recent data from the Centers for Medicare & Medicaid Services (CMS), early elective delivery (delivery before 39 weeks without a medical indication) ranges from 2% to 22%, depending on the state. From the 1990s until present day, an increase in induction of labor has mirrored the increase in cesarean birth, with slight decreases in induction of labor in recent years. This recent decrease is consistent with a widespread acknowledgement of increased morbidity and mortality of infants born before 39 weeks of pregnancy and subsequent changes in clinical practice during the same timeframe that resulted from local, state, and national efforts to reduce non-medically indicated induction of labor at less than 39 weeks. The success of these initiatives is a result of extensive outreach to childbearing women and providers in tandem with diligent monitoring locally and across hospital systems.

The decades-long concurrent increase in both cesareans and induction of labor, as well as studies comparing outcomes for induction compared to spontaneous onset of labor, has contributed to the prevailing thinking within obstetrics that induction of labor is highly associated with an increase in unplanned cesareans, and some studies have borne out that the likelihood of cesarean is higher for induced labor than for spontaneous labor, especially for nulliparas who are induced with an unfavorable cervix. In recent years, however, this consensus has been challenged by several prospective trials and meta-analyses contrasting induction of labor to expectant management, a more relevant comparison than spontaneous-onset labor. When outcomes for women who are induced are compared to women who continue with pregnancy (expectant management), there appears to be either no difference in cesarean for the women with induced labors, or possibly even a slightly decreased likelihood of cesarean for this group. These conflicting reports may lead to variations in practice, confusion amongst providers about the benefits and risks of induction of labor at term (39+0 – 40+6 weeks), and differences in how providers counsel women regarding induction of labor between 39 and 41 weeks gestation.

Many factors affect the risk of cesarean after the decision for induction of labor has been made. These factors vary by provider and by facility. How induction is managed, therefore, may be the determining factor for whether the risk of cesarean is increased. For example, whether cervical ripening is used when the cervix is unfavorable, and whether adequate time is allowed for the woman to progress into the active phase of labor before diagnosing a “failed induction” will affect the likelihood of cesarean. The “physician effect,” meaning the impact of an individual physician, affected by the facility’s management style, has also been noted as an independent risk factor for cesareans. This is important to consider because, given the increased length of latent labor in induced women.

Table 16. Glossary of Terms for Induction of Labor

<table>
<thead>
<tr>
<th>Glossary of Terms for Induction of Labor</th>
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</thead>
<tbody>
<tr>
<td>Induction of labor</td>
<td>Defined by ACOG as attempting “to achieve a vaginal delivery by stimulating uterine contractions before the onset of spontaneous labor”</td>
</tr>
<tr>
<td>Non-medically indicated (elective) induction of labor</td>
<td>“Induction of labor without an accepted medical or obstetrical indication before the spontaneous onset of labor or rupture of membranes”</td>
</tr>
<tr>
<td>Medically indicated induction of labor</td>
<td>Induction of labor when there is clear medical benefit to either the mother or the baby to end the pregnancy</td>
</tr>
</tbody>
</table>
as compared to their spontaneously laboring counterparts,\textsuperscript{245} patience by the provider and the facility is critical to determining the outcome when labor is induced.\textsuperscript{246} Recent “before-after” studies have examined the effects of labor induction policies on cesarean rates. These studies, which evaluate the impact of specific quality improvement activities on rates of cesareans in specific practice settings, are perhaps the most relevant way of examining the effect of labor induction in community hospitals. Studies by Fisch et al., Oshiro et al., and Reisner et al.\textsuperscript{232-234} revealed that rates of cesareans dropped significantly after implementing policies to limit non-medically indicated induction of labor to 39 weeks and greater (Table 17).


determining the outcome when labor is induced.\textsuperscript{246}

<table>
<thead>
<tr>
<th>Study Citation</th>
<th>eIOL Policy Change</th>
<th>Maternal Outcomes</th>
<th>Infant Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisch et al., 2009 (Magee Womens Hospital, Pittsburg, PA)</td>
<td>New guideline implemented in 2006 with eIOL allowed only after 39 weeks, and with a Bishop score of 8 or greater for nulliparas and 6 or greater for multiparas. No cervical ripening agents are allowed.</td>
<td>Total eIOL rate declined from 9.1% to 6.4%. Cesarean rate for nulliparas undergoing eIOL decreased from 34.5% to 13.8% (risk of Cesarean was decreased by 70%) NNT (nulliparas) = 10.</td>
<td>Not reported</td>
</tr>
<tr>
<td>Oshiro et al., 2009; (9 urban intermountain Healthcare hospitals in the western U.S.)</td>
<td>eIOL only after 39 weeks, and with Bishop score of 10 or greater for nulliparas and 8 or greater for multiparas. No cervical ripening agents allowed.</td>
<td>Rate of eIOL at less than 39 weeks declined from 28% in 1999 to 3.4% in 2007. Cesarean delivery for “fetal distress” decreased by 43% after implementation of guidelines (11% to 6%, NNT=20). The total Cesarean rate for women with Bishop score of 8 was 13.3% and for those with a Bishop score of 10 was 8.1%, compared to rates of 51.4% to 17.6% with Bishop scores of 1 to 5.</td>
<td>Rates of neonatal ventilator use, respiratory distress syndrome, and macrosomia were unchanged. Rate of meconium aspiration declined 43%. Stillbirth rates at 37, 38, 39, 40 and 41 weeks declined by 41% overall, with the weekly difference being statistically significant for the 37 and 38 week intervals and overall.</td>
</tr>
<tr>
<td>Reisner et al., 2009 (Swedish Medical Center, Seattle, WA)</td>
<td>eIOL restricted to 39 weeks or above, and Bishop score of greater than or equal to 6.</td>
<td>eIOL declined from 4.3% to 0.8% for nulliparas and from 12.5% to 9.3% for multiparas. Unplanned CS after eIOL for nulliparas declined from 26.9% to 17.9% and from 4.5% to 3.0% for multiparas. NNT (nulliparas) = 9 NNT (multiparas) = 48</td>
<td>Not reported</td>
</tr>
</tbody>
</table>

Failure to Identify and Intervene for the Persistently OP/OT Fetus

Malpresentation occurs in 8% to 9% of term pregnancies, with most of these due to a malpositioned fetus in vertex presentation. In order of occurrence, vertex malpositions are: occiput posterior (OP) (5.2%), brow (0.14%), and face (0.1%). Together they account for 12% of all cesarean births performed due to dystocia. Women with an OP fetus face a likelihood of cesarean that is 2 to 6 times that of women with a fetus in the occiput anterior (OA) position. Another vertex variant, occiput transverse (OT), is also encountered but most often is a transitory position.

At labor onset, 15% to 32% of vertex fetuses will be in an OP or OT position and by second stage most will rotate to the well-flexed OA position and deliver vaginally. However, 5% to 8% of these OP/OT fetuses will persist in malposition and are more likely to deliver by cesarean or operative vaginal delivery. When labor dystocia occurs in second stage, vaginal birth is optimized when clinicians determine that the woman has a malpositioned fetus and subsequently intervene to promote progress.

Professional Challenges in Work-Life Balance

Challenges in work-life balance exist for many medical professionals. Maternity providers face high delivery volumes and busy clinic practices, and nurses are notorious for working long hours and performing multiple professional roles simultaneously. Physicians must also deal with demanding surgical schedules. Providers must somehow weave an intricate balance between these demands and those of personal life and family — a balance that is often disrupted by the unpredictability of labor and birth.

The current payment structure for maternity care services may further complicate this situation (see Part I of toolkit) by creating a time-based incentive to prematurely end long labors with cesarean, or to induce labor while on-call in order to ensure the provider’s presence at the birth while also helping to “normalize” his or her time when not on-call.

These challenges have forced hospitals to evaluate the systems, teams, and staffing structures needed to provide flexible responses to the various, and often rapidly changing, needs of the laboring woman. Additionally, recent studies show that the mix of provider types available to respond to labor challenges, such as the availability of both physician and midwife “laborists,” may have a significant impact on cesarean rates. It should be noted, however, that the cesarean rate for laborist physicians within the same institution can vary greatly (a three-fold variation in a recent study). This finding once again reinforces the impact of individual physician decision making.

Liability-Driven Decision Making

Discussion of response to labor abnormalities would not be complete without addressing the effect of potential liability on provider decision-making. Compared to other specialty areas, obstetrics carries increased risk of liability claims, and providers are well aware of the potential for litigation arising out of the timing and mode of birth. The fear created by such claims may explain the positive correlation between liability pressure and cesarean birth rates, and the negative correlation between litigation and offering trial of labor after cesarean (TOLAC).

Physicians who have previously been involved in a malpractice lawsuit show an increased tendency to recommend cesarean. A small increase in rates of cesarean in the short-term and/or a decrease in overall births, has also been noted for physicians involved in litigation. Whether real or perceived, the risk of and fear of litigation may present an obstacle to success for institutions or individuals attempting to curtail rates of cesarean birth.

Improvement Strategies

1. Create Highly Reliable Teams and Improve Interprofessional Communication at Critical Points in Care

Develop Protocols and Institutional Policies that Promote and Support Teamwork and Effective Communication

Implementing highly reliable interprofessional teamwork on a perinatal unit requires a commitment to creating a culture that values safety, collegial relationships, and respectful communication. A first step is recognizing that teams, rather than individuals, ensure safety for patients. Thus, organizational leadership must be engaged to develop policies that will strengthen the quality and performance of the team. Programs that have successfully implemented a team-based approach to patient safety in labor and delivery units can provide useful models for change, including the approaches by Wagner and colleagues and McFerran and colleagues.
Create Highly Reliable Teams and Improve Interprofessional Communication at Critical Points in Care

1. Develop protocols and institutional policies that promote and support teamwork and effective communication
2. Create a culture of collegiality and mutual respect
3. Implement formal programs for the development and ongoing evaluation of teamwork and communication (e.g. TeamSTEPPS®)
4. Promote standardized communication techniques to improve efficiency and clarity of communication (e.g. SBAR)
5. Promote situational awareness through impromptu huddles, team rounds, and debriefings
6. Develop Rapid Response Teams

Implement Standard Diagnostic Criteria and Standard Responses to Labor Challenges and Fetal Heart Rate Abnormalities

1. Utilize standard diagnostic criteria and algorithms to reduce and respond to labor dystocia
2. Implement policies for the safe use of oxytocin
3. Endorse NICHD categories and standardize responses to abnormal fetal heart rate patterns and uterine activity
4. Standardize induction of labor (e.g. patient selection, scheduling, and induction process)

Utilize Operative Vaginal Delivery in Eligible Cases

1. Ensure initial training and ongoing physician competency in forceps and vacuum extraction
2. Identify malposition early (ideally by early second stage of labor), and employ the use of ultrasound if unable to clearly define the position of the vertex with digital exam and Leopold’s Maneuvers
3. Promote rotation of the vertex from an OP position with maternal positioning including during second stage, and manual or instrumented rotation by an experienced, well trained provider
4. As long as incremental descent is being made, and fetal and maternal statuses permit, allow for longer durations of the second stage (e.g. at least 4 hours for nulliparous women and at least 3 hours for multiparous women)

Identify Malposition and Implement Appropriate Interventions

1. Consider Alternative Coverage Programs (Laborist Models and MD/CNM Collaborative Practice Models)
2. Laborist models of care promote on-site readiness, remove the time-based and economic incentives to perform cesareans, and lend to the retention of core knowledge and skills
3. Midwifery care has been identified as an underused maternity service, with the potential to curb costs, improve overall outcomes, and reduce rates of cesarean

Develop Systems that Facilitate Safe, Patient-Centered Transfer of Care Between the Out-of-Hospital Birth Environment and the Hospital

1. Develop relationships with local out of hospital providers in order to increase collaborative communication and facilitate safe and respectful transfer of care

Reduce Liability-Driven Decision Making by Focusing on Quality and Safety

1. Educate providers on the benefits of a well-designed quality improvement program to reduce cesarean
2. Specifically address the situations that contribute the most to obstetric liability claims
3. Well-chosen cesareans are sometimes necessary to prevent avoidable maternal and fetal harm. The goal of a quality improvement program to reduce cesarean is not to prevent cesarean birth “at all costs”

Create a Culture of Collegiality and Mutual Respect

An important feature of effective communication is the ability to speak assertively without fear of retribution. Empowering all members of the team to participate in communication with an equal voice increases the likelihood that all observations will be shared. Members of high-functioning teams hold themselves accountable to speak up and make their concerns known. Through this process, the team is able to reach a conclusion on the patient’s status and the safest and best plan of care. Allowing all participants of the team, including the patient, to be heard and understood is critical to the communication process. Effective communication and respect also involves deep listening, which includes questioning to verify information
and gain insight. Effective communication is not complete until a course of action is both agreed upon and completed.

However, conflict arises frequently among providers, and at times even with the patient. In the context of labor management, two areas in particular that have been identified as frequent sources of conflict between providers are administration of oxytocin and interpretation of the fetal heart tracing. Therefore, it is important for the interprofessional team to practice skills for conflict resolution, which also functions as a team-building exercise. Formal programs, such as those described in the next section, can assist in learning valuable techniques for conflict resolution.

Implement Formal Programs for the Development and Ongoing Evaluation of Teamwork and Communication

Utilization of an evidence-based program can facilitate the implementation and evaluation of a team-based approach to obstetric safety. One example, developed by the Agency for Healthcare Research, is called TeamSTEPPS. Another program, MedTeam*, was developed by Dynamic Research Corporation for Emergency Departments. Both programs encourage interprofessional training that allows diverse groups to come together during the skill development process. Working in interprofessional groups allows teams to break down hierarchies and learn from one another. Practicing communication skills in a safe and controlled environment allows team members to experience collegiality and develop respect for one another and their respective disciplines.

Promote Standardized Communication Techniques to Improve Efficiency and Clarity of Communication

When labor abnormalities arise in an otherwise normal labor, effective teamwork and communication are crucial to safe care and best outcomes for the patient and her baby. Team members must work together to determine the safest course of action: to continue the labor or to expedite the birth, which may include a cesarean. Standardized communication techniques that call attention to an abnormal situation requiring urgent attention are necessary to promote a culture of safety and inform appropriate decision making. For example, a checklist for labor dystocia can be used as a “hard stop” to reinforce guidelines for proper diagnosis. Another widely used structured communication is Situation-Background-Assessment-Recommendations (SBAR), a reporting format that provides a succinct and reproducible method for urgent communication. There is also CUS: an acronym for I’m concerned, I’m uncomfortable, and I’m scared, developed by the airline industry that prompts the user to proceed through escalating levels of critical communication.

Promote Situational Awareness through Core Meetings, Impromptu Huddles, Team Rounds, and Debriefings

High-functioning team performance depends on situational awareness. Allowing time for teams to meet either formally or informally to discuss patient care and develop plans is crucial to remaining vigilant. Some facilities call this type of meeting a “huddle” or “running the board,” and engage in these activities at critical times, such as when patient census or acuity is rapidly changing. During these times, several members of the team act as a “fresh pair of eyes.” Having many eyes on the same fetal tracing, for example, can reduce errors and allow team members to feel more confident in their assessments. A few studies have revealed that eliciting a “second opinion” from a consulting physician may safely avert an unnecessary cesarean. Teams should also utilize briefings and debriefings to determine safe practices and review outcomes. Developing Rapid Response Teams

There are occasions when promoting vaginal birth in the presence of labor abnormalities requires the ability to rapidly respond from time of decision to incision. This ability to respond rapidly and efficiently once the decision is made to perform an emergency cesarean allows the team to wait patiently when faced with labor abnormalities. When interprofessional teams train together under simulated conditions, they develop skilled, coordinated responses to critical obstetric events. In this regard, the development of a Rapid Response Team on the maternity unit has been promoted by ACOG and by the Institute for Healthcare Improvement, as well as by many other stakeholders.

2. Implement Standard Diagnostic Criteria and Standard Responses to Labor Challenges and Fetal Heart Rate Abnormalities

Utilize Standard Diagnostic Criteria and Algorithms to Reduce and Respond to Labor Dystocia

The criteria for normal labor progress established in the 1950s by Friedman — 1.2 cm/hour for nulliparous women and 1.5 cm/hour for multiparous women — should no longer be used as the parameters to define labor dystocia. Instead, in response...
to the data on contemporary labor patterns, the ACOG/SMFM Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery has recommended specific guidelines that encourage a more patient approach to first and second stage labor management. Specifically, “slow but progressive labor” in the first stage is not an indication for cesarean, nor is a “prolonged latent phase” as defined by the previous Friedman parameters of greater than 20 hours for nulliparous women and 14 hours for multiparous women. It is important to remember that, under the recent guidelines, progress in labor is defined not only in terms of cervical dilation but also in reference to cervical effacement and fetal station. Likewise, progress in the second stage must consider rotation as well as descent. Furthermore, as Zhang and colleagues point out, using an “average” as the parameter for guiding labor management decisions is not suitable for management of the individual patient. Rather, women should be compared to the longest normal duration (also known as 95th percentile values) for the first and second stages of labor. Other maternal factors should also be considered before making the diagnosis of labor dystocia. For example, longer labors are more likely in older women; obese women (BMI equal to or greater than 30) are more likely to have an overall longer labor and progress more slowly through the interval between early and active labor (4-6 cm); and epidural anesthesia is associated with longer first and second stages of labor (see Part II for recommendations for women with epidural anesthesia).

Beyond the definitions and management guidelines set forth by the ACOG in Tables 19 and 20, some facilities may find it extremely useful to utilize dystocia checklists, labor algorithms, or labor duration guidelines to diagnose labor dystocia and arrest of labor. Also useful are “hard stop” checklists, used before proceeding with a cesarean for labor dystocia or failed induction (consult Appendix D, under “Labor Management,” for various examples of these types of tools).

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**Table 19. Summary of Recommendations for the First Stage of Labor (ACOG/SMFM Obstetric Care Consensus)**

<table>
<thead>
<tr>
<th>Summary of Recommendations</th>
<th>ACOG/SMFM Obstetric Care Consensus Statement</th>
<th>Safe Prevention of the Primary Cesarean (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the First Stage of Labor</td>
<td>A prolonged latent phase of greater than 20 hours in nulliparas and 14 hours in multiparas is not an indication for cesarean delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Slow but progressive labor is not an indication for cesarean delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Before 6 cm dilation, standards of active labor progress should not be applied to nulliparous or multiparous patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients who undergo cesarean delivery for active phase arrest in the first stage of labor should be at or beyond 6 cm dilation WITH ruptured membranes AND:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 4 hours of adequate contractions without cervical change, OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At least 6 hours of oxytocin with inadequate contractions and no cervical change</td>
<td></td>
</tr>
</tbody>
</table>

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**Table 20. Summary of Recommendations for the Second Stage of Labor (ACOG/SMFM Obstetric Care Consensus)**

<table>
<thead>
<tr>
<th>Summary of Recommendations</th>
<th>ACOG/SMFM Obstetric Care Consensus Statement</th>
<th>Safe Prevention of the Primary Cesarean (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the Second Stage of Labor</td>
<td>An absolute maximum length of time for the 2nd stage has not been identified</td>
<td></td>
</tr>
<tr>
<td></td>
<td>As long as maternal and fetal condition permits, the diagnosis of arrest of labor in the 2nd stage should not be made prior to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At least 2 hours of pushing for multiparous patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• At least 3 hours of pushing in nulliparous patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Longer durations may be appropriate on an individualized basis, for example with epidural anesthesia or fetal malposition as long as progress is documented)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Operative vaginal delivery by an experienced, well-trained physician is a safe and reasonable alternative to cesarean delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manual rotation of the fetal occiput of the malpositioned fetus in the 2nd stage of labor is a reasonable intervention to consider before operative vaginal delivery or cesarean delivery. Furthermore, assessment of fetal position in the 2nd stage of labor is essential, especially when abnormal descent is noted</td>
<td></td>
</tr>
</tbody>
</table>
Implement Policies for the Safe Use of Oxytocin

In the past decade, quality improvement programs have provided guidelines for the safe use of oxytocin during labor by minimizing wide variations in dosing and timing. In 2007, Steve Clark and colleagues published an approach for using a conservative checklist-based protocol within the Hospital Corporation of America’s 125 obstetric facilities. After instituting this protocol, results showed utilization of lower maximum doses of oxytocin, lower cesarean rates, and improved neonatal outcomes. Many other individual hospitals, hospital systems, the ACOG, and some state perinatal collaboratives have since created similar guidelines for the safe use of oxytocin to decrease cesarean birth rates while improving outcomes. Essential components of these programs are included in Table 21.

Endorse NICHD Categories and Standardize Responses to Abnormal Fetal Heart Rate Patterns and Uterine Activity

There is wide variation among providers and hospitals as to what constitutes a FHR tracing indicative of acidemia requiring expedited birth. It is believed this variation is due to a longstanding lack of standardized terminology, interpretation, and management guidelines.

In 2008, the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), the ACOG, and the SMFM sponsored a workshop to develop a uniform nomenclature for FHR tracings and uterine activity, to standardize interpretation, and to make recommendations for management of abnormal tracings. A three-tiered system of intrapartum FHR assessment was proposed. Category I is strongly predictive of normal fetal acid-base status. Category II, which accounts for the majority of FHR tracings in labor, contains all FHR patterns not in Category I or III; overall, Category II tracings are not predictive of abnormal fetal acid-base status, but acidemia in Category II cannot be excluded. Category III is predictive of abnormal fetal acid-base status and requires expedited birth. See Table 22 for further review of these categories.

In 2013, Clark and colleagues published an important article addressing the need for standardizing assessment of Category II FHR tracings, which account for more than 80% of intrapartum FHR patterns. Category II tracings are challenging to interpret. Over-concern for variable decelerations despite normal baseline variability have contributed to higher cesarean rates. However, under-appreciation of a fetus’s deteriorating status can result in morbidity and occasionally mortality. Although the ACOG Practice Bulletin Number 116 outlines general recommendations for management of various Category II patterns, many labor and delivery units are moving toward implementation of specific algorithms in order to simplify management of complex tracings. Clark and colleagues created such an algorithm and an accompanying table of specific clarifications. The goal of the algorithm is to assist in delivering the fetus before significant acidemia occurs, while avoiding an unnecessary cesarean in cases where the Category II tracing indicates continued fetal well-being. It should be noted that Clark’s algorithm does not include modification of management for fetal tachycardia or presence of meconium. The impact of meconium in conjunction with a Category II tracing was evaluated by Frey and colleagues in 2014. They noted that 21% of Category II tracings had meconium and that this combination was accompanied by an increased risk of neonatal morbidity.

Other facilities and perinatal collaboratives have since designed useful algorithms based on the concepts of the

<table>
<thead>
<tr>
<th>Essential Components of Safely Administering Oxytocin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardized oxytocin administration protocols and order sets</td>
</tr>
<tr>
<td>Checklists for initiation and ongoing assessment of oxytocin</td>
</tr>
<tr>
<td>Documentation required (with indication) for induction or augmentation</td>
</tr>
<tr>
<td>Fetal status assessment (initial and ongoing)</td>
</tr>
<tr>
<td>Uterine activity assessment (initial and ongoing)</td>
</tr>
<tr>
<td>Availability of a physician capable of performing an emergency cesarean section if needed</td>
</tr>
<tr>
<td>Criteria for decreasing or discontinuing oxytocin</td>
</tr>
<tr>
<td>Resuscitative measures clearly defined and documented</td>
</tr>
<tr>
<td>Resumption of oxytocin parameters clearly defined</td>
</tr>
<tr>
<td>Consideration of other extenuating factors, such as pain medication effects, epidural, fetal demise, etc that might impact oxytocin use and appropriate dosing</td>
</tr>
<tr>
<td>Data collection and evaluation related to protocol adherence, cesarean delivery, operative vaginal delivery rates, and maternal and neonatal complication rates</td>
</tr>
</tbody>
</table>
Clark model, some with even greater detail. The common thread shared by these algorithms is the initiation of clinical decision making based on the presence or absence of moderate variability and/or accelerations. Both are highly predictive of normal acid-base status, allowing the provider to immediately identify FHR patterns that may require birth to be expedited.227,278

One standard approach used by many facilities to assess Category II tracings is to reassess the tracing every 30 minutes once the Category II pattern is identified. Appropriate conservative corrective intervention(s) would be immediately implemented (Table 23), and the algorithm would be reapplied at least every 30 minutes, or at a different interval as indicated by the algorithm. Within this approach, providers respond to the bedside if there is a persistent Category II tracing. Additionally, team members seek out a second opinion when a Category II tracing is identified. Assessment of parity, labor progress, and contributing medical conditions are critical to evaluating the true severity of the tracing and making a management or delivery plan. Repeating EFM interpretation, assessment, or certification programs at least every two years may improve bedside interpretation by both nurses and providers. Regular

<table>
<thead>
<tr>
<th>Baseline rate</th>
<th>Category I (includes all of the following criteria)</th>
<th>Category II (includes any of the following criteria)</th>
<th>Category III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradycardia without absent baseline variability</td>
<td>Tachycardia</td>
<td>Absent variability WITH any of the following:</td>
<td></td>
</tr>
<tr>
<td>Moderate Variability</td>
<td>Absent, without recurrent decelerations</td>
<td>- bradycardia</td>
<td></td>
</tr>
<tr>
<td>Marked</td>
<td>Marked</td>
<td>- recurrent late decelerations</td>
<td></td>
</tr>
<tr>
<td>Marked</td>
<td>Marked</td>
<td>- recurrent variable decelerations</td>
<td></td>
</tr>
<tr>
<td>Late or variable decelerations</td>
<td>Marked</td>
<td>Or</td>
<td></td>
</tr>
<tr>
<td>Absent</td>
<td>Marked</td>
<td>Sinusoidal pattern</td>
<td></td>
</tr>
<tr>
<td>Early decelerations</td>
<td>Present or absent</td>
<td>Absence of induced accelerations after fetal stimulation</td>
<td></td>
</tr>
<tr>
<td>Accelerations</td>
<td>Present or absent</td>
<td>Absence of induced accelerations after fetal stimulation</td>
<td></td>
</tr>
</tbody>
</table>

Clark model, some with even greater detail. The common thread shared by these algorithms is the initiation of clinical decision making based on the presence or absence of moderate variability and/or accelerations. Both are highly predictive of normal acid-base status, allowing the provider to immediately identify FHR patterns that may require birth to be expedited.227,278

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| Change the patient’s position | Administer amnio-infusion if repetitive or deep variable decelerations are present |
| Give an intravenous bolus of 500–1,000 mL of Lactated Ringer’s solution | Discontinue any cervical ripening agents |
| Administer oxygen | Consider a tocolytic such as terbutaline if tachysystole is present or if uterine contractions are prolonged or coupled |
| Stop or decrease oxytocin infusion | Intermittent pushing efforts may help avoid progression to fetal acidemia if deep variables occur in the second stage of labor |
have “a clear policy regarding labor induction, including a list of acceptable indications, and should specify the definitions of a favorable cervix, options for cervical ripening in the presence of an unripe cervix, oxytocin infusion protocols, and criteria for the diagnosis of failed induction. Labor induction with an unfavorable cervix should not be undertaken unless delivery is indicated for clear maternal or fetal benefit.”

Once it is determined that the woman is at least 41 weeks gestation, or that a medical indication exists for induction at an earlier gestational age, the determination of whether the cervix is “favorable” should guide the induction process. The Bishop score, a tool originally used to identify multiparous women at term who were likely to enter spontaneous labor, is now more often used to determine cervical ripeness.28

The literature generally defines “unfavorable cervix” as a Bishop score of less than 6, while a Bishop score of 8 indicates a likelihood of vaginal birth after labor induction that is similar to spontaneous labor.229

Women undergoing induction of labor without a favorable cervix (Bishop score less than 6 for multiparous women, less than 8 for nulliparous women) should receive cervical ripening prior to starting oxytocin. The use of cervical ripeners such as misoprostol, prostaglandin E2 preparations, and mechanical methods such as Foley bulbs and laminaria tents, are associated with lower rates of cesarean birth than the use of oxytocin alone when the cervix is unfavorable.282,283 Evidence supports use of these methods in combination, such as a Foley bulb with misoprostol.284

Table 25. Examples of Accepted Medical Indications for Induction of Labor229,235

<table>
<thead>
<tr>
<th>Examples of Accepted Medical Indications for Induction of Labor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placental abruption</td>
</tr>
<tr>
<td>Fetal demise or fetal demise in prior pregnancy</td>
</tr>
<tr>
<td>Premature rupture of membranes</td>
</tr>
<tr>
<td>Gestation at or greater than 41 weeks</td>
</tr>
<tr>
<td>Maternal medical conditions such as pre-existing diabetes, gestational diabetes, renal disease, chronic pulmonary disease, choles tosis of pregnancy, maternal coagulation defects including antiphospholipid syndrome, cardiovascular diseases (congenital and other), HIV infection</td>
</tr>
<tr>
<td>Fetal conditions such as IUGR, oligohydramnios, polyhydramnios, fetal distress, isoimmunization (Rh and other), fetal-maternal hemorrhage, fetal malformation, chromosomal abnormality, or suspected fetal injury</td>
</tr>
</tbody>
</table>

Table 24. Gestational Age Terminology and ACOG Criteria for Confirmation of Term Gestation228,231

<table>
<thead>
<tr>
<th>Gestational Age Terminology</th>
<th>ACOG Criteria for Confirmation of Term Gestation229</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late preterm 34 0/7 – 36 6/7 weeks</td>
<td>Ultrasound performed at less than 20 weeks gestation confirms a gestational age of 39 weeks or greater</td>
</tr>
<tr>
<td>Early term 37 0/7 – 38 6/7 weeks</td>
<td>Documentation shows fetal heart tones by Doppler have been present for 30 weeks</td>
</tr>
<tr>
<td>Full term 39 0/7 – 40 6/7 weeks</td>
<td>36 weeks have passed since a positive urine or serum pregnancy test</td>
</tr>
<tr>
<td>Late term 41 0/7 – 41 6/7 weeks</td>
<td>Post term 42 0/7 weeks or more</td>
</tr>
</tbody>
</table>

FHR tracing reviews can reinforce accurate assessment of worrisome patterns. Inclusion of all providers and nurses in these review sessions is ideal and fosters interprofessional communication, assessment, and management of the fetal heart rate.

**Standardize Induction of Labor: Patient Selection, Scheduling, and Induction Process**

The ACOG/SMFM Consensus Statement on Safe Prevention of the Primary Cesarean Delivery29 gives clear guidance for the selection of appropriate candidates for induction of labor. While previous efforts have focused on prevention of induction of labor before 39 weeks, the new consensus guidelines urge induction of labor before 41 weeks only if medical indications are present. An increasing body of research supports that the greatest benefit to the mother and fetus is to facilitate birth somewhere between 41 and 42 weeks of gestation. Induction during this period is associated with fewer perinatal deaths (although the absolute risk is small), decreased neonatal morbidity (e.g. meconium aspiration), and decreased risk of cesarean.243,281

In 2010, the CMQCC, along with the California Department of Public Health and the March of Dimes, developed a toolkit for reduction of non-medically indicated deliveries before 39 weeks gestation.228 The toolkit outlines case studies of hospitals and hospital systems that successfully implemented programs to reduce non-medically indicated inductions. Although each facility took a slightly different programmatic approach, they all share basic foundational components that proved to be critical to success (Table 26).

At minimum, the summary of the joint NICHD, SMFM, and ACOG workshop to prevent the first cesarean birth (2012) recommends that facilities should
Mechanical methods of cervical ripening achieve similar rates of vaginal birth within 24 hours as prostaglandins and prostaglandin analogues do, and are associated with overall fewer maternal and neonatal side effects such as tachysytote and umbilical cord pH less than 7.10,282,285,286

The exact method of induction of labor should be individualized to the woman based on her Bishop score, parity, signs of pre-labor, fetal status, and patient preference. It is important to remember, and to counsel women, that latent labor is longer when labor is induced as compared to spontaneous labor.246 For this reason, the ACOG/SMFM guidelines recommend nonintervention and patience as long as failure.”

The ACOG/SMFM guidelines strongly advise reserving the diagnosis of “failed induction” for women who, after the period of cervical ripening is complete, have not achieved regular contractions and cervical change after 24 hours of oxytocin and rupture of membranes (if rupture is possible).85 The ACOG/SMFM guidelines advise the following for diagnosis of failed induction: “If the maternal and fetal status allow, cesarean deliveries for failed induction of labor in the latent phase can be avoided by allowing longer durations of the latent phase (up to 24 hours or longer) and requiring that oxytocin be administered for at least 12–18 hours after membrane rupture before deeming the induction a failure.”

Finally, there are specific cases in which women may be safely discharged from the labor and delivery unit if, for example, after 24 hours the cervix shows minimal or no change, contraction strength is minimal, membranes remain intact, and maternal and fetal statuses are reassuring. This is especially true in cases of non-medically indicated induction of labor. However, this concept can also be applied to women with certain medical indications, such as chronic hypertension that is well-controlled. In these cases, the previous 24 hours of cervical ripening and/or oxytocin serve as a negative contraction stress test. Upon discharge, a plan should be made for the woman to return in 24 to 48 hours to restart the induction.

Even when induction of labor is medically indicated, shared decision making is critical. Informed consent prior to induction should include discussion of the normal processes of labor as well as potential harms/benefits and optimal approach to induction of labor.287 Providers are encouraged to use high-quality decision aids to assist the woman in understanding the risks/benefits of induction.288 These decision aids also help the woman engage in discussion with the provider,289 and may prompt her to ask relevant questions that she may not have previously considered.

Providers often report pressure from women to induce labor for reasons related to convenience or alleviation of discomfort. In these situations, it is incumbent on the provider to be proactive in supporting the natural course of the pregnancy. Key messages include describing the risk to the baby (e.g. interrupted brain and lung development), risk to the woman (e.g. possibility of cesarean and its attendant risks, as well as the future risk of a first cesarean).228 It may be helpful to engage the woman early in the pregnancy about the importance of

<table>
<thead>
<tr>
<th>Key Components for Successfully Decreasing Non-medically Indicated (Elective) Induction of Labor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician/staff education regarding maternal and neonatal complications of non-medically indicated inductions</td>
</tr>
<tr>
<td>Patient education that defines “full term,” describes the maternal and neonatal complications of non-medically indicated inductions, and includes a detailed informed consent discussion with appropriate documentation (may also include public awareness campaigns through social media and other channels)</td>
</tr>
<tr>
<td>Department policies that establish standards set by ACOG and national quality criteria</td>
</tr>
<tr>
<td>Standardization of the scheduling process for all inductions of labor. Standardized forms may need to identify “hard stops” such as the need for the scheduler to get approval from the department chair or appropriate designee if the patient does not meet criteria for medical indications for induction</td>
</tr>
<tr>
<td>Physician leadership/clinical champions</td>
</tr>
<tr>
<td>QI data collection and feedback</td>
</tr>
</tbody>
</table>

### Table 26

**Key Components for Successfully Decreasing Non-medically Indicated (Elective) Induction of Labor**

### Table 27

**Summary of Recommendations for Induction of Labor**

**ACOG/SMFM Consensus Guidelines for Induction of Labor**

| Induction of labor before 41+0 weeks should be reserved for women with a maternal or fetal medical indication |
| Induction of labor at or after 41+0 weeks gestation is advised in order to reduce the risk of cesarean delivery and perinatal morbidity and mortality |
| Women undergoing induction of labor without a favorable cervix should receive cervical ripening |
| As long as the maternal and fetal status allow, longer durations of the latent phase (24 hours or longer) should be allowed, and oxytocin should be administered for at least 12-18 hours after rupture of membranes before declaring a “failed induction” |
due date, but at the same time to point out the normalcy of going beyond 40 weeks. There are various reasonable, psychosocial reasons a provider may decide to induce a woman at her request (e.g. partner leaving on a long military deployment, or patient lives far away and has a history of precipitous labor). However, the potential benefits of this decision should be carefully weighed against the potential for harm.

Just as providers feel pressure from women to induce labor, women often report feeling similar pressure from providers. For example, a recent study revealed that nearly one-third of the women who participated in the Listening to Mothers III national survey were told by their care providers that their baby might be getting “quite large.” Women with a suspected large baby were more likely to be induced, and were more likely to ask for and have a planned, pre-labor cesarean. Yet only 19% of those with a suspected large baby went on to deliver a baby over 4000g. The conclusion drawn from the data is that suspected macrosomia is not an indication for induction, and only in rare cases (greater than 5000 grams, or greater than 4500 grams for women with diabetes) is cesarean recommended to prevent potential birth trauma.3,188

Other reasons providers may be more commonly inclined to suggest induction of labor include provider convenience and financial incentives (see Part I, “Payment/Reimbursement Models that Conflict with High-Value, High-Quality Maternity Care”). In summary, if induction of labor is not medically indicated, suggestion by the provider to do so is in direct conflict with the provision of high-quality, high-value maternity care.

3. Utilize Operative Vaginal Delivery for Eligible Cases

When performed by a well-trained, experienced physician, and on a fetus not believed to be macrosomic, judicious use of operative vaginal delivery offers a safe alternative to cesarean birth for the management of second stage abnormalities such as fetal intolerance or dystocia due to maternal exhaustion. Caution should be exercised with mid-pelvic procedures or those where rotation of the occiput transverse or occiput posterior fetus is necessary, as this requires a high level of skill and experience to safely perform. Such procedures are less likely to be successful than low or outlet procedures, which may safely prevent a cesarean birth in most eligible cases. In fact, less than 3% of attempted operative vaginal deliveries proceed to a cesarean.292

Unfortunately, training in operative vaginal delivery in many residency programs is decreasing, especially training in the use of forceps. For operative vaginal delivery to be a safe alternative to cesarean, residency programs must encourage and incorporate training, and the skill must be maintained throughout an attending physician’s tenure.

4. Identify Malposition and Implement Appropriate Interventions

Refer to Appendix G for detailed instructions and recommendations for malposition.

Identification

Identification of malposition during labor, particularly by the early part of the second stage, is an important aspect of preventing cesarean. There are various ways to identify the OP or OT fetus. Ultrasound is the most accurate approach. Studies in second stage have reported digital examination error rates of 26% to 39% compared to the “gold standard” of abdominal ultrasound.291,294,295

### Table 28. Commonly Cited Reasons for Induction of Labor that Do Not Meet Criteria as “Medical Indications”290

<table>
<thead>
<tr>
<th>Commonly Cited Reasons for Induction of Labor that Do Not Meet Criteria as “Medical Indications”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected macrosomia*</td>
</tr>
<tr>
<td>History of fast labors</td>
</tr>
<tr>
<td>Advanced cervical dilation</td>
</tr>
<tr>
<td>Previous maternal pelvic floor injury (e.g. previous 4th degree laceration)</td>
</tr>
<tr>
<td>Partner leaving town</td>
</tr>
<tr>
<td>Family in town</td>
</tr>
<tr>
<td>Maternal exhaustion</td>
</tr>
<tr>
<td>Lives far away</td>
</tr>
</tbody>
</table>

*Suspected macrosomia is commonly cited as medical indication for induction of labor. Given that fetal estimates of weight late in gestation are imprecise, suspected macrosomia is not a medical indication for induction of labor. Cases where cesarean delivery is offered in order to avoid birth trauma should be limited to an ultrasound estimation of fetal weight of 5,000 grams, or 4,500 grams for diabetic women.
Prevention

**Avoid routine early amniotomy**

Amniotomy prior to 5 cm eliminates the cushion of the fore waters which allow for fetal repositioning, and may result in more non-reassuring FHR patterns.\[^{296}\]

**Employ preventive measures for women with epidural anesthesia**

While there is no definitive evidence establishing a causal relationship, a preponderance of evidence suggests that mothers with epidurals are up to four times as likely to have an OP fetus than women without epidurals.\[^{180,181}\] Caregivers should change the patient’s position at least every 20 minutes to maximize fetal accommodation to a more favorable position.\[^{157}\]

Promote rotation

**Intrapartum Maternal/Fetal Positioning**

Promote rotation to the more favorable OA position through maternal /fetal positioning during the intrapartum period. If it is unclear whether the fetus is OP or OT during a prolonged second stage, maternal position changes every five to six contractions may facilitate rotation to OA.\[^{157}\] Supportive care techniques from nurses to help expand and change the shape of the pelvis, such as the pelvic press and lunges, may be useful in this regard.

**Consider Pushing Positions**

For the persistently OP fetus, the doula, nurse, and provider should consider the most effective positions for pushing and the “drive angle” of the occiput relative to the maternal bony pelvis.\[^{157}\] Forward-leaning, non-dorsal pushing positions are recommended for persistent malposition. These include various squatting positions (e.g. with a squat bar or with support from the woman’s partner or doula), and forward-leaning positions while sitting (e.g. on the toilet), kneeling, or standing.\[^{157}\] For the OP fetus, when the most common modern-day pushing position is employed (the lithotomy position with “chin-to-chest”), the anterior sinciput is obstructed, gravity is not utilized, and significantly longer pushing times often result. If or when lithotomy position is used, exaggerated lithotomy (also known as the back-lying squat, or the McRobert’s position used for shoulder dystocia), with the woman’s head flat on the bed, and buttocks slightly lifted, can expand the fore pelvis sufficiently that the anterior sinciput of the OP fetus can more easily swing under the symphysis pubis.\[^{157,297}\]

**Support the Maternal Psyche and Body**

Physical and psychological support measures are critical for the woman who is fatigued and doubts her ability to give birth vaginally. If the fetus demonstrates health, a sip of liquid with some glucose (e.g. juice, Gatorade) or a light carbohydrate snack might give her a burst of energy to continue to run the “final lap.”\[^{298}\]

**Manual rotation**

Manual rotation attempts are advocated in early to mid-second stage of labor.\[^{157,299,300}\] Digital/manual rotation of the fetus from the OP position to the OA position is associated with significantly lower rates of cesarean birth\[^{180,301,302}\] and other complications associated with persistent OP position e.g. severe perineal lacerations, hemorrhage, and chorioamnionitis.\[^{249}\] A recent retrospective cohort study of over 700 women who underwent manual rotation from the OP or OT position demonstrated a high rate of success for this procedure: 74% delivered vaginally in the OA position.\[^{301}\] Instrumental rotation is a safe alternative to manual rotation for appropriate candidates when performed by a skilled, experienced physician.\[^{250,303,304}\]

**Patience, patience, patience**

The “tincture of time” approach is likely the best strategy when incremental descent is observed in the second stage, if the fetus and mother remain resilient.\[^{108}\] Longer pushing durations may be necessary in the circumstance of malposition.\[^{1}\] Evidence of progress (or lack thereof) is best ascertained when the same clinician monitors fetal descent throughout the second stage.\[^{303,305}\]
Table 29. Identification, Prevention, and Treatment of the Malpositioned Fetus

<table>
<thead>
<tr>
<th>What</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early identification</td>
<td>Manually, or by ultrasound (gold standard) if manual appraisal is uncertain</td>
</tr>
<tr>
<td>Prevention</td>
<td>Avoid early amniotomy</td>
</tr>
<tr>
<td></td>
<td>For women with epidural, assist in changing position every 5-6 contractions, or about every 20 minutes</td>
</tr>
<tr>
<td>Promote rotation</td>
<td>Maternal position changes every 5-6 contractions or about every 20 minutes</td>
</tr>
<tr>
<td></td>
<td>Consider the most effective pushing positions, such as various squatting positions and forward-leaning positions while sitting (e.g. on the toilet), while squatting with squat bar, or while standing. In lithotomy position, the woman’s head should remain flat on the bed with buttocks slightly lifted (opposite of the “curl around the baby” approach)</td>
</tr>
<tr>
<td>Support maternal psyche and body</td>
<td>Family and professional support and encouragement is critical at this time</td>
</tr>
<tr>
<td></td>
<td>Offer sips of carbohydrate liquid or light carbohydrate snack</td>
</tr>
<tr>
<td>Attempt to rotate the baby</td>
<td>Early to mid-second stage of labor; manually or by instrument if indicated</td>
</tr>
<tr>
<td>Tincture of time</td>
<td>Be patient! In instances of malposition, longer pushing durations for the healthy fetus are often necessary</td>
</tr>
</tbody>
</table>

5. Consider Alternative Coverage Programs (Laborist Models and Collaborative Practice Models)

Physicians and Midwives as Hospitalist Providers (Laborists)

Though OB hospitalists or laborists were originally engaged to care for a population of unassigned patients, and to be a safety net for emergencies, other beneficial effects have emerged. Recent studies that focused on the relationship between cesarean rate and laborist coverage have shown a statistically significant reduction in cesarean births with “around-the-clock care.” The definition of around-the-clock care differs from facility to facility, with models ranging from physicians available only as safety-net providers in case of significant events, on one end of the spectrum, to true laborists attending to and delivering all patients. The recent analysis by Iriye and colleagues showed that it was not simply a matter of having around-the-clock coverage alone, but of having an independent group (a laborist “staff model”) whose only function is to care for inpatients, without outside responsibilities, that makes a difference in the number of cesareans. It is unclear whether this is due to being on-site and ready to respond, or due to the removal of economic and/or time-based incentives to perform a cesarean. Whatever the precise dynamics, laborist models have clear, unique advantages, including “retention of core knowledge, high intrapartum competence,” and quick response times.

Marin General Hospital, a California community hospital that implemented an innovative, collaborative midwife-physician laborist model, reported its significant comparison of cesarean birth rates in two recent studies. One study evaluated over 9,000 singleton live births through a retrospective comparison of a traditional private practice model and a midwife-physician laborist model. The NTSV cesarean rate for the traditional model was 29.8%, compared to 15.9% for the collaborative laborist model. The second study involved the evaluation of a prospective cohort of privately insured women between 2005 and 2014, and compared the NTSV cesarean and VBAC rates before and after a change from a private practice model to a collaborative midwife-physician laborist model. The primary cesarean rate fell from 31.7% to 25.0%, with a 7% drop in the very first year after implementation of the new model.

Collaborative Practice between Physicians and Midwives

Collaborative practice between midwives and physicians is the inter-professional provision of care toward a common goal that utilizes and respects the separate expertise of both provider types. Collaborative practice between physicians and midwives
Midwifery care has been identified as an underused maternity service in the United States, with the potential to curb costs, improve overall outcomes, and reduce rates of cesarean. Of particular note are the international landmark studies provided in the 2014 *Lancet Series on Midwifery*. This series noted that “midwifery is a vital solution to the challenges of providing high-quality maternal and newborn care for all women and newborn infants, in all countries.” Within the *Lancet Midwifery Series*, Renfrew and colleagues identified over 50 outcomes that are impacted positively by midwifery care, including reduced rates of cesarean. Similar results documenting lower cesarean rates with midwifery care have been noted in the United States, and the “style” of care and interventions employed by midwives have been identified as practices that can lower primary cesarean rates (many of which have already been noted in Part II of this toolkit). Furthermore, women who give birth in states where regulations support the autonomous practice of Certified Nurse-Midwives have lower odds of cesarean birth. In order to maximize utilization of the nurse-midwifery workforce, hospitals and clinic settings should update policies and procedures to ensure that they are not more restrictive than what is legally allowed in the state. Frequent, outdated policies can be found that limit the nurse-midwifery scope of practice without evidence-base. Granting nurse-midwives privileges consistent with their legal scope can expand the clinical care capacity of the facility, improve clinical outcomes, and further facilitate cesarean reduction efforts.

### 6. Develop Systems that Facilitate Safe, Patient-Centered Transfer of Care between the Out-of-Hospital Birth Environment and the Hospital

In February 2015, the ACOG in conjunction with the SMFM published the *Obstetric Care Consensus on Levels of Maternal Care* that was endorsed by the ACNM, AWHONN, the American Association of Birth Centers (AABC), and many other professional organizations. This statement recommends a tiered system of care based on maternal level of risk, starting with out-of-hospital birth centers staffed by midwives and progressing through a hierarchy from Level I Hospital (Basic) to Level IV (Perinatal Regional Care Center). In alignment with the *Lancet Midwifery Series*, the consensus statement suggests modifying care to suit individual need based on risk. Shifting to a “wellness model of care” that safely reduces routine intervention and matches the magnitude of response and intervention to the needs and risk level of the patient is a key part of transforming maternity care, lowering overall costs, and in particular lowering the cesarean birth rate (refer to Part II for more on this topic). While full discussion of this consensus statement is beyond the scope of this toolkit, the future of care delivery in obstetrics will almost certainly involve increased care by midwives and family physicians, expansion of collaborative care and laborist models, and increased utilization of out-of-hospital birth. To accommodate this change, hospitals must design systems of care that safely and efficiently allow for the seamless transfer of care from the out-of-hospital environment to the hospital environment. This will require “effective interdisciplinary teamwork and integration across facility and community settings.” An integrated system of care embraces the understanding that some women will choose to birth safely in an out-of-hospital environment and that a minority of these women will require transport and transfer to medical care within the hospital. Interprofessional dialogue between out-of-hospital and in-hospital providers should remain respectful and cooperative. The safety of mothers and babies, and the future of a fully integrated system, will be at risk if women and out-of-hospital providers perceive they will be received with judgment and disrespect for timely, necessary, and medically-sound transfers of care.

### 7. Avoid Defensive Medicine: Focus on Quality and Safety

Providers are affected by the risk of litigation, whether that risk is real or only perceived. A landmark report in 2013, *Maternity Care and Liability: Pressing Problems, Substantive Solutions*, the first of its kind in recent decades, takes a comprehensive look at the current environment of liability in maternity care and at solutions that hold great potential. Studies noted in this report revealed that only 0.6% of women and 0.2% of newborns receiving care in U.S. hospitals experienced “negligent injury.” Furthermore, while providers often worry about non-meritorious claims, the reality is that 75% of paid claims involve “injury due to substandard care.”

Despite this data, providers continue to practice defensively in certain situations. One defensive practice involves “assurance” behaviors, meaning the overuse of tests, procedures, or referral to other providers. Many studies have attempted to describe the link between cesarean births and assurance behaviors by providers (the maternity liability
report noted above outlines a full, comprehensive list of 13 recent studies). Collectively, these studies reveal that liability pressure is positively correlated to cesarean rates, though it likely accounts for only a small increase in those rates. As described previously, the decision to do a cesarean involves many factors, and while liability seems to play some role, it is likely a limited one.

From a clinical perspective, this information points to a real, tangible solution for providers and hospitals: focus on quality and safety. A real impact can be made on the 75% of claims filed for serious negligent behavior by focusing on care improvement strategies for providers and the systems that deliver care. Quality improvement efforts have the potential to significantly decrease overall litigation, premium costs, and payouts. Examples of these efforts range from maternity centers implementing electronic “real time” alerts for deviation from standards of care, to focusing on specific quality improvement tasks, to implementing comprehensive safety programs. These programs resulted in improved outcomes and lowered cesarean rates, while significantly reducing malpractice claims and decreasing birth trauma.

Easing distress and reducing fear of litigation can be accomplished by carefully educating providers on the benefits of a well-designed program to reduce cesarean, acknowledging providers’ concerns, and specifically addressing the situations that contribute the most to obstetric liability claims. A recent evaluation of 882 obstetric claims revealed that delayed or inappropriate treatment for fetal distress and response to or prevention of shoulder dystocia remain the top reasons for liability claims. Failure to properly consent patients with a prior cesarean birth regarding the very unlikely, but real risk, of fetal injury associated with uterine rupture after previous cesarean has also been noted to be a top reason for medical litigation. Therefore, cesarean reduction programs should focus on these key elements of liability, ensuring that providers understand how programmatic approaches can actually reduce malpractice risks and increase vaginal birth rates.

Protocols and workflows that focus on labor techniques (e.g. induction with ripe cervix or admission after onset of active labor) can reduce risk by avoiding a cascade of interventions and reducing oxytocin usage. Standardized oxytocin guidelines have been shown to help reduce claims while also reducing rates of cesarean. Common language for FHR interpretation can avoid errors of miscommunication, and standardized intervention protocols improve timely intervention for fetal distress. These methods also enhance communication and lead to less conflict, a frequently cited component in many malpractice claims. Standardized protocols for presumed macrosomia and shoulder dystocia management have been shown to reduce the risk of permanent injury. To reduce the likelihood of litigation from a trial of labor after cesarean, institutions should have standardized consents, and patient education and protocols for prompt intervention with suspected uterine rupture.

As previously discussed, one of the most critical elements of a well-designed quality improvement program is the involvement of the patient in determining the plan of care prior to labor. Shared decision making affords the patient part of the responsibility for the plan and reduces feelings of powerlessness and anger in the event of a poor outcome. Shared decision making serves as a sort of contractual relationship between the provider and the patient. Providers who document these discussions with patients and who have developed caring relationships either before the event in question, or after performing an operative delivery, often avoid litigation.

Institutional programs and alternative coverage programs, like the laborist approach described in the previous section, offer a promising strategy to reduce malpractice risk. Hospitalist programs, with the availability of prompt response, allow for more trials of labor, systematic labor intervention, and support for the timely interpretation of FHR patterns. Expansion of on-site labor support from midwives and doulas enhances the patient experience and involvement in the labor process and decision making, potentially lowering risk of malpractice claims.

Some experts have raised the fear of litigation if cesarean reduction programs result in unintended consequences or poor neonatal outcomes. It is important to point out that previous programs to reduce cesarean rates have not shown an increase in poor outcomes for women and babies, nor did the three pilot hospitals in California that implemented key portions of this toolkit in 2014.

First and foremost, it should be understood that a cesarean reduction program seeks to reduce unnecessary cesarean births. The program’s charter must clearly recognize that timely and well-chosen cesareans are sometimes necessary to prevent avoidable fetal and maternal harm.
Part IV. Reporting and Systems Learning: Using Data to Drive Improvement

Underlying Principles for Reporting and Systems Learning

A key strategy for successful quality improvement (QI) projects is the use of rapid-cycle data to help drive change. Achieving the goal of reducing avoidable cesarean births will depend on accurate and timely measures provided to clinicians and organizations about the care provided to patients. Both process and outcome measures help clinicians and organizations assess the quality of care but must be chosen carefully. The measures must accurately depict how care is provided, as well as identify which provider is responsible for which care decisions. Both provider level and organizational level assessments are critical to guide improvement efforts.

The first step is to create the ability to 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**

This section will review the barriers and strategies to accomplish these goals. Please refer to Appendix H for a description of current measures, with advantages and limitations of each, that are currently in use or have been proposed for labor and delivery.

In any quality improvement program, it is important to be vigilant for unintended consequences whereby unexpected harm might appear as a result of the project. Therefore, to ensure safety (and reassure all participants), all programs should track measures that assess maternal and newborn outcomes that could be affected by changes in labor management strategies. These are called balancing measures. Typical balancing measures used for projects to support vaginal birth and reduce cesareans would include term neonatal outcomes such as the NQF metric for Term Unexpected Newborn Complications (major and moderate neonatal complications among infants without any preexisting complications, such as poor intrauterine growth, birth defects, or multiple gestations). The rate of third and fourth degree lacerations is commonly used to illustrate that more vaginal births are not creating more maternal morbidity.

Transparency of hospital-level data is absolutely critical to QI for cesarean reduction. Public reporting improves consumer knowledge of quality providers, thus harnessing the power of consumer decision making to create a positive feedback cycle where quality is both created through...
transparency and sought out as a result of transparency. Table 30 outlines the public benefit of transparency and public reporting.

Table 30. Public Benefit of Transparency and Public Reporting

<table>
<thead>
<tr>
<th>Benefit</th>
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<tbody>
<tr>
<td>Gives consumer the ability to compare providers and organizations and make selections that truly consider cost, quality, and safety</td>
</tr>
<tr>
<td>Gives consumer the ability to make informed decisions about care</td>
</tr>
<tr>
<td>Improves trust between the public and providers/organizations</td>
</tr>
<tr>
<td>Incentivizes providers to focus on quality improvement</td>
</tr>
</tbody>
</table>

Only a few measures are appropriate for public release. They should be carefully vetted measures of the highest quality and easy to understand. It is important to identify the best way to reach the public with this information. Simply releasing results on a website may not result in much impact or public awareness. Placing the same measures in many communication channels at once and linking the data with partner organization websites and other marketing entities will result in greater awareness. An additional step is to provide prenatal clinics and offices with current data that they can share with women.

Implementation Barriers for Data-driven QI

The Task Force identified six main implementation barriers to using data to drive cesarean reduction. These represent common and repetitive issues faced in all QI projects but will be discussed in the specific context of cesarean reduction projects.

Table 31. Barriers to Using Data to Drive Reduction in Cesareans

<table>
<thead>
<tr>
<th>Barrier</th>
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<tbody>
<tr>
<td>Lack of awareness of the scope of the issue by providers and the public</td>
</tr>
<tr>
<td>Lack of transparency</td>
</tr>
<tr>
<td>Poor data quality</td>
</tr>
<tr>
<td>Lack of actionable data related to cesarean births</td>
</tr>
<tr>
<td>Data burden</td>
</tr>
<tr>
<td>Need for new measures to drive quality improvement</td>
</tr>
</tbody>
</table>

For data and information to work effectively as a driver of improvement, it must not only be clear and accurate, but also delivered in a manner that can be used to create action. Historically, however, there has been a lack of such actionable information (data) related to avoidable cesarean births for hospitals and providers. For example, the traditional Primary Cesarean Delivery Rate measured by hospitals may inform the organization that its rate is elevated but does not pinpoint why and, in turn, fails to identify strategies for improvement based upon that data. Furthermore, the data are usually not risk adjusted, and are therefore open to the response: “My practice (or hospital) takes care of more high risk patients and that accounts for our higher rate.” This often-heard sentiment has undermined many QI efforts in the past.

Measures used in QI are commonly divided into three categories:

- **Outcome (generally, measures of death, injury, complications or disabilities)**
- **Process (adherence of healthcare activities to guidelines, such as preoperative use of antibiotics or prophylaxis for venous thromboembolism)**
- **Structure (whether the facility or medical staff has appropriate resources, equipment and staffing)**

Cesarean rates do not fall neatly into any of these categories. But nationally, as issues of overuse and underuse are being examined, another quality category has been identified: “utilization rate.” This focuses on whether a facility (or provider) performs a procedure or activity too frequently or infrequently, and is the most appropriate category for cesarean birth measures.

In addition to the problem of the timeliness of actionable data, there have been a number of barriers to obtaining good data to help drive QI projects for cesarean birth. Risk adjustment and risk stratification did not have a national consensus until recently, and was not widely available. In addition, provider-level data for cesarean birth is difficult to ascertain for many organizations and clinicians. The physician of record for the cesarean may not have been the provider of care for the woman’s prenatal care or for the labor leading up to the decision to proceed with a cesarean. This makes it difficult to focus on the key decisions affecting labor outcome. Thus, organizations must ensure that the data resulting from measurement activities is attributed to the appropriate clinician. Accurate measurement strategies will help organizational and clinical leadership identify changes needed to make improvements, as well as understand progress towards the goal of reducing avoidable cesarean births.

Implementation Strategies for Data-driven QI

The key strategies for data-driven QI for cesarean reduction are shown in Table 32. Once again, these principles apply to most data driven QI projects, but will be discussed within the specific context of cesarean reduction efforts.
For this project on reducing avoidable cesarean births, there are two main strategies. First, the extraordinary variation in cesarean rates among hospitals and providers raises the obvious question: Why should such high rates in some

### Table 32. Key Strategies for Using Data to Drive Reduction in Cesareans

1. **Strategies to Make Data Compelling to Providers**
   - Provide timely data to providers in a persuasive manner using display tools, background information, benchmarks, historical data, and broader outcome data (such as infant outcomes and maternal morbidity measures)
   - Present comparative data in a manner that demonstrates a sense of urgency
   - Present identical measures across multiple levels – MD / practice group / hospital / medical group / health plan / purchaser /region / state
   - When presenting the data, include a goal that is attainable/achievable by showing that other similar providers have already reached the goal
   - “Package” the data for the audience – data can be supplemented by patient stories, not just graphs and figures

2. **Strategies to Assist Organizations to Understand Data Associated with their Hospital, and Identify Steps to Improve Care**
   - Create meaningful sub-measures that indicate the drivers for the cesarean rate and benchmark these against other facilities
   - For internal hospital use, create provider level rates to utilize “peer pressure” and identify those who would benefit from specific educational programs including reviews of their processes of care

3. **Strategies to Assist Providers to Understand their Cesarean Rates and be Comfortable with the Quality of the Data**
   - Provider-level data is a very important tool for driving QI but opens new issues of attribution, especially in facilities that have midwives or family medicine physicians who perform vaginal births with covering obstetricians performing the cesarean deliveries
   - Create data tools that allow practitioners to “roll-up” outcomes together (group statistics) or reassign attribution within the data set
   - Create tools for sub-analysis of physician-level rates to help providers understand where improvement opportunities lie

4. **Strategies to Engage Women, Employers, and the General Public in the Improvement Project**
   - Public release of selected hospital-level measures that have been well vetted
   - Provide a lay explanation of the measures
   - Widely distribute these measures through multiple media channels to capture the greatest attention

1. **Create Awareness**
   Before QI projects can approach success, the reason for change has to be articulated and widely communicated. In change literature, this is known as creating the “burning bridge” whereby the current “status quo” can no longer be sustained and movement is required. The drivers for lack of awareness that such change is necessary are shown in Table 33.

   For this project on reducing avoidable cesarean births, there are two main strategies. First, the extraordinary variation in cesarean rates among hospitals and providers raises the obvious question: Why should such high rates in some
institutions be supported when the outcomes are just as
go good if not better in locations with lower rates? Here, it is
important to have the discussion as broadly as possible with
all stakeholders: the media, consumer groups, employers,
health plans and professional groups. The variation in
cesarean rates among California hospitals is shown in Figure
6a for Total Cesarean Delivery Rate and in Figure 6b for Risk-
stratified Cesarean Delivery Rate, using the Nulliparous, Term,
Singleton, Vertex (NTSV) rate that addresses the risk adjust-
ment question posed in Figure 6a. The large variation among
California hospitals, even after risk adjustment, is obvious
and has opened a dialog for reexamination of the drivers for
cesarean birth throughout California.
The second major strategy for this project is to create a
network of concerned organizations that can support the
creation and maintenance of pressure for change. This
involves multiple meetings for outreach and education,
with organizations at all levels of the health system as well
as consumer organizations. The press is also an important
partner in this endeavor. Explaining the figures above, and
that variation between hospitals did not change even after
risk adjustment, has proved to be an effective strategy for
engagement.

2. Promote Transparency

Many hospital-level statistics are difficult to find, and in some
states they are not released at all. In the past, such statistics
frequently ended up on relatively obscure websites that
escape the attention of most pregnant women. Patients must
frequently rely on the provider’s self-descriptions — “I never
do unnecessary cesareans” or “My rate is below others in

Table 33. Lack of Awareness of the Need for Cesarean Reduction

<table>
<thead>
<tr>
<th>Drivers include:</th>
<th>Poor public understanding of the issue / appropriate cesarean rates (including purchasers, health plans, hospitals, and providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not compelling/Not an important issue</td>
<td>Data is not timely (several years old)</td>
</tr>
<tr>
<td>Not easy to gain access to the data/Not publicly available</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6a. Large Variation of the Total Cesarean Rate Among 251 California Hospitals: 2014

![Figure 6a](image)

Table 34. Lack of Transparency of Cesarean Data

<table>
<thead>
<tr>
<th>Lack of Transparency of Cesarean Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drivers include:</td>
</tr>
<tr>
<td>Not publicly available / not easy to find on the Web or easy to navigate the site on which it is reported</td>
</tr>
<tr>
<td>Data is not timely (old data)</td>
</tr>
<tr>
<td>No publicity to drive people to the data when first released</td>
</tr>
<tr>
<td>No continuing publicity for continued attention</td>
</tr>
</tbody>
</table>

Figure 6b. Large Variation of the NTSV Cesarean Rate Among 251 California Hospitals: 2014

![Figure 6b](image)
this facility”—without having access to evidence that could confirm or contradict those assertions. The drivers for lack of transparency are shown in Table 34.

Strategies for overcoming these obstacles are underway in California. After two years of low-key release of hospital–level cesarean data with little website traffic and little publicity, a broader approach was undertaken in January 2016. The risk-adjusted NTSV cesarean rate, with background commentary, for every hospital in California was released to the press in multiple cities. That data is now available on several websites, including CalQualityCare.org (a collaboration between California Hospitals Assessment and Reporting Taskforce and California Health Care Foundation) and CaHealthcareCompare.org (from the California Department of Insurance and Consumer Reports). Both of these websites use measures created by CMQCC, which in turn were derived from statewide data sets from the Office of Statewide Health Planning and Development (OSHPD) and from vital records.

3. Improve Data Quality

Providers rightfully want to ensure that performance measures are based on the highest quality data. The first response from providers with high rates of cesarean is to attack the quality of the data. As mentioned earlier, another often-heard concern from providers is that their high rate is not truly reflective of their care because they have higher-risk patients. These concerns underscore the need to address the issue of risk stratification or risk adjustment in ways that both providers and patients can understand. Lastly, it is discouraging for leaders and staff to have different results on the same measure reported by different agencies. This often results when staff from different departments release different data sets. These issues, and other drivers for poor data quality of cesarean birth measures, are shown in Table 35.

Table 35. Poor Data Quality

<table>
<thead>
<tr>
<th>Poor Data Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drivers include:</td>
</tr>
<tr>
<td>Difficulties with attribution to the correct provider</td>
</tr>
<tr>
<td>Need for risk adjustment</td>
</tr>
<tr>
<td>Variation in hospital coding for cesarean birth</td>
</tr>
<tr>
<td>Variation in birth certificate coding</td>
</tr>
<tr>
<td>Lack of institutional documentation and data governance standards</td>
</tr>
</tbody>
</table>

Strategies for overcoming these obstacles start with identifying the best sources for each of the key data elements and concentrating on data elements that are rarely the source of error. Gestational age and parity are well recorded on the birth certificate; fetal presentation and multiple gestation are accurately recorded in either the birth certificate or hospital discharge diagnosis files (ICD-9/10) and the provider who performed the cesarean is best found on the birth certificate. ICD-9/10 codes can provide additional data for further adjustment but are of lower quality than the previously-described data elements. Similarly, the birth certificate provides other data useful for risk adjustment, such as maternal age (excellent quality) and maternal body mass index (BMI) (good quality).

The CMQCC Maternal Data Center (MDC) receives and links together birth certificate and ICD-9/10 data sets. The MDC takes the best quality data fields from each set to create performance measures. In addition, many hospitals send other clinical data from their Electronic Health Record as process measures that are then linked to the existing data. Data quality is monitored using a comparison between the data sets, which allows for comparison of overlapping data elements such as presentation and plurality. The nationally recognized risk stratified cesarean measure—Nulliparous, Term, Singleton, and Vertex (NTSV)—can be calculated only using high quality data elements (parity, gestational age, plurality, and presentation) available in these administrative data. The need to further risk adjust the NTSV measure is under active investigation. Current findings indicate that major individual risk factors such as advanced maternal age and large BMI tend to cancel each other out at the hospital level. For example, California hospitals with a large number of nulliparous women of advanced maternal age also tend to have patients with lower or average BMI, and vice versa (CMQCC internal analysis of California data). Similar findings have been noted in Massachusetts. The MDC has access to data identifying the provider at the birth, and can calculate provider specific rates with good accuracy. However, in facilities that have midwives and family medicine doctors attending births, special data-collection accommodations must be made to account for the cesareans performed by covering obstetricians. The MDC has developed several strategies to mitigate this issue: (1) the ability to combine all the midwives, family medicine doctors, and covering obstetricians into an NTSV rate for the entire group; and (2) the ability to reassign attribution for births, recognizing the midwife or family medicine
doctor as the delivering provider even for cesareans. This is an internal facility activity specific to hospitals that have more sophisticated attribution needs, the accuracy of which depends on the clerk or staff assigned to data entry. The MDC is able to display lists of patients, making this process easier for those tasked with this duty. These issues make provider-level statistics a work in progress. They are very practical for internal use and, indeed, one of the most effective tools for driving physician change. However, provider-level data are not yet ready for public release until further experience is gathered.

4. Create Actionable Data

The mere availability of hospital performance measures is often not enough to drive QI projects. The measures must get into the right hands and appropriate comparisons to other facilities or providers must be presented with a sense of urgency and with action steps. There is growing recognition of the value of reporting the same measures at multiple levels of the health care system. This allows for better alignment of incentives and activities throughout the system. The barriers to actionable data are shown in Table 36.

Table 36. Lack of Actionable Data for Cesarean Births

<table>
<thead>
<tr>
<th>Lack of Actionable Data for Cesarean Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drivers include:</td>
</tr>
<tr>
<td>Not compelling / No sense of urgency</td>
</tr>
<tr>
<td>Data fatigue</td>
</tr>
<tr>
<td>Lack of appropriate comparison groups</td>
</tr>
<tr>
<td>Challenge of multiple levels (MD/Practice Group/ Hospital/ Medical Group/ Health Plan/ Purchaser/ State)</td>
</tr>
<tr>
<td>Difficulties with attribution to the correct provider</td>
</tr>
<tr>
<td>Lack of packaging of “How to’s” for departments to use for QI</td>
</tr>
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</table>

For this hospital, this analysis allows the QI efforts to focus on spontaneous labor as the main area for improvement. This is further broken down in Figure 8 to identify whether failure to progress/cephalopelvic disproportion (FTP/CPD) or FHR concerns are the major driver.

Figure 8. Example Screenshot from Maternal Data Center

Here, the analysis clearly points to FTP/CPD as the area that needs QI attention, an area directly related to labor support and management (see Part II and Part III of the toolkit for more specifics on improvement in these areas). The MDC also has the ability to track process measures to mark progress in these areas during the improvement
process. The MDC creates a case list appropriate for the improvement topic (e.g. cesarean for labor dystocia or cesarean for fetal concern). After simple chart reviews, using a checklist directly taken from the ACOG/SMFM guidelines, outlier cases can be identified (Figure 9).

**Figure 9.** Dystocia Checklist for Data Collection

<table>
<thead>
<tr>
<th>CMQCC Dystocia Checklist for Data Collection (ACOG/SMFM Criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Diagnosis of Dystocia/Arrest Disorder (all 3 should be present)</strong></td>
</tr>
<tr>
<td>☐ Cervix 6 cm or greater</td>
</tr>
<tr>
<td>☐ Membranes ruptured, then</td>
</tr>
<tr>
<td>☐ No cervical change after at least 4 hours of adequate uterine activity (e.g. MVUs &gt; 200), or at least 6 hours of oxytocin administration with inadequate uterine activity</td>
</tr>
<tr>
<td><strong>5. Diagnosis of failed induction before 6 cm dilation (both should be present)</strong></td>
</tr>
<tr>
<td>☐ Bishop score &gt;6 when undergoing elective induction</td>
</tr>
<tr>
<td>☐ Oxytocin administered for a minimum of 12 hours after membrane rupture</td>
</tr>
</tbody>
</table>

The MDC calculates, presents, and tracks over time the proportion of cases that meet the process measures. Results of this analysis on a sample of charts of women with FTP/CPD for a single time period are shown in Figure 10.

**Figure 10.** Example Screen Shot from Maternal Data Center

These kinds of analysis and visual presentation have been very productive in the pilot sites (see Part V for success stories at these pilot hospitals).

5. Reduce Data Burden

In this era of tight hospital operational budgets and competing requests for data support for required Medicare metrics, it is important to have systems in place to minimize the costs and duplication of efforts for data collection and data analysis for maternity QI projects. The drivers of data burden are shown in Table 37.

**Table 37.** Data Burden

<table>
<thead>
<tr>
<th>Data Burden</th>
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</thead>
<tbody>
<tr>
<td><strong>Drivers include:</strong></td>
</tr>
<tr>
<td>Data collection burden on staff, especially chart reviews</td>
</tr>
<tr>
<td>Many organizations asking for data (sometimes the same, sometimes slightly different)</td>
</tr>
</tbody>
</table>

Strategies for overcoming these barriers focus on the reuse of existing data sets wherever possible. This can be accomplished by combining ICD-9/10 data with birth certificate data, as the MDC does. Using MDC sub-analyses focuses the topics for review to those that will have the largest “bang for the buck.” Furthermore, the administrative data within the MDC are used as a first screen to efficiently identify cases that need chart review. The process metrics that are based on these reviews have simple criteria (e.g. 6 cm, 4 hours with ruptured membranes) and can be quickly processed by a nurse reviewer. The use of administrative data also allows easier continued surveillance, a critical step for QI sustainability.

Great effort has been made in California to have the same set of metrics used by all parties. Nationally, TJC, CMS, and Leapfrog Group (LFG) now use the NTSV cesarean measure as the metric for cesarean births. CMQCC uses the same measure in the public release data file for all California hospitals (not every hospital reports to TJC, LFG, and CMS) and as the main cesarean metric for the MDC. Some hospitals that use only internally generated metrics employ older measures, such as the Primary Cesarean Rate. Unfortunately, that measure distorts hospital level comparisons because of lack of risk adjustment and the inclusion of both nulliparous and multiparous patients in the same measure. Multiparous women have cesarean rates 4 to 6 times lower than nulliparous women, and hence markedly lower the overall Primary Cesarean Rate when mixed together with data from nulliparous women. This matters because the proportion of nulliparous to multiparous women varies greatly between hospitals (from 22% nulliparous to 60% nulliparous). Indeed, nulliparity is the single most important risk adjuster. Not adjusting for nulliparity can easily create inaccurate and confusing comparisons. In the end, it is very important for all public release organizations to use the same metrics and to coordinate so that the released numbers are as accurate as possible. The MDC can
CMQCC and the MDC have piloted cesarean process measures using the recent ACOG/SMFM Obstetric Care Consensus on Safe Prevention of the Primary Cesarean Delivery. Thus far, the process measures have worked well as tools for driving change in the pilot hospitals. The process measures most widely used are the criteria for FTP/CPD and criteria for failed induction. Preliminary work suggests that using criteria for fetal distress, such as those outlined by Clark and colleagues, is also useful. The important principle in designing these process measures is to use a standard guideline, such as the guidelines for labor management, induction of labor, and active labor admission proposed in the Safe Deliveries Roadmap Labor Management Bundle used by the Washington State Hospital Association.

Measures that assess nursing engagement are quite important but still in the formative stage. Appendix H reports on several proposed measures from AWHONN, such as freedom of movement in labor, labor support, and non-directed pushing. Though evidence exists to support these concepts, their formulation into specific clinical measures has not yet been tested. CMQCC and MDC welcome research in this area and look forward to incorporating new process measures in the future.

The MDC represents a major advance for supporting maternity QI projects. Most of the barriers to data-driven QI identified in this analysis have already been addressed by the MDC. To date, MDC methods and tools have been tested in QI projects in three states: California, Washington, and Oregon. Successful data-driven pilot projects in California hospitals that reduced NTSV cesarean rates by using MDC tools and other strategies outlined in this toolkit are described in Part V.

For further information about the Maternal Data Center, please contact Anne Castles, MPH, Program Manager, at: acastles@cmqcc.org

### Table 38. Need for New Cesarean QI Measures

<table>
<thead>
<tr>
<th>Drivers include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process measures needed to support QI</td>
</tr>
<tr>
<td>Lack of full team assessment, especially nursing support during labor</td>
</tr>
<tr>
<td>The question of further risk adjustment of the NTSV measure</td>
</tr>
</tbody>
</table>

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

75
Part V. Success Stories: Lessons Learned from California Hospitals

Table 39. Summary of Lessons Learned

<table>
<thead>
<tr>
<th>Lesson Learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>External experts are helpful to initiate the project</td>
</tr>
<tr>
<td>Internal interprofessional champions (doctors, midwives, nurses) are critical to achieve improvement</td>
</tr>
<tr>
<td>Administrative support is important to establish institutional backing</td>
</tr>
<tr>
<td>Change may take time, but improvement can be rapid once a critical mass of early adopters “buys in.” Late adopters do not prevent success. Stay the course!</td>
</tr>
<tr>
<td>Use feedback from end-users to reliably hard wire unit-level changes, such as with checklists and hard-stop policies</td>
</tr>
<tr>
<td>OB hospitalists retain core knowledge and skills, respond promptly, act as key consultants when cesarean birth is in question, and remove the time incentives for patients to give birth on any particular shift schedule</td>
</tr>
<tr>
<td>Collaborative practice between midwives and physicians creates an overall culture of care that values and accepts normal variations in labor, and the judicious use of interventions</td>
</tr>
<tr>
<td>Provider-level feedback about individual NTSV cesarean rates that is unblinded and shared for all to see, can have a significant and rapid effect on clinical practice—doctors don’t like being outliers!</td>
</tr>
<tr>
<td>How the message is packaged (e.g. how the data is delivered) is critical!</td>
</tr>
</tbody>
</table>

The Pacific Business Group on Health / CMQCC Pilot Project for Cesarean Reduction

In 2014, the Pacific Business Group on Health (PBGH), working with the California Maternal Quality Care Collaborative, and funded by the Robert Wood Johnson Foundation, instituted a pilot program to reduce cesarean births at three hospitals in Southern California (Hoag Hospital in Newport Beach and two MemorialCare hospitals, Miller Children’s and Women’s Hospital in Long Beach and Saddleback Memorial Medical Center in Laguna Hills). These hospitals were selected because they exhibited the optimal conditions to initiate cesarean reduction programs, including high birth rates, higher than state average NTSV rates, strong leadership, readiness to engage in the project, and employer concerns about potentially unnecessary cesareans for the large number of employees receiving care at those particular facilities. According to Allyson Brooks MD, Executive Medical Director at Hoag Women’s Health Institute, the cesarean rate at Hoag had reached the point where major employers in the area, and individual patients, were voicing concern over the inordinate risk of cesarean at their institution. At MemorialCare, the rates had also reached a level that seemed unacceptable. According to David Lagrew MD, Chief Integration and Accountability Officer: “We had a long emphasis on keeping rates low but had seen a gradual rise to the point where we were seeing the negative outcomes in subsequent pregnancies, such as placenta accreta and massive maternal hemorrhage.”

PBGH was successful in identifying major local employers and health plan partners who were interested in taking part in the project. The three institutions and their associated medical groups were matched with a major health plan partner and agreed to work together in a pilot payment reform program characterized by a “blended rate” for birth, for both providers and facilities respectively. As described in Part I of this toolkit, this method involves setting a benchmark cesarean rate and then reimbursing all births at a single rate regardless of mode of birth, essentially creating a “blend” of the proportion of vaginal to cesarean births. The resulting reimbursement rate was above the typical reimbursement rate for vaginal birth, but below typical reimbursement for cesarean. This change in payment signaled to the hospital systems that major payers
were actively reducing any financial incentives for cesareans, and also prompted senior administrative support at each facility. There were significant delays in renegotiating the contracts for the blended payment program and the actual change in payments did not occur until after 9 months into the project. Nonetheless, the three institutions and their respective providers were motivated by these proposed payment changes, employer concerns, and a commitment to improve quality of care.

All three institutions showed impressive improvement. Hoag Hospital started with a mean quarterly baseline NTSV cesarean rate of 32.6%. QI was initiated in January of 2014 and the NTSV cesarean rate dropped to 24.7% by the end of the first quarter of 2015 (a 24.2% reduction). Miller Children’s and Women’s Hospital showed a similar drop – from a mean baseline NTSV cesarean rate of 31.2%, to a rate of 24.3% during the initial QI period (a 22% reduction). Likewise, Saddleback Memorial decreased from a mean baseline NTSV rate of 27.2% to 21.9% in under a year (a 19.5% reduction). All three institutions started above the state average and dropped below the state average following the QI implementation, with an average decrease of over 20%, a remarkable accomplishment.

CMQCC assisted with implementation of the individual QI programs at each facility, providing mentorship and provider-level feedback data through the Maternal Data Center (MDC). According to Jennifer McNulty MD, the external expertise from Dr. Elliott Main and the CMQCC team helped to validate and legitimize the internal efforts. The hospital hosted Dr. Main for a system-wide kickoff lecture and many providers were motivated by the common sense approach and thoughtful data feedback presented. According to Dr. Marlin Mills from Hoag, the department-wide conversations facilitated by CMQCC demonstrated to bedside providers the importance of their work. Dr. Mills also felt that the individual provider-level cesarean rates, initially confidential but eventually unblinded and openly shared among all providers, strongly incentivized a good number of their staff. In addition, Dr. Brooks credits the hard stop policies for induction scheduling and staff education as key components. These views are echoed by Kim Mikes, Executive Nursing and Operations Director at Hoag Women’s Health Institute, who encouraged strong staff support and education in an interprofessional fashion, and spearheaded a focus on the nurse’s critical support role in supporting labor and preventing unnecessary cesarean. Similarly, Terri Deeds, Director of Women’s and Children’s Services at Saddleback Memorial, noted the success of these same improvement strategies, along with feedback from providers, and prioritizing such discussions at department meetings. At Miller Children’s and Women’s Hospital, Dr. Kenneth Chan and Janet Trial, EdD, CNM are expanding the QI efforts to include a clinical checklist utilizing the newer definitions for arrest of labor and second stage management. The checklist, which is completed by the health care team prior to proceeding with cesarean birth in cases of failure to progress, thus far seems to be the single most effective intervention in decreasing the NTSV cesarean birth rate. According to Dr. McNulty, the MemorialCare Women’s Best Practice Team is spearheading efforts to automate the electronic record system to provide detailed clinical feedback to MemorialCare providers. Finally, OB hospitalists were utilized. Two of the hospitals (Hoag and Saddleback) already had active full-time OB hospitalist (laborist) services at the time. Of the two, the Saddleback program sought out more direct engagement of the hospitalist by allowing nursing staff to routinely seek their involvement in all labors. The hospitalist presence allowed on-call physicians to more easily meet professional and personal off-site duties while their patients labored, gave more immediate attention to all laboring women and decreased potential time or financial incentives to prematurely end labors.

According to these leaders, while the majority of doctors and nurses have supported these efforts and the hospitals are continuing to work on lowering rates, change is still not universal and not all providers are fully committed to the program. The combination of payment reform, unit policy changes, overall cultural change on the labor and delivery unit, and continued provider-level feedback should continue the trend in cesarean reduction. Nonetheless, persistence and commitment will be essential to sustained success.

John Muir Medical Center

In 2014, John Muir Medical Center had approximately 2800 births, and an NTSV cesarean rate of 17.4%. Approximately 25 private obstetricians, 2 perinatologists, and 4 midwives (making up a total of 15 practice groups) have delivery privileges at this facility. While most delivering patients experience a traditional private practice model, where the prenatal provider (or someone from that particular provider group) attends to their own patients at the time of birth, John Muir has also created a 24/7 quasi-hospitalist approach, where a rotating schedule determines the physician who is assigned to cover emergencies, precipitous births, and other events not otherwise covered by the private practice groups.

According to Jamie Vincent, Clinical Nurse Specialist with John Muir for 26 years, a turning point came with one of the first quality improvement initiatives related directly to cesarean, that of improving VBAC rates and offering TOLAC...
to more eligible women. John Muir now boasts a VBAC success rate above 80%. While not intentional, it seems this philosophy of care, or one that Jamie Vincent describes as “a culture that says vaginal birth is important” now informs the care practices and overall attitude of supporting intended vaginal birth for every patient.

The practices now embedded in the culture of care at John Muir include patience with the length of labor as long as the fetus and mother are doing well, external cephalic version for women with a singleton breech fetus, skilled providers who attend to vaginal breech deliveries in the rare cases that present, a safe use of oxytocin policy, a push toward eliminating non-medically indicated induction of labor, encouragement of ambulation during labor, intermittent monitoring for low-risk patients (and telemetry units available for women who need to be continuously monitored but who desire freedom of movement), delayed pushing (passive descent) in the second stage, and a commitment to providing a “low intervention birth experience” for women who desire a hospital delivery but wish to have a birth experience where interventions are based upon need rather than convenience and routine use. Furthermore, a philosophy of patience permeates the culture at John Muir. For example, when patients are brought to the operating room, it is not a forgone conclusion that a cesarean will occur. The providers and nurses are willing to assess the situation further while there and, in many cases, return to the patient’s room to continue labor when fetal and maternal statuses permit. This host of policies, practices, and beliefs – along with nurses and providers who care deeply about quality of care – has led to an embedded philosophy of support for intended vaginal birth.

Feedback is important. Cesarean rates and quality measures from other improvement projects are openly shared. Nurses and providers are curious and informed. They request timely data and are not shy in questioning the data to ensure accuracy. The members of the interprofessional Perinatal Quality and Safety Committee form the foundation of a stable leadership team that researches and implements most improvement activities. Like many high performing organizations, teamwork and interdisciplinary communication is a work in progress. Understanding the relationship between teamwork and the ability to consistently perform well in both emergencies and day to day operations, John Muir continues to make this a priority, engaging in High Reliability Organization trainings and consistently prioritizing teamwork and better communication.

Kaiser Permanente Roseville Medical Center

The Kaiser Permanente Roseville Medical Center opened in 2009 with a Level III NICU and high-risk expertise in maternity care. Kaiser Roseville’s 2014 NTSV cesarean rate was 16.9%, despite its many high-risk patients and a total birth rate of approximately 5,000 per year.

While there has always been a “quasi-hospitalist” model at Kaiser (in the sense that providers worked shifts on the labor and delivery unit as opposed to being called in for births), Kaiser Roseville recently created a specific OB hospitalist position. Now, in addition to the other physicians who work in shifts on the labor and delivery unit but who may also attend to multiple other clinical obligations, the unit is staffed 24/7 by an OB hospitalist whose main priority is the management of laboring patients. According to Dr. Belinda Perez, OB hospitalist, this creates a sense of continuity and smooth transition between providers, and an understanding that patients are not on a timeline based upon any particular shift. Furthermore, according to Dr. Carolyn Odell, Maternity Subchief, the OB hospitalist is a resource to the other physicians when complicated cases arise. The hospitalists are expected to develop and retain skills in operative vaginal delivery, manual rotation, external cephalic version, and breech extraction of the second twin. Even if another physician is managing a patient, the hospitalist is available as a “second pair of eyes” for consultation, or to help as needed.

Kaiser Roseville also has 15 midwives. Just as there is always an OB hospitalist, there is also a midwife on the unit around-the-clock. The midwife attends low-risk births and, as appropriate, co-manages higher risk patients who need physician oversight but prefer a midwifery approach to labor management. The midwifery group has positively influenced both physician and nursing practice in terms of how normal labor is managed. These influences include accepting that there are normal variations in the length of labor, encouraging ambulation, using alternative methods of pain relief, and judiciously using interventions such as oxytocin and continuous monitoring. For women meeting low-risk criteria, intermittent monitoring is the standard of practice.

Holly Champagne, Clinical Nurse Specialist, notes that Kaiser Roseville, like many Kaiser facilities, maintains a culture of quality improvement, adherence to evidence based practice, and a strong interprofessional leadership team that enforces a constant culture of safety and
attention to quality. For example, when Spong and colleagues published *Preventing the First Cesarean Delivery* in 2012, the Perinatal Patient Safety Committee quickly took the lead in reframing for providers and nurses the parameters for normal labor duration and, ultimately, succeeded in letting go of the Friedman curve. Dr. Perez notes that doing so reduced the overall number of cesareans for failure to progress. Furthermore, chart reviews indicate that there are now rarely cases of “failure to progress” that do not meet the new definitions. While it did take some time for all providers to “digest” and accept this new information, leadership by the OB hospitalists and expertise of the midwives in normal birth helped to further solidify this new concept into the culture of care.

Dr. Perez and Susan Stone, CNM (previous Chief Nurse-Midwife) agree that gatekeeping, or hard-stop policies, are also an important component of keeping cesarean rates low. For example, Kaiser Roseville has a policy of no inductions without medical indication before 40 weeks, and providers are strongly encouraged to schedule postdates inductions at or after 41 weeks. This is enforced through a method of online scheduling that requires a medical indication. When there is no medical indication for induction, review by the OB hospitalist and nurse manager is required.

Other ongoing quality improvement activities and patient safety initiatives at Kaiser Roseville may also directly impact cesarean rates, including the recent institution of a safe usage of oxytocin policy and checklist, interdisciplinary team trainings for critical events, and instituting algorithms and decision making tools for Category II fetal tracings.

Holly Champagne notes that the labor and delivery nurses at Kaiser Roseville are absolutely integral to the quality improvement process, and are exceptional in both support to the patient and technical aptitude. Nonetheless, she states there is an expectation of constant improvement, noting the recent midwife-led trainings for labor support and recent emphasis on alternative coping methods, such as use of TENS and the upcoming integration of nitrous oxide into the labor and delivery suites.

Finally, data is important. Dr. Odell notes that cesarean rates are routinely discussed and remain a priority topic at monthly Perinatal Patient Safety Committee meetings. Also, providers and nurses are given feedback and provided with timely data to show the success of each quality improvement effort. Holly Champagne agrees wholeheartedly that interdisciplinary leadership and buy-in is critical to this process, but also notes that the stable leadership team at Kaiser Roseville is adept at packaging the information appropriately for each member of the labor and delivery team. She states that while the nurses, doctors, and midwives all care deeply about patients and quality, each discipline benefits from unique, tailored “messaging” that aligns data feedback and policy change. Although subtle, these differences in messaging are critical to the acceptance of change and identifying potential points of resistance.
In the First Stage of Labor

- A prolonged latent phase of greater than 20 hours in nulliparas and 14 hours in multiparas is not an indication for cesarean delivery
- Slow but progressive labor is not an indication for cesarean delivery
- Before 6 cm dilation, standards of active labor progress should not be applied to nulliparous or multiparous patients
- Patients who undergo cesarean delivery for active phase arrest in the first stage of labor should be at or beyond 6 cm dilation WITH ruptured membranes AND:
  - 4 hours of adequate contractions without cervical change, OR
  - At least 6 hours of oxytocin with inadequate contractions and no cervical change

In the Second Stage of Labor

- An absolute maximum length of time for the 2nd stage has not been identified
- As long as maternal and fetal condition permits, the diagnosis of arrest of the labor in the 2nd stage should not be made prior to:
  - At least 2 hours of pushing for multiparous patients
  - At least 3 hours of pushing in nulliparous patients (longer durations may be appropriate on an individualized basis, for example with epidural anesthesia or fetal malposition as long as progress is documented)

Operative vaginal delivery by an experienced, well-trained physician is a safe and reasonable alternative to cesarean delivery
- Manual rotation of the fetal occiput of the malpositioned fetus in the 2nd stage of labor is a reasonable intervention to consider before operative vaginal delivery or cesarean delivery. Furthermore, assessment of fetal position in the 2nd stage of labor is essential, especially when abnormal descent is noted

Fetal Surveillance

- Amnioinfusion is recommended as a safe intervention for repetitive variable decelerations and may reduce the rate of cesarean
- Scalp stimulation can be used to assess fetal acid-base status in the presence of an abnormal or indeterminate fetal tracing e.g. minimal variability

Induction of Labor

- Induction of labor before 41 0/7 weeks of pregnancy should be performed if medical indications for the patient or fetus are present. Inductions at 41 0/7 weeks and beyond should be performed to reduce the risk of cesarean delivery
- When a woman with an unfavorable cervix must be induced, cervical ripening methods should be used
- If maternal and fetal status permit, a longer latent phase should be allowed in patients undergoing induction of labor (24 hours or longer) and oxytocin should be administered for at least 12-18 hours after rupture of membranes before a failed induction is diagnosed

Fetal Malpresentation

- Fetal presentation should be assessed and documented at 36 0/7 weeks. External cephalic version should be offered to patients with a noncephalic-presenting fetus

Suspected Macrosomia

- Patients should be counseled that estimates of fetal weight at term gestation are imprecise. Cesarean delivery for suspected macrosomia should be limited to estimated fetal weights of:
  - At least 5000g in non-diabetic women
  - At least 4500g in diabetic women

Excessive Maternal Weight Gain

- Women should be counseled on the IOM maternal weight guidelines in order to avoid excessive weight gain

Twin Gestations

- Women with cephalic/cephalic-presenting twins or cephalic/noncephalic-presenting twins should be counseled to attempt vaginal delivery

Other

- Stakeholders (individuals, providers, policy makers) should work together to ensure research is conducted to further guide decisions regarding cesarean delivery and encourage policies that safely reduce the rate of primary cesarean delivery
SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

**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.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.

**RECOGNITION AND PREVENTION**

*Every patient*

- Implement standardized admission criteria, triage management, 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.
- 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 birth.
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.
- 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.
- 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.

REPORTING/SYSTEMS LEARNING

Every birth facility

- Track and report labor and cesarean measures in sufficient detail to: 1) compare to similar institutions, 2) conduct case review and system analysis to drive care improvement, and 3) assess individual provider performance.
- Track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety.
### Tools for Part I of Toolkit - For Providers and Hospitals

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<tr>
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<td>Lamaze International Policy Brief - Evidence-Based Childbirth Education: A Key Strategy to Improve U.S. Childbirth Outcomes</td>
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<td>Center for Healthcare Quality and Payment Reform Slide Deck - How Payment Reform Can Lower Costs and Improve Quality (slide deck)</td>
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### Tools for Part I of Toolkit - For Women

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<td>Washington State Hospital Association Safe Deliveries Roadmap - Best Practice Bundles (Labor Management Bundle includes criteria for delayed admission, algorithm and checklist for spontaneous labor, and many more labor tools)</td>
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<td>Birth Positions Pushing with Epidural (You Tube)</td>
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## Appendix C

### Tools by Section

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<td>Model Policy for Fetal Surveillance - Zuckerberg San Francisco General Hospital (includes procedures and exclusion criteria for intermittent auscultation)</td>
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<td>ACNM Healthy Birth Initiative – Reducing Primary Cesareans – Intermittent Auscultation (includes identifying appropriate patients for intermittent auscultation, procedures, clinical decision making, and criteria for discontinuing intermittent auscultation and implementing EFM)</td>
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<td>Denver Health Slide Deck – Intermittent Auscultation (includes identifying appropriate patients for intermittent auscultation, procedures, clinical decision making, and criteria for discontinuing intermittent auscultation and implementing EFM)</td>
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### TOOLS FOR PART II OF TOOLKIT – FOR WOMEN

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<td>AWHONN Go the Full 40 Campaign (toolkit, grand rounds slide deck, and multiple patient downloads and infographics)</td>
<td><a href="http://www.health4mom.org/nurses-resources">http://www.health4mom.org/nurses-resources</a></td>
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<td>2</td>
<td>ACNM – Share With Women – Am I in Labor? (includes decision tree to assist women with deciding whether they are in labor and when to go to hospital)</td>
<td><a href="http://onlinelibrary.wiley.com/doi/10.1016/S1526-9523(03)00147-8/pdf">http://onlinelibrary.wiley.com/doi/10.1016/S1526-9523(03)00147-8/pdf</a></td>
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<td>1</td>
<td>AHRQ TeamSTEPPS® (strategies and tools to enhance team performance and patient safety)</td>
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<td><a href="http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html">http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html</a></td>
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<td>Pre-caesarean Checklist for Labor Dystocia or Failed Induction (adapted with permission from Miller Children’s and Women’s Hospital)</td>
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<td>ACOG- Optimizing Protocols in Obstetrics: Oxytocin for Induction of Labor (includes model polices for safe use of oxytocin and the Hospital Corporation of America’s pre-oxytocin and in-use checklists)</td>
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## Appendix C

### Tools by Section

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### TOOLS FOR PART III OF TOOLKIT – FOR WOMEN

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### Childbirth Education - For Patients

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### Delay of Latent (Early) Labor Admission - For Providers and Hospitals

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### Delay of Latent (Early) Labor Admission - For Patients

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### Doula Care and Labor Support - For Providers and Hospitals

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## Appendix D

### Tools by Topic

#### DOULA CARE AND LABOR SUPPORT – FOR WOMEN

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#### FETAL SURVEILLANCE – FOR PROVIDERS AND HOSPITALS

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<tr>
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<td>Auscultation Bundle</td>
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| Part 2 –  | Denver Health Slide Deck – Intermittent Auscultation (includes identifying  |            | http://birthtools.org/birthtoolfiles/BirthToolFiles/FILFNAME/00000000024/MOC-FWB |}
| Strategy 6| appropriate patients for intermittent auscultation, procedures, clinical    |            | IntermittentAuscultation-DenverHealth.pptx                        |
|           | decision making, and criteria for discontinuing intermittent auscultation     |            |               |                                                                          |
|           | and implementing EFM)                                                      |            |               |                                                                          |
| Strategy 6| Collaborative (includes exclusion criteria for intermittent monitoring,      |            | Practice_Guidelines_FINAL_12.12.12_POSTED_ON_THE_WEBSITE.pdf     |
|           | procedures for intermittent methods, and FHR management algorithm)           |            |               |                                                                          |
| Part 2 –  | Model Policy for Fetal Surveillance – Zuckerberg San Francisco General        |            | Model Policies - Appendix T                                       |
| Strategy 6| Hospital (includes procedures and exclusion criteria for intermittent       |            |               |                                                                          |
|           | auscultation)                                                                |            |               |                                                                          |
| Strategy 2| Electronic Fetal Heart Rate Assessment and Initial Intervention               |            | Practice_Guidelines_FINAL_12.12.12_POSTED_ON_THE_WEBSITE.pdf     |
|           | (found in Appendix 4 of Guideline for Fetal Monitoring in Labor and Delivery) |            |               |                                                                          |
| Part 3 –  | Algorithm for Management of Intrapartum Tracings                            |            | Appendix Q        |                                                                          |
| Strategy 2|                                                                               |            |               |                                                                          |
| Strategy 2| in ACOG Optimizing Protocols in Obstetrics: Oxytocin for Induction)         |            |               |                                                                          |
| Part 3 –  | Steven Clark MD - Algorithm for the Management of Category II Fetal Heart    |            | Appendix P       |                                                                          |
| Strategy 2| Rate Tracings                                                               |            |               |                                                                          |

#### FETAL SURVEILLANCE – FOR PATIENTS

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## Appendix D

### Tools by Topic

#### INDUCTION OF LABOR – FOR PROVIDERS AND HOSPITALS

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<td>Tallahassee Memorial Hospital - Induction of Labor Consent Form</td>
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<td><a href="https://www.cmqcc.org/resource/appendix-a5-consent-form">https://www.cmqcc.org/resource/appendix-a5-consent-form</a></td>
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<td>Part 3 ~ Strategy 2</td>
<td>Model Policy for Induction of Labor Scheduling Process and Scheduling Form - Hoag Hospital</td>
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<td>Model Policies - Appendix T</td>
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#### INDUCTION OF LABOR – FOR PATIENTS

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<tr>
<td>Part 3 ~ Strategy 2</td>
<td>AWHONN Go the Full 40 Campaign (toolkit, grand rounds slide deck, and multiple patient downloads and infographics)</td>
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<td><a href="http://www.health4mom.org/nurses-resources">http://www.health4mom.org/nurses-resources</a></td>
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#### LABOR MANAGEMENT – FOR PROVIDERS AND HOSPITALS

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<tr>
<td>Part 3 ~ Strategy 2</td>
<td>Pre-cesarean Checklist for Labor Dystocia or Failed Induction (adapted with permission from Miller Children’s and Women’s Hospital)</td>
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### Appendix D

**Tools by Topic**

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<td>Part 2 ~ Strategy 3</td>
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<td>Washington State Hospital Association Safe Deliveries Roadmap - Best Practice Bundles (Labor Management Bundle includes criteria for delayed admission, algorithm and checklist for spontaneous labor, and many more labor tools)</td>
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<td><a href="http://www.wsha.org/quality-safety/projects/safe-deliveries/">http://www.wsha.org/quality-safety/projects/safe-deliveries/</a></td>
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<td>Model Policies - Appendix T</td>
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**LABOR SUPPORT AND SUPPORT INFRASTRUCTURE – FOR PROVIDERS AND HOSPITALS**

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### LABOR SUPPORT - FOR PATIENTS

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### MALPOSITION - FOR PROVIDERS AND HOSPITALS

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<td>Part 3 - Strategy 4</td>
<td>Spinning Babies: Easier Birth with Fetal Positioning (educational website for the prevention and treatment of malposition through maternal positioning; also includes workshops and events)</td>
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<td><a href="http://spinningbabies.com">http://spinningbabies.com</a></td>
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### LIABILITY - FOR PROVIDERS AND HOSPITALS

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### NON-MEDICALLY INDICATED (ELECTIVE) CESAREAN - FOR PROVIDERS AND HOSPITALS

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<td>Informed Consent for Elective Cesarean (adapted with permission from Hoag Hospital)</td>
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### OXYTOCIN - FOR PROVIDERS AND HOSPITALS

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<td>ACOG - Optimizing Protocols in Obstetrics: Oxytocin for Induction of Labor (includes model policies for safe use of oxytocin and the Hospital Corporation of America's pre-oxytocin and in-use checklists)</td>
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<td><a href="http://mail.ny.acog.org/website/OxytocinForInduction.pdf">http://mail.ny.acog.org/website/OxytocinForInduction.pdf</a></td>
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92 | CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans |
## Appendix D

### Tools by Topic

### PAIN ASSESSMENT AND MANAGEMENT - FOR PROVIDERS AND HOSPITALS

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### PAIN MANAGEMENT - FOR PATIENTS

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### PAYMENT REFORM - FOR PROVIDERS AND HOSPITALS

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### PERFORMANCE MEASURES - FOR PROVIDERS AND HOSPITALS

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### PRENATAL CARE - FOR PROVIDERS AND HOSPITALS

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### TEAMWORK AND COMMUNICATION - FOR PROVIDERS AND HOSPITALS

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</table>
| Part 3 ~  
| Strategy 1 | AHRQ TeamSTEPPS® (strategies and tools to enhance team performance and patient safety) | • | http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html |
| Part 3 ~  

### TRANSFER OF CARE FROM OUT-OF-HOSPITAL BIRTH ENVIRONMENT - FOR PROVIDERS AND HOSPITALS

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| Part 3 ~  

### SHARED DECISION MAKING - FOR PROVIDERS AND HOSPITALS

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| Strategy 2 | CMQCC Birth Preferences Guide (Birth Plan) | • | Appendix E |

### SHARED DECISION MAKING - FOR PATIENTS

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</table>
| Part 1 ~  
| Strategy 2 | CMQCC Birth Preferences Guide (Birth Plan) | • | Appendix E |
| Part 1 ~  
My Preferences for Labor and Birth: A Plan to Guide Decision Making and Inform My Care Team

Your Name and Date of Birth:

Your Due date:

Physician/Midwife:

Pediatrician/Family Doctor:

Your Labor Support Team (please include partner, doula, friends, relatives, or children who will be present):

While low-risk women will need very little intervention, women with certain medical conditions may need procedures, such as continuous monitoring or induction of labor, to improve safety and ensure a healthy delivery. Your provider can tell you about the benefits, risks and alternatives of the decisions you may face during labor and birth. This is an opportunity to share your values and preferences and make informed decisions together, based on your specific needs. This form should go with you to the hospital to be shared with your care team and reviewed as labor progresses.

Environment:
Which options will make you most comfortable?

_____ I would like to limit the number of guests in my room while I am in labor by having a sign posted on the door to my labor and delivery room

_____ I would like to have the lights dimmed during labor

_____ I plan to bring in music from home (my own MP3 player, CD player, etc.)

_____ I plan to bring in essential oils/aromatherapy (no flames, please).

_____ I plan to bring in a “focal point” from home

Preferences for Food and Fluids

_____ I prefer to keep myself hydrated by drinking fluids. I would like to avoid intravenous fluids unless it is medically necessary

_____ I do not mind receiving intravenous hydration during labor

_____ If it is safe for me to do so, I would like to eat lightly during labor

Labor Preferences

_____ If safe to do so, I prefer to labor at home during the early phase of labor, and be admitted to the hospital when I am in active labor

_____ I would like to have freedom of movement while I am in labor (walking, standing, sitting, kneeling, using the birth ball, etc.), if safe and possible

_____ I prefer to move around or change positions to improve my labor progress before trying Pitocin to increase my labor progress

_____ If labor is progressing normally, I prefer to be patient and let it proceed on its own without Pitocin to speed it up

_____ I would prefer to wait for the amniotic membrane (bag of waters) to rupture spontaneously. If the need to have my water broken arises, please discuss this with me before breaking my water

_____ I would like to have my IV capped off (saline locked) so that I am free to move around during labor

Some of your decisions before and during childbirth may affect your risk of cesarean. These decisions are best made in collaboration with your provider during prenatal care visits, well in advance of the time of birth. Here are some common decision points:

- whether to wait for labor to begin on its own (induction of labor may increase your risk of cesarean)
- whether to be admitted to the hospital in early labor or to wait until active labor (being admitted in active labor improves your chances of having a vaginal birth)
- how to monitor your baby’s fetal heart rate (low-risk women who are continuously monitored may be more likely to have a cesarean)
- whether to have continuous labor support by a trained caregiver like a doula (continuous labor support improves your chances of having a vaginal birth)
- how to help manage labor pain and labor progress
- how to stay hydrated and maintain stamina (strength) during labor
- whether to remain mobile and upright during labor
- how to push around the time of birth
- what practices to engage in shortly after your baby is born and before you go home
Preferences forManaging Pain

____ I would like to have the option to use hydrotherapy (shower, or tub if available) for pain relief
____ I prefer natural childbirth (no pain medications or epidural)
____ Please do not offer me any sort of pain medications. If I decide to use pain medication or an epidural, I will ask for them
____ I plan to use intravenous pain medication (pain medication through my IV) to cope with the pain of labor and birth
____ I plan to use an epidural in active labor to cope with the pain of labor and birth
____ I am considering using IV pain medication and/or having an epidural, but will decide when I am actually in labor

Preferences for Monitoring the Baby:

____ I prefer to have by baby monitored intermittently (not continuous monitoring)
____ I prefer to monitor my baby continuously (I understand this may limit my movement and may keep me in bed during labor)
____ If my baby needs to be continuously monitored, I prefer a portable monitor (if available, and if my condition permits me to move freely)

Preferences for Cervical Examination:

____ I prefer as few cervical exams as possible
____ If safe to do so, and my bag of water is not broken, I prefer to check dilation regularly so I know how labor is progressing

Birth Preferences

____ I would like to push in a position of my choosing (squatting, kneeling, side lying, lithotomy, etc.)
____ I want to avoid an episiotomy if possible
____ I would like to use a mirror to view the birth of my baby
____ I would like __________________________ to cut the umbilical cord
____ I would like my baby placed directly on my chest right after birth
____ If safe and possible, I would like to have delayed clamping and cutting of the umbilical cord
____ I am planning to bank my baby's cord blood
____ I would like to take my placenta home with me

Cesarean Birth Preferences

Our goal for every woman is to have a healthy vaginal birth. If a cesarean birth is necessary, we will continue to consider your preferences as much as possible throughout your stay. Sometimes, emergency situations necessitate a rapid conversation about risks and benefits of cesarean birth. We encourage your participation in the decision for cesarean birth.

____ I would like my partner to stay with me at all times
____ If possible, I would like to bring another support person with me into the operating room in addition to my partner. My other support person is __________________________
____ I would like to ask my anesthesiologist if the screen could be lowered so that I can watch the birth of my baby
____ If my anesthesiologist determines that it is safe and possible, I would like to have an arm left free so that I can touch my baby
____ I would like to have my partner or support person cut (shorten) the umbilical cord
____ I would like my baby placed skin-to-skin with me in the operating room if we are both doing well
____ I would like to hold my baby skin-to-skin during the recovery period

Newborn Care Preferences

____ I would like all newborn procedures and medications explained to me before they are carried out or administered by the staff
____ If my baby needs to leave my side for any reason, I would like __________________________ to accompany my baby, and to remain present for all procedures
____ I would like to be present for my baby's first bath
____ I plan to exclusively breastfeed my baby
____ I may have questions about breastfeeding or need help getting off to a good start
____ If my baby needs formula for a medical reason, I would like to be informed first
____ If my baby requires ongoing supplementation, I would like help from a lactation nurse in learning how to hand express or pump my own milk for my baby
____ If I have a boy, I plan to have him circumcised
What is most important to you during labor and birth (your biggest goals or priorities)?

Please let us know if you have any religious or cultural practices/traditions that are important to you during childbirth, and what we can do to accommodate these needs.

Please describe any additional preferences, concerns about labor and birth, specific fears, or other information that will help us provide the best possible care to meet your individual needs.

Signatures

I have talked about and shared my labor and birth preferences with my provider during prenatal care visits, and both of us understand it. I recognize that my preferences and wishes may not be followed just as written and may need to change if medical needs arise in order to ensure a safe and healthy birth for my baby and me.

Health care provider’s signature: ________________________________ Date: _______________

My signature: _______________________________________________ Date: _______________
Appendix F

Coping with Labor Algorithm v2 ©

Observe for cues on admission and throughout labor.
Assessment per protocol:
Ask: “How are you coping with your labor?”
- Every shift
- PRN
- At signs of change.

Cues you might see if woman is coping:
- States she is coping
- Rhythmic activity during contraction (Rocking, swaying)
- Focused inward
- Rhythmic breathing
- Able to relax between contractions
- Vocalization (moaning, counting, chanting)

Cues you might see if woman is NOT coping
(May be seen in transition)
- States she is not coping
- Crying (May see with self-hypnosis)
- Sweaty
- Tremulous voice
- Thrashing, wincing, writhing
- Inability to focus or concentrate
- Clawing, biting
- Panicked activity during contractions
- Tense

Physiologic: Natural process of labor
Patient desires pharmacological intervention
- IV pain med [L]
- Epidural [S]
- Nitrous Oxide [I]

Patient desires non-pharmacological intervention
- Interventions as to what would give best relief and is indicated (what does the patient desire):
  - Tub/bath/shower [S]
  - Hot pack/cold pack [*]
  - Water injections [S]
  - Massage/pressure [*]
  - Movement/ambulation position changes [S]
  - Birth ball [*]
  - Focus points [*]
  - Breathing techniques [*]
  - Acupuncture [S]
  - Self-Hypnosis [S]
  - TENS [*]

Follow:
- Unit
- Service line
- Hospital
Guidelines/standards for pharmacologic intervention

Interventions as to what would give best relief and is indicated (what does the patient desire):
- Tub/bath/shower [S]
- Hot pack/cold pack [*]
- Water injections [S]
- Massage/pressure [*]
- Movement/ambulation position changes [S]
- Birth ball [*]
- Focus points [*]
- Breathing techniques [*]
- Acupuncture [S]
- Self-Hypnosis [S]
- TENS [*]

Physical Environment

Emotional: Psychosocial
- Mood [*]
- Lighting [*]
- Music [*]
- Fragrance [*]
- TV/Movie [*]
- Temperature [*]
- Whispering voices [*]

The nurse should consider:
- One-on-One Support [S]
- Doula [S]
- Midwifery Care being “With Woman” [S]

Offer social work consult

Reassessment

Legend
[S] = Sufficient Evidence
[L] = Limited Evidence
[I] = Insufficient Evidence
[*] = No Evidence & No Harm

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Appendix G

Second Stage Management of Malposition

I. Identification of malposition during labor is an important aspect of preventing cesareans:

Although the mother’s report of back pain or “back labor” is thought to be a reliable indicator of occiput posterior position, this is not supported by the literature.1 When any woman experiences a prolonged second stage of labor, even in the absence of back pain, malposition must be considered.2

First, assess fetal lie/position/presentation with Leopold’s and visual examination. Leopold’s maneuvers are a four-step approach which, when performed by an experienced examiner, may assist in identification of the malpositioned fetus. In particular with the second maneuver, when fetal small parts are palpated more easily anteriorly than the more firm fetal back (which in OA position will be on either right or left maternal side) OP presentation can be suspected.3,4 The maternal abdomen that is scaphoid in the lower part may also indicate OP position, as the fetal back is more proximal to the mother’s back and the small parts in the anterior abdomen result in the appearance of a “dip.” Limitations of Leopold’s maneuvers and abdominal examination to assess for possible malposition are provider experience and the maternal habitus.

Auscultation of the fetal heart with placement of the electronic fetal monitor transducer at either the extreme maternal lower left or right side rather than in the right or left lower quadrant may also indicate OP or OT position e.g. if placed on the extreme maternal right side, then fetus may be ROP or ROT.

When OP or OT is suspected, findings of the digital examination may reveal:

• For OP, the larger diamond [anterior] fontanelle in the right or left upper pelvic quadrants and/or the smaller triangle [posterior] fontanelle in the right or left lower pelvic quadrants. In OT presentation the sagittal suture is palpated horizontally. If the posterior fontanelle is on the mother’s right, the position is either ROP or ROT, and if the posterior fontanelle is on the mother’s left, then the fetus is LOP or LOT.

• Caput related to sub-optimal fit of the malpositioned fetus, which may obscure suture and fontanelle landmarks. Adding to the difficulty is that the OP fetus is not as well-flexed as the OA fetus. Sub-optimal flexion of the OP fetus may result in the anterior fontanelle being more easily identified than the posterior one and may result in an incorrect assessment that the fetus is in OA position instead of OP.5,6

• A persistent anterior cervical lip suggesting that the narrower anterior sinciput of the OP fetus is unable to keep the cervix retracted in the fore pelvis. Note: this finding may also be present when the fetal position is asynclitic.7

• Palpation of the helix of the fetal ear.8 As the examiner usually must insert much of the hand to find the ear, this examination is very uncomfortable for the mother who does not have regional anesthesia.

Intrapartum ultrasound is the most accurate approach to identify the malpositioned fetus. Although accuracy of digital examination is greater in second stage than in first stage of labor, studies in second stage have reported digital examination error rates of 26% to 39% compared to the “gold standard” of abdominal ultrasound.9,11 It is highly recommended to utilize ultrasound to confirm malposition if malposition is suspected.

II. When malposition is identified, strategies should consider the five Ps: “powers,” “passenger,” “passage” (pelvis and soft tissues), “position” (maternal), and “psyche”

Powers – By second stage, nursing and provider interventions must ensure that labor contractions and maternal efforts are adequate to facilitate the fetus’ pelvic descent and cardinal movements (rotations).3,5

Passenger – The prolongation of the second stage of labor associated with OP/OT positions is due to increased fetal diameters associated with the less well-flexed head. Cardinal movements associated with OP/OT are: a) the fetus rotates to the OA position at some point during labor and delivers readily by flexion and extension; b) if rotation to OA does not occur, the suboptimal flexion associated with OP position prolongs the descent until the vertex finally flexes anteriorly on the perineum after which fetal head extends to effect the birth; or c) if the OT fetus does not rotate to an OP or OA position there will be a deep transverse arrest and the fetus will not likely deliver vaginally without operative assistance.3,5
Passage – Maternal risk factors for malposition include primiparity and pelvic shape.

- Primiparity: The tauter, untested pelvic passage in women having their first vaginal birth may diminish the fetus’ ability to rotate to the more favorable OA position. Compared to multigravidas, primiparas are not only more likely to have a malpositioned fetus at the onset of labor but are also less likely to achieve spontaneous vaginal delivery with persistent OP position.12

- Pelvis: The wider posterior aspects of the anthropoid (oval) and android (heart-shaped) pelvic types are more likely to hold the fetus in OP position. It is beneficial to ask the woman if her mother or if she has ever had a baby that was born “sunny side up” or “looking at the ceiling”. If so, this may add to your suspicion that she has an anthropoid or android pelvis that is more likely to hold the fetus in an OP position.

Position and Psyche – noted in “strategies” below.

III. Strategies:

- Prevent malposition by avoiding routine early amniotomy
  – Amniotomy prior to 5 cm eliminates the cushion of the fore waters which allow for fetal repositioning and results in more non-reassuring fetal heart rate patterns.19
  – Promote rotation to the more favorable OA position through maternal/fetal positioning
  – When the mother is positioned in the lateral Sims position on the same side as the fetal back e.g. right Sims with ROP fetus, rotation to OA is theoretically more likely. Conversely, when the fetus is on its back with its head towards the mother’s side (lateral) or towards the mother’s back (posterior), the labor may be longer and more painful.14 If it is unclear whether the fetus is malpositioned during a prolonged second stage, maternal position changes every five to six contractions may facilitate rotation to OA.14
  – Hands and knees position during pregnancy cannot be recommended as an intervention to rotate the occiput posterior/occiput transverse fetus.18 However, it should be considered if the mother finds it comfortable as the use of hand/knees position in labor is associated with reduced backache.19
  – Utilize techniques to expand and change the shape of the pelvis e.g. pelvic press, lunges. Refer to Simkin P, Ancheta R “The labor progress toolkit: Part 1. Maternal positions and movements” for detailed instructions, figures, and indications.14

- Digital/manual rotation of the fetus from the OP position to the OA position decreases cesarean delivery and other complications associated with persistent OP position: severe perineal lacerations, hemorrhage, and chorioamnionitis.20 Rotation attempts are advocated in early to mid-second stage of labor.6,21,22 Shaffer and colleagues reported that four attempted rotations were necessary to avert one cesarean and that women with unsuccessful rotations were at greater risk for cervical laceration.20 Refer to Barth “Persistent occiput posterior” for an excellent resource with detailed instructions and figures.6 Alternatively, an accessible online quick guide to manual rotation exists in Table 3 of Cargill Y, MacKinnon C “SOGC: clinical practice guidelines.”23

- Instrumental rotation is a safe alternative to manual rotation for appropriate candidates when performed by a skilled, experienced physician.5,8,24

- Promote progress when malposition persists
  – Epidural anesthesia and timing of epidural - It is not completely clear if epidural anesthesia predisposes to persistent malposition or if the prolonged labor/increased discomfort associated with the malpositioned fetus increases the need for regional anesthesia. While there is no evidence to suggest that regional anesthesia causes malposition, the preponderance of the evidence suggests that mothers with epidurals are up to four times as likely to have an OP fetus than women without epidurals.25,26 Evidence also suggests that delaying epidural placement to later in labor (> 5 cm dilatation or > 0 station) results in fewer persistent malpositions. The current recommendation for timing of regional anesthesia during labor does not require that women reach an arbitrary cervical dilation before placing an epidural. As such, since women with epidural anesthesia do not change their positions in response to their sensations of discomfort as do women without regional anesthesia, caregivers should change the patient’s position at least every 20 minutes to maximize fetal accommodation to a more favorable position.7
  – Psyche - Support measures for the mother who is fatigued and doubts her ability to birth vaginally are critical at this juncture. Family or professional support persons (doulas, montrices) are as important as medical personnel to stave off an unnecessary cesarean.28 If the fetus demonstrates health, a sip of liquid with some glucose (juice, Gatorade) will give her a burst of energy to continue to run the “bell lap.”29 Support persons should be apprised of the mother’s progress so that they can continue to cheer her on.

Second Stage Management of Malposition
Appendix G
Second Stage Management of Malposition

- Pushing positions - For the persistently OP fetus, the doula, nurse, and provider should consider the most effective positions for pushing and the “drive angle” of the occiput relative to the maternal bony pelvis. Forward-leaning, non-dorsal pushing positions are recommended for persistent malposition. These include various squatting positions (e.g. with a squat bar or with support from the woman’s partner or doula), and forward-leaning positions while sitting (e.g. on the toilet), kneeling, or standing. For the OP fetus, when the most common modern-day pushing position is employed (the lithotomy position with “chin-to-chest”), the anterior sinciput is obstructed, gravity is not utilized, and significantly longer pushing times often result. If or when lithotomy position is used, exaggerated lithotomy (also known the back-lying squat, or the McRoberts Position used for shoulder dystocia), with the woman’s head flat on the bed, and buttocks slightly lifted, can expand the fore pelvis sufficiently that the anterior sinciput of the OP fetus can more easily swing under the symphysis pubis.1,4,10

• Tincture of time” is important when incremental descent is observed in second stage.21 Patience is of the essence when fetus and mother demonstrate resilience. Optimal evidence of progress (or lack thereof) is best ascertained when the same clinician monitors the fetal descent in second stage. 3,24

IV. References
Second Stage Management of Malposition


## Appendix H
### Performance Measures Used To Assess Cesarean Births (Jan 2016)

#### Recommended Measures in Yellow

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source/ Supporting Organization(s)</th>
<th>Specifications for Denominator (Numerator for each is: “Among the denominator, those with a cesarean delivery”)</th>
<th>Strengths</th>
<th>Limitations (including data quality issues)</th>
<th>Utility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cesarean Rate</td>
<td>•Traditional</td>
<td>All mothers giving birth ≥ 20 weeks gestation</td>
<td>Easy to collect using either Discharge Diagnosis or Birth Certificate Files</td>
<td>Includes repeat CS and mixes CS rates for nulliparous with multiparous women (all of which occur at significantly different rates among hospitals)</td>
<td>Used for general population surveillance, but distorts hospital level comparisons because of lack of risk adjustment</td>
</tr>
<tr>
<td>Primary Cesarean Rate</td>
<td>•Traditional</td>
<td>All mothers giving birth ≥ 20 weeks gestation without a prior cesarean birth</td>
<td>Easy to collect using either Discharge Diagnosis or Birth Certificate Files</td>
<td>Mixes CS rates for nulliparous with multiparous women (which occur at significantly different frequencies among hospitals and have very different CS rates) and includes CS for breeches and twin gestations. Some hospitals don’t code prior CS well so that repeat CS can end up in the primary rate</td>
<td>Used for general population surveillance, but distorts hospital level comparisons because of lack of risk adjustment</td>
</tr>
<tr>
<td>Repeat Cesarean Rate</td>
<td>•Traditional</td>
<td>All mothers giving birth ≥ 20 weeks gestation who had at least one prior cesarean birth</td>
<td>Focused on women with prior cesareans</td>
<td>Some hospitals don’t code prior CS well so that repeat CS can end up in the primary rate</td>
<td>Reverse of VBAC (Vaginal birth after Cesarean) rate, either one is useful. The rate of VBAC or repeat CS is often driven by medical-liability concerns</td>
</tr>
<tr>
<td>Standard Nullip aka, Low-risk First-birth (NTSV or Nulliparous, Term, Singleton, Vertex) Cesarean Rate</td>
<td>•NQF: #0471 •TJC: PC-02 •Leap Frog Group •CMS/CHPRA •ACOG •HP2010/2020 •NCHS</td>
<td>All mothers giving birth ≥ 20 weeks gestation who were Para=0 (nulliparous), At term ≥37 wks, singleton and presenting with a vertex (cephalic) presentation</td>
<td>Creates a standardized nullip population rate that can better compare hospitals. Excludes common conditions with very high CS rates such as breech, twins and prior CS. Concentrating on first births allows focus on labor management, the major issue for QI. NCHS also reports this measure for every state</td>
<td>Requires either Birth Certificate file or a hospital database that records parity (hospital discharge data does not capture parity). This excludes the possibility for calculation using claims data unless linked to the Birth Certificate. The name of “Low-risk” raises questions as the specifications clearly do not exclude all high risk conditions—“Standard nullip” is a much better descriptor</td>
<td>Important for other organizations to adopt to promote harmonization as every hospital that belongs to the Joint Commission with &gt;300 annual births will be reporting this measure. Allows QI efforts to better focus on labor issues</td>
</tr>
<tr>
<td>Cesarean Delivery Rate (Term, Singleton, Vertex)</td>
<td>•AHRQ: IQI 21</td>
<td>All mothers giving birth ≥ 20 weeks gestation who were ANY parity, at term (≥37 wks), singleton and presenting with a vertex (cephalic) presentation (using ICD9 codes)</td>
<td>Easy to collect using Discharge Diagnosis Files</td>
<td>Mixes CS rates for nulliparous with multiparous women who have 5-8x lower CS rates then nulliparous women and nulliparous women have wide variation in frequency among hospitals (20-55%). Very high correlation with Total CS rate</td>
<td>Can give widely different results than NTSV CS because multip CS rates are so much lower than nullips’. Therefore the TSV rate is heavily dependent on the proportion of multips to nullips at the hospital</td>
</tr>
<tr>
<td>Primary Cesarean Delivery Rate (Term, Singleton, Vertex, no prior cesarean births)</td>
<td>•AHRQ: IQI 33</td>
<td>All mothers giving birth ≥ 20 weeks gestation who were ANY parity, at term (≥37 wks), singleton and presenting with a vertex (cephalic) presentation (using ICD9 codes)</td>
<td>Easy to collect using Discharge Diagnosis Files</td>
<td>Mixes CS rates for nulliparous with multiparous women who have 5-8x lower CS rates then nulliparous women and nulliparous women have wide variation in their frequency among hospitals (20-55%). Very high correlation with Primary CS rates. It is also dependent on coding for the prior CS (which can easily be missed) and therefore at risk for falsely including mothers having a repeat CS</td>
<td>Can give widely different results than NTSV CS because multip CS rates are so much lower than nullips’. Therefore the TSV rate is heavily dependent on the proportion of multips to nullips at the hospital</td>
</tr>
</tbody>
</table>

### General Comments for Cesarean Birth Measures

1. Note that the denominators are always mother-based and not baby-based. This prevents double or triple counting (or more) for multiple gestations. If using Birth Certificates (a baby-based data system), a common short cut is to restrict the population to the first birth of a multiple gestation. This will miss a tiny number of cases where the first baby in a multiple gestation was a vaginal birth and a subsequent baby was a cesarean delivery. By design, this is not an issue for NTSV CS as multiple gestations are excluded.

2. Additional factors that can affect the risk for CS for individuals include: maternal age, BMI, weight gain during pregnancy, fetal weight, race, maternal diabetes and HTN. Two large studies have suggested that these factors are less important for hospital-level rates for two reasons: (1) Age and weight appear to occur in inverse frequencies in hospital populations (high maternal age first mothers are generally thinner), thus often cancelling out their effects; (2) the frequency of pre-gestational diabetes and severe HTN are low and not particularly mal-distributed. Furthermore, most major pregnancy-related indications for primary CS such as placenta previa or severe preclampsia are much more likely to occur before 37 weeks or in multips (and hence be excluded). Correspondingly, the studies noted that fuller risk-adjustment models did not add appreciably to NTSV.
### Appendix H

#### Performance Measures Used To Assess Vaginal Births (Jan 2016)

##### Recommended Measures in Yellow

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source/Supporting Organization(s)</th>
<th>Specifications for Denominator and Numerator</th>
<th>Strengths</th>
<th>Limitations (including data quality issues)</th>
<th>Utility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Episiotomy Rate</td>
<td>-NQF: #0470 -Leapfrog Group</td>
<td>Denominator: All vaginal delivery discharges Numerator: Among the denominator, cases with an episiotomy ICD-9 procedure code</td>
<td>Easy to collect using Discharge Diagnosis File (ICD-9 Code)</td>
<td>Not as linked to an outcome (serious injury to the perineum) as we would want</td>
<td>Can be used for general population. More commonly used in nulliparous women but should be low in all groups so that risk adjustment is not needed</td>
</tr>
<tr>
<td>3rd/4th Degree Laceration Rate</td>
<td>-Traditional (Note: NQF has withdrawn support for all 3rd/4th laceration metrics)</td>
<td>Denominator: All vaginal delivery discharges Numerator: Among the denominator, cases of 3rd or 4th degree lacerations</td>
<td>Easy to collect using Discharge Diagnosis File (ICD-9/10 Codes)</td>
<td>Ignores major risk factors such as baby size, malposition, maternal race, instrument delivery and most importantly, nulliparity. Also, there is poor consensus on the definition of a partial 3rd degree creating concern over consistency and comparability between facilities</td>
<td>Promoted for use in general population surveillance, but distorts hospital level comparisons because of lack of risk adjustment. Also has been used to promote and increase in CS rates!</td>
</tr>
<tr>
<td>3rd/4th Degree Laceration Rate: Obstetric Trauma-Vaginal Delivery with instrument</td>
<td>-AHRQ: PSI 18</td>
<td>Denominator: All vaginal delivery discharges with any procedure code for instrument-assisted delivery. Numerator: Among the denominator, cases of 3rd or 4th degree lacerations</td>
<td>Easy to collect using Discharge Diagnosis File (ICD-9/10 Codes). Lacerations are much higher with operative vaginal delivery so this addresses one risk factor (but not others)</td>
<td>Ignores major risk factors such as baby size, malposition, maternal race, and most importantly, nulliparity. Also, there is poor consensus on the definition of a partial 3rd degree creating concern over consistency and comparability between facilities</td>
<td>Promoted for use in general population surveillance, but distorts hospital level comparisons because of lack of risk adjustment. Also has been used to promote and increase in CS rates!</td>
</tr>
<tr>
<td>3rd/4th Degree Laceration Rate: Obstetric Trauma-Vaginal Delivery without instrument</td>
<td>-AHRQ: IQI 33</td>
<td>Denominator: All vaginal delivery discharges without any procedure code for instrument-assisted delivery. Numerator: Among the denominator, cases of 3rd or 4th degree lacerations</td>
<td>Easy to collect using Discharge Diagnosis File (ICD-9/10 Codes). Lacerations are much higher with operative vaginal delivery so this addresses one risk factor (but not others)</td>
<td>Ignores major risk factors such as baby size, malposition, maternal race, and most importantly, nulliparity. Also, there is poor consensus on the definition of a partial 3rd degree creating concern over consistency and comparability between facilities</td>
<td>Promoted for use in general population surveillance, but distorts hospital level comparisons because of lack of risk adjustment. Also has been used to promote and increase in CS rates!</td>
</tr>
</tbody>
</table>
## Appendix H

### Performance Measures Used To Assess Term Neonatal Outcomes (Jan 2016)

#### Recommended Measures in Yellow

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source/ Supporting Organization(s)</th>
<th>Specifications for Denominator and Numerator</th>
<th>Strengths</th>
<th>Limitations (including data quality issues)</th>
<th>Utility</th>
</tr>
</thead>
</table>
| Birth Trauma — Injury to Neonate | •AHRQ: PSI 17 | Denominator: Live births excluding cases (using ICD-9/10 codes) with birth weight <2,000g, or brachial plexus injury or osteogenesis imperfecta  
Numerator: Among the denominator, those with ICD9/10 codes for birth trauma (the ICD-9 series of 767.x but not including Erb’s palsy or clavicle fracture) | Easy to collect using Discharge Diagnosis File (ICD-9/10 Codes) | The coding for birth weight can be incomplete. The selection of diagnosis codes for birth injuries has raised many questions: why exclude brachial plexus and Erb’s palsy? Most important however is the fact that 2/3 of the identified cases are because of the code: 767.8 “Other Specified Birth Trauma” which can refer to a wide range of mild to moderate issues that are very dependent on the coder | The limitations have led to a lack of endorsement by NQF but it is still used by some because of its ease of collection. It generally runs at 0.2% |
| Healthy Term Newborn, aka Unexpected Neonatal Complications | •NQF: #0716  
•CMQCC | Denominator: Live births at term without preexisting conditions (excludes IUGR, all fetal anomalies and conditions, maternal drug use)  
Numerator: Among the denominator, cases with very low Apgars, neonatal transfer, death, major or moderate complications by ICD-9/10 codes some with LOS parameters to guard against over-coding | Collected using administrative data only (no chart review). Serves an important role as a balancing measure to ensure that neonatal outcomes are preserved when working to lower the CS rate | Requires a Neonatal Discharge Diagnosis file linked to a Birth Certificate file to generate all the potential complications and exclusions. It is a complicated set of algorithms to generate the measure | Used wisely in California and by NPiC |
## Performance Measures Used To Assess Vaginal Birth After Cesarean (Jan 2016)

### Recommended Measures in Yellow

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source/</th>
<th>Specifications for Denominator and Numerator</th>
<th>Strengths</th>
<th>Limitations (including data quality issues)</th>
<th>Utility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Birth After Cesarean (VBAC) Rate</td>
<td>Traditional • AHRQ: IQI 34</td>
<td>Denominator: All women delivering with a prior cesarean birth Numerator: Among the denominator, those with a vaginal birth</td>
<td>Easy to collect using Discharge Diagnosis File (ICD-9/10 Codes or Birth Certificate Codes). Vaginal birth is much better coded than a trial of labor</td>
<td>While vaginal birth is much better coded than a trial of labor. Some hospitals don’t code prior CS well so that some repeat CS cases can end up in the primary rate</td>
<td>Given the current low availability of VBAC this metric now serves as an important access measure rather than a quality measure</td>
</tr>
<tr>
<td>VBAC Attempt Rate</td>
<td>Traditional</td>
<td>Denominator: All women delivering with a prior cesarean birth Numerator: Among the denominator, those with a trial of labor (successful or not)</td>
<td>Easy to collect using Discharge Diagnosis File (ICD-9/10 Codes or Birth Certificate Codes) but has accuracy issues noted in limitations</td>
<td>Often difficult to identify those women who had a trial of labor. While there are ICD9/10 codes and Birth Certificate codes there is room for improvement. It is much simpler to just identify those who had a vaginal birth (VBAC rate)</td>
<td>This measure is a component of the VBAC rate and identifies the most common issue with a low VBAC rate—that of poor attempt rate</td>
</tr>
<tr>
<td>VBAC Success Rate</td>
<td>Traditional</td>
<td>Denominator: All women with a prior Cesarean birth who are having a trial of labor Numerator: Among the denominator, those with a vaginal birth</td>
<td>Easy to collect using Discharge Diagnosis File (ICD-9/10 Codes or Birth Certificate Codes) but has accuracy issues noted in limitations</td>
<td>Often difficult to identify those women who had a trial of labor. While there are ICD9/10 codes and Birth Certificate codes there is room for improvement. It is much simpler to just identify those who had a vaginal birth (VBAC rate)</td>
<td>This measure is a component of the VBAC rate and identifies the portion of the VBAC rate that has the least variation, it is nearly always 70% +/-10%</td>
</tr>
<tr>
<td>Vaginal Birth After Cesarean (VBAC) Rate, Uncomplicated</td>
<td>AHRQ: IQI 22</td>
<td>Denominator: All women delivering with a prior cesarean birth, excluding cases with breech presentations, preterm or multiple gestations, and fetal deaths Numerator: Among the denominator, those with a vaginal birth</td>
<td>This attempts to address concerns over including women with prior CS who had other contraindications for VBAC in an attempt to increase the Face Validity of the measure. Easy to collect using Discharge Diagnosis File (ICD-9/10 Codes or Birth Certificate Codes)</td>
<td>The extra codes don’t add much burden but as noted above, Some hospitals don’t code prior CS well so that some repeat CS cases can end up in the primary rate. There is not a good reason to exclude all births before 37 weeks of gestation</td>
<td>Highly correlated (r2=0.99) with IQI 34 (overall VBAC rate) that is much better known so does not really add value</td>
</tr>
</tbody>
</table>
It should be noted that the development of new performance measures is actually a very difficult task and requires significant effort for validation.

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Specifications for Denominator and Numerator</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous Labor and Birth</td>
<td>•Proposed by AMA-PCPI Taskforce (2010)</td>
<td>Denominator: All mothers with nulliparous singleton, term, vertex pregnancies Numerator: Among the denominator, those with a spontaneous labor onset (no induction) and a spontaneous vaginal delivery without an episiotomy</td>
<td>Can be collected using Discharge Diagnosis File (ICD-9/10 Codes) but requires the addition of parity. Provides an easy to understand metric for consumers</td>
<td>Requires a linked data set. Unsure if this measure adds value beyond the NTSV Cesarean rate and the episiotomy rate</td>
<td>No testing yet performed. Unknown if adds more than current measures. Judgment is withheld until testing has been reported</td>
</tr>
<tr>
<td>Second Stage of Labor: Mother-Initiated, Spontaneous Pushing</td>
<td>•Proposed by AWHONN (#02) (2014)</td>
<td>Denominator: All women in Second Stage labor (and not having a scheduled cesarean) Numerator: those from the denominator with documentation in the medical record providing evidence of mother-initiated, spontaneous pushing</td>
<td>Likely to be used to drive practice change rather than public reporting</td>
<td>Requires chart review of 30 randomly selected retrospective cases. Frequency is not yet determined. This also represents a challenging charting requirement for the nurse. Unclear if requirement is mother-initiated, spontaneous pushing for the entire second stage or a partial period. The evidence base for this measure is not as strong as usually desired</td>
<td>No testing yet performed. Unclear whether it will lead to any changes in outcomes. Judgment is withheld until testing has been reported</td>
</tr>
<tr>
<td>Labor Support</td>
<td>•Proposed by AWHONN (#10a) (2014)</td>
<td>Denominator: All women in labor (spontaneous or induced excluding medical reasons for admission) Numerator: those from the denominator with documentation in the medical record of continuous labor support</td>
<td>Likely to be used to drive practice change rather than public reporting</td>
<td>Requires chart review of 30 randomly selected retrospective cases. Frequency is not yet determined. This also represents a challenging charting requirement for the nurse. Continuous labor support is defined as being “in the room continuously” and providing a series of non-pharmacologic interventions. Apparently can be provided by an RN or Doula, but is vague for other individuals (family or friends)</td>
<td>No testing yet performed. Continuous support for the entire labor is very difficult to support currently on most L&amp;D’s. Hard to justify for early labor and induction patients (such as cervical ripening). Judgment is withheld until testing has been reported</td>
</tr>
<tr>
<td>Partial Labor Support</td>
<td>•Proposed by AWHONN (#10b) (2014)</td>
<td>Denominator: All women in labor (spontaneous or induced excluding medical reasons for admission) Numerator: those from the denominator with documentation in the medical record indicating that the woman received at least one non-pharmacologic nursing intervention to support labor every hour for the duration of the First stage of labor</td>
<td>Likely to be used to drive practice change rather than public reporting</td>
<td>Requires chart review of 30 randomly selected retrospective cases. Frequency is not yet determined. Will require extensive charting. While there is data to support continuous labor support and fewer Cesarean births, this measure of partial labor support has no underlying studies to support it. The non-pharmacologic interventions are poorly defined and poorly validated</td>
<td>No testing yet performed. Hard to justify for early labor and induction patients (such as cervical ripening). Judgment is withheld until testing has been reported</td>
</tr>
</tbody>
</table>
It should be noted that the development of new performance measures is actually a very difficult task and requires significant effort for validation.

| Freedom of Movement during Labor | Part A sample: Denominator: All women ≥37 weeks of gestation in the first stage of labor without epidural analgesia and without scheduled cesarean Numerator: at a randomly selected observation point, those among the denominator who are laboring in a location other than a bed | Part B sample: Denominator: All women ≥37 weeks of gestation in the First stage of labor with epidural analgesia and without scheduled cesarean Numerator: at a randomly selected observation point, those among the denominator who are laboring in a position other than supine | At least 30 randomly selected observations for each of the two samples, including cases from all shifts. Frequency is not yet determined. Appears to involve organized observations of practice rather than chart reviews. Either way there is significant data collection burden and ability to skew results ("The observer is now on the floor"). Does not take into account a women's desire to be in bed for part of her labor or be supine after epidural. No normative data available | Likely to be used to drive practice change rather than public reporting | Interesting process measure but no testing yet performed. Unclear that intervention will lead to outcome improvements |
Appendix I

Understanding the Risks of Elective (Non-medically Indicated) Cesarean Birth with your First Pregnancy

Birth is a normal, natural process. The vast majority of women can have safe, normal vaginal births. There are health conditions where a cesarean birth is necessary for the wellbeing of the mother and/or the baby. Recently however, more mothers are giving birth by cesarean for non-medical reasons. A cesarean poses risks as well as benefits for mother and baby, and should not be undertaken lightly.

Expectant Mothers Name:

Obstetrician (OB Physician):

A cesarean delivery is an operation where a baby is delivered by making a cut in the mother’s lower abdominal wall (abdominal incision) and a cut in her uterus (uterine incision). A cesarean operation is a major surgical procedure with additional risks beyond those of a vaginal delivery.

RISKS ASSOCIATED WITH A CESAREAN AS COMPARED TO A VAGINAL BIRTH:

1. I am more likely to have more blood loss and a longer recovery time.
2. I am more likely to have accidental surgical cuts to my bladder, bowel, or gastrointestinal tract.
3. I am more likely to have a serious infection in my incision, uterus, or bladder.
4. I am more likely to have thick scarring (adhesions) inside my abdomen that may cause chronic pain for years after my cesarean. This scarring can make any future abdominal operation I may need more difficult.
5. I may have uncontrolled bleeding and need an emergency hysterectomy (removal of the uterus) if the bleeding cannot be stopped.
6. I am more likely to have complications from anesthesia.
7. I am more likely to develop blood clots that can travel to my lungs (pulmonary embolism) or my brain (stroke).
8. I am more likely to be admitted to intensive care.
9. I am more likely to need to return to the hospital for complications from the cesarean operation.
10. I am more likely to feel pain and/or numbness at the surgical site for several months after my surgery.
11. I am more likely to have a repeat cesarean delivery if I choose to undergo a cesarean for my first delivery.
12. I am more likely to experience “high risk” conditions in subsequent pregnancies, such as ectopic pregnancy, infertility, and abnormal attachments of the placenta to the uterine wall.

I have read and understand the risks associated with a cesarean delivery vs. a vaginal delivery.

PATIENT SIGNATURE:

PATIENT NAME: DATE:

This form was adapted with permission from Hoag Hospital; original educational content is from the Coalition for Improving Maternity Services (CIMS)
Pre-cesarean Checklist for Labor Dystocia or Failed Induction

Patient Name: ___________________  MR#: ___________________

Gestational Age: _______  Date of C-section: _________

Time: ______________________________________________________

Obstetrician: ___________________  Initial:___________

Bedside Nurse: ___________________  Initial:___________

Indication for Primary Cesarean Delivery:

___ Failed Induction (must have both criteria if cervix unfavorable, Bishop Score < 8 for nullips and <6 for multipis)

___ Cervical Ripening used (when starting with unfavorable Bishop scores as noted above). Ripening agent used: ____________________  Reason ripening not used if cervix unfavorable: ____________________  AND

___ Unable to generate regular contractions (every 3 minutes) and cervical change after oxytocin administered for at least 12-18 hours after membrane rupture.*  *Note: at least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

___ Latent Phase Arrest  <6 cm dilation (must fulfill one of the two criteria)

___ Moderate or strong contractions palpated for > 12 hours without cervical change

OR

___ IUPC > 200 MVU for > 12 hours without cervical change

*As long as cervical progress is being made, a slow but progressive latent phase e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women is not an indication for cesarean delivery as long as fetal and maternal statuses remain reassuring. Please exercise caution when diagnosing latent phase arrest and allow for sufficient time to enter the active phase.

Active Phase Arrest  > 6 cm Dilation (must fulfill one of the two criteria)

Membranes ruptured (if possible), then:

___ Adequate uterine contractions (e.g. moderate or strong to palpation, or ≥ 200 MVU, for ≥ 4 hours) without improvement in dilation, effacement, station or position

OR

___ Inadequate uterine contractions (e.g. < 200 MVU) for ≥ 6 hours of oxytocin administration without improvement in dilation, effacement, station or position

Second Stage Arrest (must fulfill any one of four criteria)

___ Nullipara with epidural pushing for at least 4 hours

OR

___ Nullipara without epidural pushing for at least 3 hours

OR

___ Multipara with epidural pushing for at least 3 hours

OR

___ Multipara without epidural pushing for at least 2 hours

Although not fulfilling contemporary criteria for labor dystocia as described above, my clinical judgment deems this cesarean delivery indicated

___ Failed Induction: Duration in hours: ____________

Latent-Phase Arrest: Duration in hours: ____________

Active-Phase Arrest: Duration in hours: ____________

Second-Stage Arrest: Duration in hours: ____________

Comments:

Adapted with permission from Miller Children’s and Women’s Hospital.
<table>
<thead>
<tr>
<th>CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Diagnosis of Dystocia/Arrest Disorder (all 3 should be present)</strong></td>
</tr>
<tr>
<td>☐ Cervix 6 cm or greater</td>
</tr>
<tr>
<td>☐ Membranes ruptured, then</td>
</tr>
<tr>
<td>☐ No cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs &gt; 200), or at least 6 hours of oxytocin administration with inadequate uterine activity</td>
</tr>
<tr>
<td><strong>2. Diagnosis of Second Stage Arrest (only one needed)</strong></td>
</tr>
<tr>
<td><strong>No descent or rotation for:</strong></td>
</tr>
<tr>
<td>☐ At least 4 hours of pushing in nulliparous woman with epidural</td>
</tr>
<tr>
<td>☐ At least 3 hours of pushing in nulliparous woman without epidural</td>
</tr>
<tr>
<td>☐ At least 3 hours of pushing in multiparous woman with epidural</td>
</tr>
<tr>
<td>☐ At least 2 hours of pushing in multiparous woman without epidural</td>
</tr>
<tr>
<td><strong>3. Diagnosis of Failed Induction (both needed)</strong></td>
</tr>
<tr>
<td>☐ Bishop score &gt;6 for multiparous women and &gt; 8 for nulliparous women, before the start of induction (for non-medically indicated/elective induction of labor only)</td>
</tr>
<tr>
<td>☐ Oxytocin administered for at least 12-18 hours after membrane rupture, without achieving cervical change and regular contractions. *Note: At least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit</td>
</tr>
</tbody>
</table>


### FIRST STAGE LATENT LABOR: Cervical dilation of 0-6 cm

<table>
<thead>
<tr>
<th>State</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL</td>
<td>Difficult to define due to challenge of determining the onset of labor</td>
</tr>
<tr>
<td></td>
<td>• No range exists for the new latent labor definition of 0-6 cm per Zhang</td>
</tr>
<tr>
<td></td>
<td>o Nulliparas (data exists only for 3-6cm): Median duration of 3.9 hours; 95th percentile 17.7 hours</td>
</tr>
<tr>
<td></td>
<td>o Multiparas (data exists only for 4-6cm): Median duration of 2.2 hours; 95th percentile 10.7 hours</td>
</tr>
<tr>
<td></td>
<td>• Per Friedman: &lt;20 hours in the nullipara, and &lt;14 hours in the multipara from 0-3cm</td>
</tr>
<tr>
<td>PROLONGED</td>
<td>• No range exists for the new latent labor definition of 0-6 cm</td>
</tr>
<tr>
<td></td>
<td>o Nulliparas: &gt;18 hours from 3-6cm</td>
</tr>
<tr>
<td></td>
<td>o Multiparas: &gt;10.7 hours from 4-6cm</td>
</tr>
<tr>
<td></td>
<td>• Per Friedman: &gt;20 hours in the nullipara, &gt;14 hours in the multipara from 0-3cm</td>
</tr>
</tbody>
</table>

### FIRST STAGE ACTIVE LABOR: Cervical dilation of 6-10 cm

<table>
<thead>
<tr>
<th>State</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL</td>
<td>• Nulliparas: Median duration of 2.1 hours; 95th percentile 7 hours</td>
</tr>
<tr>
<td></td>
<td>• Multiparas: Median duration of 1.5 hours; 95th percentile 5.1 hours</td>
</tr>
<tr>
<td>PROLONGED/SLOW SLOPE</td>
<td>Slow progress from 6-10cm: Presence of labor progress, but duration outside the 95th percentile range of normal (&gt; 7 hours in a nullipara, or &gt; 5 hours in a multipara)</td>
</tr>
<tr>
<td>ARREST</td>
<td>Dilation of 6 cm or more, with membrane rupture and absence of cervical change for:</td>
</tr>
<tr>
<td></td>
<td>• 4 hours OR MORE of adequate UCs (MVUs &gt;200) OR</td>
</tr>
<tr>
<td></td>
<td>• 6 hours OR MORE with Pitocin if UCs inadequate</td>
</tr>
</tbody>
</table>

### SECOND STAGE LABOR: Complete dilation to birth of the neonate

<table>
<thead>
<tr>
<th>State</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>NORMAL</td>
<td>• Nulliparas: &lt;3 hours WITHOUT epidural, &lt;4 hours WITH epidural</td>
</tr>
<tr>
<td></td>
<td>• Multiparas: &lt;2 hours WITHOUT epidural, &lt;3 hours WITH epidural</td>
</tr>
<tr>
<td>PROLONGED</td>
<td>Presence of descent, but duration outside normal range.</td>
</tr>
<tr>
<td></td>
<td>• Nulliparas: &gt;3 hours without epidural, &gt;4 hours with epidural</td>
</tr>
<tr>
<td></td>
<td>• Multiparas: &gt;2 hours without epidural, &gt;3 hours with epidual</td>
</tr>
<tr>
<td>ARREST</td>
<td>No (or minimal) descent after good pushing efforts for:</td>
</tr>
<tr>
<td></td>
<td>• Nulliparas: &gt;3 hours without epidural, &gt;4 hours with epidural</td>
</tr>
<tr>
<td></td>
<td>• Multiparas: &gt;2 hours without epidural, &gt;3 hours with epidual</td>
</tr>
<tr>
<td></td>
<td>*NOTE: According to a 2014 retrospective cohort study by Cheng and colleagues, of 42,268 women who delivered vaginally and had normal neonatal outcomes, the 95th percentile duration of second stage labor with epidural anesthesia is more than two hours greater for both nullips and multips (as opposed to one hour) when compared to women in second stage labor without epidural use. Additionally, according to the ACOG/SMFM guidelines, a specific absolute maximum amount of time for the second stage of labor has not been identified.</td>
</tr>
</tbody>
</table>

Adapted with permission from the authors Ana Delgado CNM, Jyesha Wren Serbin, CNM, and Anna Yen Tran, CNM, Zuckerberg San Francisco General Hospital.
Appendix M

Spontaneous Labor Algorithm

If Maternal or Fetal Medical Indication for Admission: DO NOT USE THIS ALGORITHM

- Spontaneous Labor
- Intact membranes
- Stable Mother and Baby
- Term, Singleton, Vertex (TSV)

Cervix less than 4 cm

Home (if still less than 4 cm)

Walk and Reassess

Inadequate Progress First Stage

Depending on assessment; Home, AROM and/or Oxytocin, or Cesarean
(ACOG criteria for Arrest of Labor: at least 6 cm dilation with ruptured membranes, AND at least 4 hours of adequate contractions without cervical change OR 6 hours of oxytocin with inadequate contractions and no cervical change)

For Induction of Labor: See Induction Algorithm (if enters active phase, follow arrow)

Cervix ≥ 4 cm & in Labor.
*Note: special circumstances such as severe fatigue, multiple triage visits, prolonged latent phase, and difficulty coping may warrant admission before 4 cm.

Inadequate Progress

Operative Delivery or Cesarean Delivery
(ACOG criteria for 2nd Stage Arrest: at least 3 hours of pushing for nulliparas, at least 4 hours of pushing for nulliparas with epidural; at least 2 hours of pushing for multiparas, at least 3 hours of pushing for multiparas with epidural)

Adequate Progress

AROM and/or Oxytocin if not already done

Vaginal Delivery

Vaginal Delivery

Admit to L&D

Adequate Progress First Stage

Adequate Progress Second Stage

Inadequate Progress Second Stage

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Adapted with permission from Washington State Hospital Association
Algorithm for the Management of Second Stage of Labor

**Cervix 10cm**

**NO EPIDURAL**

Encourage the woman to listen to her body. Many women without an epidural still experience a period of physiologic rest before having an urge to push. Allow rest and hydration during this time. Encourage the woman to push for as long as seems natural with each contraction. Open glottis pushing is preferable to “purple pushing” or “counting to 10” while holding breath. If pushing seems ineffective, advise 3 to 4 pushing efforts of 6 to 8 seconds in length, per contraction. Provide continuous nursing presence when pushing.

**1 HOUR Pushing**
If slow or no progress, RN to notify provider and document appropriately.

**1.5 - 2 HOURS**
If continued slow progress, RN to notify provider. Provider to bedside at 1.5 hours to evaluate progress and address cause.

**3 HOURS**
Provider to bedside to evaluate progress

**EPIDURAL**

Evaluate pushing. Open glottis pushing is preferable to “purple pushing” or “counting to 10” while holding breath. However, women with epidurals may need more coaching and may find holding their breath while pushing to be more effective. If pushing seems ineffective, advise 3 to 4 pushing efforts of 6 to 8 seconds in length, per contraction. Provide continuous nursing presence when pushing.

**1 HOUR Pushing**
RN to notify provider of progress. Continue pushing.

**2 HOURS**
If slow or no progress, RN to notify provider. Provider to bedside to evaluate progress and address cause.

**3 HOURS**
If continued slow progress, RN to notify provider. Provider at bedside to evaluate progress since last exam.

**4 HOURS**
Provider to bedside to evaluate progress

**NULLIP**

Continue frequent position changes (e.g. modified squat with squat bar, sidelying with open pelvis) to promote fetal rotation and prevent malposition.

If malposition is suspected, confirm by u/s and consider manual rotation. Continue frequent position changes to encourage fetal rotation if necessary. RN to communicate frequently with provider with status updates.

If malposition is suspected, confirm by u/s. Consider manual rotation. Continue frequent position changes to encourage fetal rotation if necessary.

Consider continued pushing if FHR reassuring and approaching NSVD; consider operative vaginal delivery (OVD) if appropriate; CS if delivery remote or OVD not possible.

Consider continued pushing if FHR reassuring and approaching NSVD; consider operative vaginal delivery (OVD) if appropriate; CS if delivery remote or OVD not possible.

Consider continued pushing if FHR reassuring and approaching NSVD; consider operative vaginal delivery (OVD) if appropriate; CS if delivery remote or OVD not possible.
Appendix 0
Active Labor Partogram

This partogram is meant to guide labor management and indicate when interventions may be necessary to promote labor progress and/or to assist with diagnosis of failure to progress. It can be useful for both multiparous and nulliparous labors, but is not meant to cover all clinical situations.

**ACTIVE LABOR PARTOGRAM**

**Term ≥ 37 Weeks Gestation**

Instructions:

- For time “0,” enter the time of the exam when it was first noted that the patient’s cervix met the definition of active labor (6cm dilation or greater). Progress should NOT be plotted on this partogram prior to 6cm dilation.
- At each subsequent cervical evaluation, note the time and how many hours have passed since the patient was first determined to be in active labor. Plot a point on the graph at the intersection between the number of hours since active labor was first noted (x-axis) and the woman’s cervical dilation at that exam (y-axis).

*Note that each box on the x-axis represents one additional hour in active labor, and the corresponding time of day should be entered into these boxes.

Example: the patient was first noted to be in active labor at 1300 hours, with a cervical dilation of 7 cm. At time “0,” 1300hrs was written in the box, and a dot was plotted at the (x-coordinate,y-coordinate) pair corresponding to (0,7). At 1600 hours, or 3 hours after the first exam, the patient was noted to be 9 cm. At time “3,” 1600hrs was written in the box, and a dot was plotted at the (x-coordinate,y-coordinate) pair corresponding to (3,9).

NOTE: Patients with “plotted lines” that cross over into the “Consider Interventions” zone are laboring at a rate that is slower than the 50th %tile duration for nulliparous labor. Patients whose lines cross over the half-way point of the “Consider Interventions” zone are laboring at a rate slower than the 95th %tile duration for nulliparous labor. Adverse maternal and neonatal events increase for labor durations in this zone. Furthermore, at 6 cms or more, 4 hours without cervical change is >95th %tile. Successful vaginal delivery is less likely and maternal and neonatal complications increase. Therefore, interventions should be considered well before the “Make Delivery Plan” zone. Interventions may include ambulation or position changes, AROM if not already done, and oxytocin administration.

Algorithm for Management of Category II Fetal Heart Rate Tracings

**Algorithm for management of category II fetal heart rate tracings**

- Moderate variability or accelerations
  - **Yes:** Significant decelerations with \( \geq 50\% \) of contractions for 1 hour
    - **Yes:** Significant decelerations with \( \geq 50\% \) of contractions for 30 minutes
      - **Yes:** Persistently abnormal pattern
      - **No:** Normal progress
        - **Yes:** Cesarean section
        - **No:** Observe
  - **No:** Normal labor progress
    - **Yes:** Cesarean section
    - **No:** Observe

---

**TABLE Management of category II fetal heart rate patterns: clarifications for use in algorithm**

1. Variability refers to predominant baseline FHR pattern (marked, moderate, minimal, absent) during a 30-minute evaluation period, as defined by NICHD.
2. Marked variability is considered same as moderate variability for purposes of this algorithm.
3. Significant decelerations are defined as any of the following:
   - Variable decelerations lasting longer than 60 seconds and reaching a nadir more than 60 bpm below baseline.
   - Variable decelerations lasting longer than 60 seconds and reaching a nadir less than 60 bpm regardless of the baseline.
   - Any late decelerations of any depth.
   - Any prolonged deceleration, as defined by the NICHD. Due to the broad heterogeneity inherent in this definition, identification of a prolonged deceleration should prompt discontinuation of the algorithm until the deceleration is resolved.
4. Application of algorithm may be initially delayed for up to 30 minutes while attempts are made to alleviate category II pattern with conservative therapeutic interventions (eg, correction of hypotension, position change, amnioinfusion, tocolysis, reduction or discontinuation of oxytocin).
5. Once a category II FHR pattern is identified, FHR is evaluated and algorithm applied every 30 minutes.
6. Any significant change in FHR parameters should result in reaplication of algorithm.
7. For category II FHR patterns in which algorithm suggests delivery is indicated, such delivery should ideally be initiated within 30 minutes of decision for cesarean.
8. If at any time tracing reverts to category I status, or deteriorates for even a short time to category III status, the algorithm no longer applies. However, algorithm should be reinstated if category I pattern again reverts to category II.
9. In fetus with extreme prematurity, neither significance of certain FHR patterns of concern in more mature fetus (eg, minimal variability) or ability of such fetuses to tolerate intrapartum events leading to certain types of category II patterns are well defined. This algorithm is not intended as a guide to management of fetus with extreme prematurity.
10. Algorithm may be overridden at any time if, after evaluation of patient, physician believes it is in best interest of the fetus to intervene sooner.

---

Appendix Q
Example Algorithm for the Management of Intrapartum Fetal Heart Rate Tracings

This is an example of one possible algorithm to assist the nurse and provider in the management of intrapartum fetal heart rate patterns. It does not cover all possible clinical situations. The algorithm assumes that the abnormal fetal heart rate pattern has been recently recognized, and that the preceding tracing is not already associated with the potential for significant acidemia. The algorithm also assumes the presence of active labor with normal labor progress. If the preceding tracing is already associated with the potential for significant acidemia, or if vaginal delivery is unlikely before significant acidemia occurs (e.g. as with a protraction disorder of the active phase or if the patient is still in the latent phase of labor), then sound clinical judgment dictates that the algorithm should be abandoned and delivery should be expedited.

*Clinically significant decelerations include:
- Variable decels lasting > 60 sec with a nadir > 60 BPM below baseline
- Variable decels > 60 sec with a nadir < 60 BPM regardless of baseline
- Late decels of any depth
- Any prolonged decel as defined by NICHD


**Corrective measures include:
- Oxygen administration
- Maternal position change
- Fluid bolus
- Reduction or discontinuation of pitocin
- Administration of terbutaline for tachysystole
- Administration of pressors, if hypotension present
- Amnioinfusion for deep, repetitive variable decelerations

Appendix R

Induction of Labor Algorithm

**INDUCTION**

Per ACOG guidelines, induction of labor before 41 weeks should only be performed if there is a maternal or fetal medical indication to do so. If 39 - 41 weeks without a medical indication for induction of labor, do so only with a favorable cervix.

**Unfavorable Cervix:**
- Bishop Score ≤ 8 for Nulliparas, ≤ 6 for Multiparas
  (proceed only if medical indication for induction exists)

- Mechanical or Pharmacological Cervical Ripening

- **No Cervical Change**
  - Repeat with Different Method
  - No Response Consider Oxytocin Trial
    - Home (if appropriate) or Cesarean.
      (*Note: ACOG guidelines state that failed induction in the latent phase can be avoided by allowing for longer durations of the latent phase, 24 hours or more)

- If successful, follow right side of algorithm (favorable cervix)
  - Continue/Start Oxytocin And Consider ROM
  - See active labor partogram and/or labor duration guidelines

**Favorable Cervix:**
- Bishop Score ≥ 8 for Nulliparas, ≥ 6 for Multiparas

- Initiate Oxytocin

- Cervical Change, and Cervix ≥ 6cm
  - See active labor partogram and/or labor duration guidelines

- AROM and No Cervical Change for 12-18 hours of Oxytocin.
  (*Note: 24 hours of oxytocin is preferable if fetal and maternal statuses permit)

- Cervix < 6 cm, UNABLE To AROM and No Cervical Change with 24 Hours Oxytocin
  - Consider Home if Elective and/or Medically Stable

- **Favorable Cervix:**
  - Cervical Change, but Cervix < 6 cm
    - No Cervical Change
      - Continue/Start Oxytocin And Consider ROM

- **Failed Induction**
  - Proceed to Cesarean

Adapted with permission from Washington State Hospital Association
### Labor Definitions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source/ Specifications for Denominator and Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine contractions</td>
<td>Avoid the term 'prodromal labor'. Can be spontaneous in onset, spontaneous in onset and subsequently augmented, or induced</td>
</tr>
<tr>
<td>resulting in cervical</td>
<td></td>
</tr>
<tr>
<td>change (dilation and/or</td>
<td></td>
</tr>
<tr>
<td>effacement) Phases:</td>
<td></td>
</tr>
<tr>
<td>Latent phase – from the</td>
<td></td>
</tr>
<tr>
<td>onset of labor to the</td>
<td></td>
</tr>
<tr>
<td>onset of the active phase</td>
<td></td>
</tr>
<tr>
<td>Active phase – accelerated cervical dilatation typically beginning at 6 cm</td>
<td></td>
</tr>
<tr>
<td>Spontaneous Onset of</td>
<td>May occur at any gestational age</td>
</tr>
<tr>
<td>Labor</td>
<td></td>
</tr>
<tr>
<td>Labor without the use of</td>
<td></td>
</tr>
<tr>
<td>pharmacologic and/or</td>
<td></td>
</tr>
<tr>
<td>mechanical interventions to</td>
<td></td>
</tr>
<tr>
<td>initiate labor</td>
<td></td>
</tr>
<tr>
<td>Does not apply if AROM is</td>
<td></td>
</tr>
<tr>
<td>performed before the onset</td>
<td></td>
</tr>
<tr>
<td>Induction of Labor</td>
<td>Still applies even if any of the following are performed:</td>
</tr>
<tr>
<td>The use of pharmacologic</td>
<td>Unsuccessful attempts at initiating labor</td>
</tr>
<tr>
<td>and/or mechanical methods</td>
<td>The use of pharmacologic and/or mechanical methods to initiate labor following spontaneous ruptured membranes without</td>
</tr>
<tr>
<td>to initiate labor</td>
<td>following spontaneous ruptured membranes with contractions</td>
</tr>
<tr>
<td>Examples of methods include but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>Artificial rupture of membranes, balloons, oxytocin, prostaglandin, laminaria, or other cervical ripening agents</td>
<td></td>
</tr>
<tr>
<td>Augmentation of Labor</td>
<td>Does not apply if Induction of Labor is performed</td>
</tr>
<tr>
<td>The stimulation of uterine contractions using pharmacologic methods or</td>
<td></td>
</tr>
<tr>
<td>artificial rupture of</td>
<td></td>
</tr>
<tr>
<td>membranes to increase their frequency and/or strength following the onset of spontaneous labor or contractions following spontaneous rupture of membranes.</td>
<td></td>
</tr>
</tbody>
</table>

---


(appendix 3: http://download.lww.com/wolterskluwer_vitalstream_com/PermaLink/AOG/A/AOG_124_1_2014_05_28_MENARD_14-107_SDC3.pdf)

Discussion to help clarify Induction versus Augmentation:

- In the setting of SROM: if any contractions + oxytocin = augmentation; if absolutely no contractions + oxytocin = induction (rare).

- For prolonged latent phase: if there is slow changing but protracted rate of change then addition of oxytocin is augmentation (labor is cervical dilation or effacement). No labor + oxytocin = induction, otherwise it is augmentation.

- For prolonged latent phase: if there is no change of dilation or effacement and oxytocin is used then it is induction; if there is slow changing but protracted rate of change then addition of oxytocin is augmentation (labor is cervical dilation or effacement). No labor + oxytocin = induction, otherwise it is augmentation.

- For the above examples, for oxytocin, one can substitute “misoprostol” or “vaginal prostaglandin” or “foley catheter placed in cervix” or other methods for cervical ripening or stimulation of contractions including AROM. (N.B. cervical ripening = induction)

AIM/CMQCC, April 2016
Zuckerberg San Francisco General Hospital. Fetal Monitoring Policy. Includes procedure for intermittent auscultation and exclusion criteria. Used with permission.

TITLE: FETAL MONITORING/UTERINE CONTRACTION ASSESSMENT AND DOCUMENTATION

PURPOSE: The purpose of the policy is to provide guidelines for fetal monitoring and uterine contraction assessment and documentation in the Birth Center.

STATEMENT OF POLICY: To provide guidelines for the trained registered nurse to initiate, assess and document the appropriate monitoring of the fetal heart rate (FHR) and uterine contraction (UC) patterns.

To provide standardized interpretation and communication regarding FHR and UC data based on criteria set forth by the National Institute of Child Health and Human Development (NICHD). (See Appendix C.)

To utilize informed consent and clinical judgment to provide a level of monitoring customized to the patient’s clinical condition and personal preferences, with the goal of achieving a delivery without significant acidemia or unnecessary iatrogenic interventions. It is the policy of SFGH Birth Center that women with low risk pregnancies have the choice to be intermittently auscultated or continuously monitored.

To provide guidelines for the registered nurse to utilize FHR and UC monitoring and assessment to support the overall goals of supporting maternal coping and labor progress, maximizing uterine and umbilical blood flow, maximizing oxygenation, and maintaining appropriate uterine activity.

Indications
(See Appendix A.)

1. Admission / Triage monitoring:
   Upon admission or presentation to triage in the Birth Center, generally all patients greater than 24 weeks gestation are monitored for a minimum of 20 minutes. The tracing should be continuous until Category I (if greater than 28 weeks). Notify provider if not Category I after 40 minutes and/or variant FHR patterns are noted. If the patient has been ambulating for a period of time (2 hours or more), another 20 minute tracing of the fetal heart rate and uterine activity should be completed prior to discharge from triage. If patient is laboring, accelerations may not be required to determine Category I tracing.

   See Antenatal Testing Center policy for antenatal testing patients in triage.
Patients less than 24 weeks may have a Doppler check for presence and rate of fetal heart tones. Patient’s refusal to be monitored must be documented.

2. Antepartum monitoring (patient not in labor):
   Antepartum fetal monitoring should be individualized for each patient dependent on condition and risk factors

3. Labor monitoring: Intermittent Auscultation (IA vs. Continuous EFM (CEFM))
   The two methods of fetal heart rate monitoring accepted by the American College of Obstetrician Gynecologists (ACOG) and the American College of Nurse Midwives (ACNM) are: intermittent auscultation (IA) and continuous electronic fetal monitoring (CEFM).

There is widespread support for the use of continuous EFM for high-risk women, while IA is the preferred method of monitoring for low-risk laboring women. There have been many studies comparing IA with EFM among low-risk pregnant women. There are advantages and disadvantages with the use of either method. Some of the differences include:

1. Women who were monitored by CEFM had a 1.66 times increased risk of Caesarean birth.
2. Women who were monitored by CEFM had a 1.2 times increased risk of operative vaginal birth
3. Women who were monitored by CEFM had a 50% decrease in neonatal seizures as compared with those monitored with IA.
4. Case-control studies have shown correlation of EFM abnormalities with umbilical artery base excess. Our institution now transfers these infants to UCSF as part of the “head cooling” protocol.
5. Meta-analysis of the randomized controlled trials comparing EFM with IA have found no effect on the incidence of cerebral palsy or perinatal death.

Advantages and Disadvantages of CEFM and IA

Intermittent Auscultation
1. IA helps to normalize the birth process by allowing freedom of movement and reducing the use of technology
2. IA has been shown to reduce Cesarean and operative vaginal birth rates
3. IA increases the amount of time that women receive hands-on bedside care and support
   For nurses not accustomed to IA, IA can seem like more work or may seem more intrusive. Some nurses may not feel comfortable performing IA if they have more than one patient
4. The literature shows an increase in neonatal seizures for babies monitored with IA and a higher incidence of umbilical artery base excess.
Continuous External Fetal Monitoring

1. CEFM is more appropriate for women at risk for complications because fetal conditions can deteriorate more rapidly in those cases
2. CEFM may be easier to monitor if RN staffing is a concern

<table>
<thead>
<tr>
<th>FHR Characteristic</th>
<th>Doppler without Paper Printout</th>
<th>Electronic FHR Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variability</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Baseline rate</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Accelerations</td>
<td>Detects increases</td>
<td>Yes</td>
</tr>
<tr>
<td>Decelerations</td>
<td>Detects decreases</td>
<td>Differentiates types of decelerations</td>
</tr>
</tbody>
</table>

Deciding on the Appropriate Method of Monitoring (See Appendix A)

1. **The Patient’s Role**
   All low-risk patients should be offered IA. Ideally this conversation should take place in the antenatal period and be documented in the patient’s chart. In the absence of clinical risk factors or staffing problems, the patient can decide whether IA is right for her labor.

2. **The Nurse’s Role**
   The ability to use IA will be part of the standard skill set of all nurses taking care of laboring patients at the Birth Center. The nurse has the responsibility to decline to use IA if he or she feels that staffing does not permit IA. In these cases the nurse should let the provider know in a timely fashion that the nurse is unable to provide IA. The nurse can advocate for IA in a patient that he or she feels qualifies for IA or advocate for EFM in the patient who he or she feels needs to have EFM.

3. **The Provider’s Role**
   On admission the provider will evaluate the initial fetal monitoring tracing and the patient’s risk factors and decide whether the patient is appropriate for IA. All low risk women should be offered IA and counseled regarding the advantages and disadvantages.
PROCEDURE:
(See Appendix D for the Procedure of Fetal Monitoring)

FREQUENCY OF ASSESSMENT AND DOCUMENTATION

Documentation of the FHR in the medical record may occur at intervals that are different from assessment. When assessment and documentation are done at different intervals, this should be specified in the notes section of WatchChild. For example, “assessing FHR q 5” can be written in the notes, while a complete “Fetal Assessment” screen is done every 15 minutes. (See Appendix B for further documentation instructions.)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antepartum, not in labor</strong></td>
<td>Individualized per orders.</td>
</tr>
<tr>
<td><strong>Latent phase labor</strong></td>
<td>If on continuous monitoring, assess hourly, unless clinical condition indicates increased frequency of assessment/documentation.</td>
</tr>
<tr>
<td><strong>Active phase labor:</strong></td>
<td>Assess every 30 minutes</td>
</tr>
<tr>
<td>Intermittent Auscultation</td>
<td>Document every 30 minutes</td>
</tr>
<tr>
<td>Note: There is no need to get a continuous EFM strip at the change of shift</td>
<td></td>
</tr>
<tr>
<td><strong>Active phase labor:</strong></td>
<td>Assess every 15 minutes</td>
</tr>
<tr>
<td>Continuous EFM</td>
<td>Document every 30 minutes</td>
</tr>
<tr>
<td><strong>Second stage labor, if actively pushing:</strong></td>
<td>Assess every 5 minutes</td>
</tr>
<tr>
<td>Intermittent Auscultation</td>
<td>Document every 15 minutes</td>
</tr>
<tr>
<td><strong>Second stage labor, if actively pushing:</strong></td>
<td>Assess every 5 minutes</td>
</tr>
<tr>
<td>Continuous EFM</td>
<td>Document every 15 minutes</td>
</tr>
</tbody>
</table>

APPENDICES:
- Appendix A: FETAL HEART RATE CHARACTERISTICS
- Appendix B: Examples for Considering Continuous EFM
- Appendix C: The Procedure of Fetal Monitoring
- Appendix D: Documentation of Fetal Monitoring

CROSS REFERENCES:
- Nursing Dept. Policy 6.5/Notification of Physician for Change in Patient Condition
- Birth Center Policy – Documentation: WatchChild

REFERENCES:
1. Alfirevic Z, Devane D, Gyte GML. Continuous cardiotocography (CTG) as a form of

Created 2/2016


**SUPERSEDES:**

- L&D Policy 5.1/Electronic Fetal/Toco Monitoring-External (2/94)
- OB-Policy/Electronic/Toco Monitoring (10/89)
- L&D Policy 1.6/Assisting with the Insertion of Intrauterine Pressure Catheter (IUPC)
APPENDIX A: FETAL HEART RATE CHARACTERISTICS

1. **Baseline rate**: mean (average) FHR rounded to increments of 5 bpm during a 10 minute segment **excluding**:
   a. Periodic or episodic changes
   b. Periods of marked FHR variability
   c. Segments of the baseline that differ by > 25 bpm

   ***Baseline rate is determined over a 10-minute window. Minimum baseline duration must be at least 2 minutes of the baseline, or the baseline for that period is indeterminate. You may refer to the previous 10-minute segment to determine the baseline.

   **Normal baseline rate is 110-160**
   Tachycardia = FHR > 160 bpm for ≥ 10 minutes in duration
   Bradycardia = FHR < 110 bpm for ≥ 10 minutes in duration

2. **Baseline variability**: Fluctuations in the baseline FHR of 2 cycles per minute or greater. Fluctuations are irregular in amplitude and frequency (overall irregularity of the heart rate) and are visually quantified by the amplitude from peak to trough (high to low) in bpm and are labeled as follows:
   a. **Absent** = amplitude range is undetectable
   b. **Minimal** = amplitude range is between 2 ≤ 5 bpm
   c. **Moderate** = amplitude range is 6-25 bpm
   d. **Marked** = > 25 bpm
   Sinusoidal pattern is a smooth sine wave-like pattern of regular frequency and amplitude and is excluded in the definition of FHR variability.

3. **Acceleration**: a visually apparent abrupt increase (defined as onset of acceleration to peak in < 30 seconds) in FHR above the baseline. The increase is identified from the most recently determined portion of the baseline. The acme (peak) of the acceleration is ≥ 15 bpm above the baseline and lasts ≥ 15 seconds and is < 2 minutes in duration from onset to return to the baseline. Prior to 32 weeks gestation, acceleration = an acme (peak) of ≥ 10 bpm above the baseline and a duration of ≥ 10 seconds.
   **Prolonged acceleration** is ≥ 2 minutes and < 10 minutes in duration. An acceleration of ≥ 10 minutes is a baseline change.

4. **Late deceleration**: A visually apparent gradual (onset of deceleration to nadir is ≥ 30 seconds) decrease and return to baseline FHR and is associated with a uterine contraction. Decrease is calculated from the most recently determined portion of the baseline. The nadir of the deceleration occurs after the peak of the contraction. Usually, the onset, nadir and recovery of the deceleration occur after the beginning peak and ending of the contraction.

5. **Early deceleration**: A visually apparent gradual (onset of deceleration to nadir ≥ 30 seconds) and return to baseline FHR and is associated with a uterine contraction. The decrease is calculated from the most recently determined portion of the baseline. The nadir of the deceleration occurs simultaneously to the peak of the contraction. Usually the onset, nadir
and recovery of the deceleration occur simultaneously to the peak of the contraction.

6. **Variable deceleration**: A visually apparent abrupt decrease (onset of deceleration to the beginning of the nadir < 30 seconds) in FHR below baseline. The decrease is calculated from the most recently determined portion of the baseline. The decrease in FHR below the baseline is ≥ 15 bpm, lasting ≥ 15 seconds, and < 2 minutes from onset to return to baseline FHR. When associated with uterine contractions, their onset, depth and duration commonly vary with successive uterine contractions.

7. **Prolonged deceleration**: A visually apparent decrease in FHR below the baseline. The decrease is calculated from the most recently determined portion of the baseline. The decrease from the baseline is ≥ 15 bpm, lasting ≥ 2 minutes but < 10 minutes from onset to return of FHR baseline. A prolonged deceleration of ≥ 10 minutes is a baseline change.

8. **Reactive FHR tracing**: A tracing is identified as “reactive” when the tracing exhibits 2 accelerations / 20 minutes, ≥ 15 bpm above baseline lasting ≥ 15 seconds in association with moderate variability and a baseline between 110-160 bpm. If before 32 weeks gestation = 2 accelerations / 20 minutes with accelerations ≥ 10 bpm above baseline lasting for ≥ 10 seconds.

**Quantification**:

1. Any **deceleration** is quantified by the depth of the nadir in bpm below FHR baseline and excludes any transient spikes or electronic artifact. The duration is described in minutes and seconds beginning to the end of the deceleration. They are defined as recurrent if they occur with ≥ 50% of uterine contractions in a 20 minute period.

2. Any **acceleration** is quantified by the height of the peak in bpm above FHR baseline and excludes any transient spikes or electronic artifact. The duration is described in minutes and seconds from beginning to the end of the acceleration.

3. **Bradycardia** and **tachycardia** are quantified by the actual FHR in bpm or the visually determined range if the FHR does not remain at one rate.

<table>
<thead>
<tr>
<th>Category I Normal</th>
<th>Category II Indeterminate</th>
<th>Category III Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Baseline rate: 110–160 beats per minute (bpm)</td>
<td><strong>Baseline rate</strong></td>
<td>• Absent baseline FHR variability and any of the following:</td>
</tr>
<tr>
<td>• Baseline FHR variability: moderate</td>
<td>• Bradycardia not accompanied by absent baseline variability</td>
<td>- Recurrent late decelerations</td>
</tr>
<tr>
<td>• Late or variable decelerations: absent</td>
<td>• Tachycardia</td>
<td>- Recurrent variable decelerations</td>
</tr>
<tr>
<td>• Early decelerations: present or absent</td>
<td><strong>Baseline FHR variability</strong></td>
<td>- Bradycardia</td>
</tr>
<tr>
<td>• Accelerations: present or absent</td>
<td>• Minimal baseline variability</td>
<td>• Sinusoidal pattern</td>
</tr>
</tbody>
</table>
Accompanied by recurrent decelerations
• Marked baseline variability

**Accelerations**
• Absence of induced accelerations after fetal stimulation

**Periodic or episodic decelerations**
• Recurrent variable decelerations accompanied by minimal or moderate baseline variability
• Prolonged deceleration ≥ 2 minutes but < 10 minutes
• Recurrent late decelerations with moderate baseline variability
• Variable decelerations with other characteristics, such as slow return to baseline, "overshoots," or "shoulders"

### Interpretation of Auscultation Findings

<table>
<thead>
<tr>
<th>Category I</th>
<th>Category II</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Normal FHR baseline between 110 and 160 bpm</td>
<td>• Irregular rhythm</td>
</tr>
</tbody>
</table>
| • Regular heart rhythm                         | • Presence of FHR decreases or decelerations from the baseline
  o Note: When recurrent decelerations are detected, a transfer to EFM is indicated. EFM will be able to determine if the decreases from baseline are early, late, or variable decelerations and a diagnostic category I, II, or III will then be assigned using NICHD criteria for EFM generated FHR tracings. |
Appendix T
Model Policies

| • Absence of FHR decreases or decelerations from the baseline | • Tachycardia (baseline >160 bpm >10 minutes in duration) |
| • Note: Presence of FHR increases of accelerations from the baseline may or may not be present in a FHR auscultated and determined to be Category I. Accelerations should be assessed for and documented if present. If present, FHR accelerations signify fetal well-being at the time they are noted. | • Bradycardia (baseline <110 bpm >10 minutes in duration) |
Appendix B: Below, find examples for considering continuous EFM, optimal monitoring will be determined by CNM / MD order

**Maternal Conditions**

**Chronic Disorders**
1. Active drug use that may affect neonatal morbidity
2. Chronic HTN
3. SLE or antiphospholipid syndrome
4. Thyroid disease, if uncontrolled

Diabetes requiring insulin or uncontrolled gestational diabetes
1. History of IUFD
2. Previous cesarean birth

**Obstetric history**
1. History of IUFD
2. Previous cesarean birth

**Current pregnancy**
1. No prenatal care
2. Cholestasis
3. Diabetes that requires insulin or uncontrolled gestational diabetes
4. Gestational hypertension
5. Increased maternal serum AFP or HCG
6. Malpresentation
7. Twins
8. Oligohyramnios
9. Prolonged pregnancy >41 weeks
10. Pre-eclampsia
11. Prematurity (less than 36 weeks)
12. Preterm premature ROM (<36 weeks)

**Labor**
1. Chorioamnionitis
2. Epidural anesthesia
3. Meconium
4. Pitocin administration
5. Vaginal bleeding greater than bloody show
6. Misoprostol administration within two hours

**Fetal Conditions**
1. IUGR
2. Known congenital anomaly
3. Polyhydramnios
4. Red cell alloimmunization in the presence of erythroblastosis

**NOTE:** The following ARE NOT exclusions to IA:
1. Fentanyl administration
2. ROM at term with clear fluid, regardless of duration
APPENDIX C: The Procedure of Fetal Monitoring

1. **Intermittent Auscultation**
   a. Auscultation: When using auscultation as a mode of intermittent monitoring, a Doppler is used. FHR baseline should be established between contractions. Auscultation should be performed before, during and continued for one minute after the completion of a contraction. Maternal pulse to be determined immediately prior to and during auscultation. If maternal pulse and FHR cannot be distinguished from one another consider electronic monitoring and/or use of maternal pulse oxymetry.
   b. Utilizing abdominal palpation, contraction frequency, duration and intensity will be assessed and documented with the same frequency as FHR.

2. **External Fetal Monitoring (EFM/Doppler):**
   a. Precautions / Contraindication: unknown. Although some patients may exhibit sensitivity to aquasonic gel, KY lubricating gel may be used instead.
   b. Assess the need for fetal heart rate monitoring
   c. Operate and set up monitoring equipment appropriately
   d. Explain to the patient the need for FHR monitoring and what data the monitoring will provide
   e. Assess the monitor is functioning properly
   f. Observe the FHR tracing for consistency to verify clarity of input
   g. When monitoring is in progress observe area of abdomen under EFM monitor piece for redness, adjust as needed
   h. Reapply gel as needed
   i. Whenever in doubt, auscultate FHR and check maternal heart rate by applying the pulse ox (or manually).

3. **External Uterine Monitoring/Tocotransducer:**
   a. Precautions / Contraindication: unknown. Although some patients could experience skin breakdown // irritation. Frequently reposition the monitor
   b. Position the woman comfortably. Ensure uterine displacement to reduce compression of the inferior vena cava and position toco transducer on abdomen where fundus is most easily palpable and least maternal tissue is present. Avoid placing toco over umbilicus.
   c. Adjust the control button between contractions to record an artificial baseline tonus of approximately 10 mmHg to prevent the tracing from failing to record
   d. When monitoring is in progress check under the toco for redness and reposition every few hours

4. **Internal uterine pressure catheter monitoring (IUPC):**
   a. The Registered Nurse knowledgeable in this procedure is responsible for assisting the physician and or CNM with the insertion of an intravuterine pressure catheter.
   b. Physicians, Certified Nurse Midwives (CNMs), and medical and midwifery students
under appropriate direction may insert an intrauterine pressure catheter.*

c. Amniotic membranes must be ruptured and cervix adequately dilated prior to
insertion.

d. An intrauterine pressure catheter should not be used if placenta previa is present or
suspected.

e. Indications: A direct means of detecting frequency, duration, and intensity and
resting tone of contractions.

f. An IUPC may be used to determine Montevideo units. Montevideo units (MVUs)
are a unit of measure of the intensity or force of a contraction. MVUs are determined
by taking the sum of the peak of the contractions in a 10 minute period. Charting
frequency remains, if charting every 30 minutes either average the MVU’s or chart a
range in the comments section of the uterine activity box. Adequate MVUs are
considered to be in the range of:

• 200-280 mmHg if the baseline uterine tone is subtracted from the total.
• 240-300 mmHg if the baseline tone is included in the total.
• Maximal uterine activity is considered to be 280-300 MVUs.

g. Adequacy of uterine activity with an IUPC may also be established by following
criteria:

• A contraction pattern with contractions > 2 minutes and ≤ 3 minutes apart.
• Uterine contractions that are ≥ 50 mmHg above the baseline resting tone.

h. Average uterine resting tone is considered to be 5-25 mmHg. A higher resting tone
may be noted for Pitocin induction, multiple fetuses, and amnionitis. An elevated
baseline resting tone > 25 mmHg may warrant further evaluation to determine
etiology.

i. An intrauterine pressure catheter (IUPC) has been associated with rare complications
such as uterine perforation, abruption placenta and possibly amniotic fluid embolus.
Use of IUPC in labor has not resulted in a decrease in Cesarean birth; hence its routine
use is not recommended.

5. Procedure for IUPC set-up

a. Explain procedure and indication to patient and family to decrease anxiety and
increase cooperation

b. Position patient in dorsal lithotomy position.

c. Prepare equipment as follows:

• Gather supplies: catheter, cable and sterile gloves.
• Turn on the fetal monitor and plug in IUPC cable
• Open sterile catheter package.
• Connect the cable to the IUPC connection site.
• Maintain zero slide in the “closed” position and zero the monitor. This
establishes a zero baseline for the catheter.
• Assist care provider with the insertion of the IUPC.
• Secure catheter to patient’s thigh.

d. Documentation in WatchChild computer system:

• Fetal Assess screen: Change monitor type. Chart initial baseline reading and
uterine resting tone in both lateral positions and while patient is supine.
• MVUs after 10 minutes

*CMQCC note: Nurses who have been appropriately trained can insert IUPCs, if in accordance with unit policy and procedure
6. Internal Fetal Monitoring/Fetal Scalp Electrode (FSE):
   a. Fetal presentation should be documented prior to insertion via exam or ultrasound.
   b. Assist provider with FSE insertion by obtaining FSE packet and positioning patient
   c. Attach cable to FSE leg plate
   d. Attach FSE device to leg plate
   e. Secure leg plate to patient’s anterior thigh
   f. Observe tracing for clarity and functioning. If unclear or erratic, check leg palte
      contact and check cable attachment. If tracing does not improve, notify
      provider to replace FSE.
   g. To remove electrode, turn 1 ½ times counter clockwise and pull gently.
   h. The fetal scalp electrode (FSE) may rarely cause infection at the site of insertion
   i. The use of a FSE is relatively contraindicated in instances of potential vertical
      transmission of infection, such as HIV, hepatitis B, and hepatitis C. Risk / benefit
      analysis must be individualized in these circumstances. Contraindications: face
      presentation.
   j. With known fetal coagulopathies, the FSE may cause excessive bleeding.
      Consultation with a High Risk specialist is advisable, as risk/benefit analysis must be
      individualized in these circumstances.
APPENDIX D: Documentation of Fetal Monitoring

Documentation with Intermittent Auscultation

2) Fetal assessment includes the following:
   a. mode
   b. Fetal heart rate
   c. Rhythm: regular or irregular
   d. Increases (accelerations), presence or absence
   e. Decreases, depth, timing and duration (Type of deceleration per EFM definitions cannot be accurately described with IA)
   Note: FHT variability is not assessed with IA

3) Uterine activity includes the following:
   a. Mode
   b. Frequency: from the beginning of one contraction to the beginning of the next contraction
   c. Duration
   d. Intensity

Documentation with the External Fetal Monitor

1) Fetal assessment includes the following:
   a. Baseline FHR
   b. FHR variability
   c. Presence of accelerations.
   d. Periodic or episodic decelerations.
   e. Changes or trends of FHR patterns over time
   Note: FHR patterns have been given descriptive names. Nurses should use these terms in both written and verbal communication. The terms used at the Birth Center are established by the National Institute of Child Health and Human Development (NICHD) and the National Institutes of Health as universal nomenclature for EFM interpretation. See Appendix C for description of fetal heart rate characteristics.

2) Uterine activity includes the following:
   a. Mode
   b. Frequency: from the beginning of one to beginning of next one
   c. Duration
   d. Intensity

Use narrative notes, flow sheets, and summary.

Policy: Provide the laboring woman freedom to walk, move about, and assume the position of her choice during labor and birth unless restriction or a specific position is needed because of an underlying maternal-fetal condition.

Purpose: Freedom of movement in labor reduces maternal and neonatal morbidity, facilitates uterine contractility and labor progression, and enhances maternal satisfaction of the childbirth process. Restricting a laboring woman’s movement may adversely affect physiologic and psychologic elements during labor and childbirth, resulting in increased utilization of obstetrical interventions, oxytocin augmentation, and operative delivery.

- There has been no evidence of increased maternal or neonatal morbidity or increased obstetrical interventions in allowing a birthing mother the freedom to ambulate (move about) or change position during labor and birth.
- When a laboring woman is restricted to supine positioning, compression of the inferior vena cava by the weight of the fetus results in maternal hypotension and decreased uteroplacental perfusion. Higher pH and higher values of PO₂ and lower values of PCO₂ are in the cord blood of women who labor and birth in nonsupine positions.
- Ambulation, movement, and upright maternal positioning are likely to reduce the length of the first stage of labor by facilitating fetal descent. Restriction of movement decreases the fetal ability to descend, flex, rotate, and engage into the pelvis.
- Women who ambulate during the first stage of labor are less likely to have an operative delivery, defined as cesarean section, forceps, or vacuum extraction.
- When given the freedom to ambulate, move, and change position during labor and birth, most women find this to be an effective form of pain relief and are less likely to receive regional anesthesia.

Procedure:
1. The laboring woman will have freedom to change position to obtain a position of comfort, including, but not limited to, walking, standing, kneeling, squatting, and the use of chair, stool or birthing ball, unless a restriction on movement is required due to treatment or assessment of an underlying medical condition.
2. Utilization of nonevidence-based practices restrictive to a laboring woman’s freedom of movement (including continuous pulse-oximetry or continuous electronic fetal monitoring for low-risk obstetric clients) should be discouraged and dictated only by the underlying maternal-fetal condition versus institutional protocol.
3. Utilization of technology that affords a laboring woman freedom of movement during labor and childbirth including fetal telemetry and Doppler for intermittent fetal heart rate auscultation should be readily available to all intrapartum nursing and obstetrical staff.
4. The laboring woman whose labor is progressing slowly should be encouraged by the health care team to assume upright positions such as walking, kneeling forward, or rocking on a birthing ball, as ambulation and/or movement may encourage the progression of labor.


Category: Patient Care Services  Effective Date: See footer
Owner: Labor and Delivery OR Manager
Title: Cesarean Delivery / Induction of Labor Scheduling

PURPOSE: To eliminate non-medically indicated (elective) deliveries prior to 39 weeks. Non-medically indicated cesarean delivery or induction of labor prior to 39 completed weeks gestation requires approval of the Hoag Physician Leader or designee.

SCOPE: Labor and Delivery

AUTHORIZED PERSONNEL: Labor and Delivery Director, Charge Nurses, OR Manager, Clerical Coordinators

<table>
<thead>
<tr>
<th>Description</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 SCHEDULING DEFINITIONS:</td>
<td></td>
</tr>
<tr>
<td>1.1 Clock In Time: Patient in the room and anesthesia ready to be administered, surgeon has presented to the department</td>
<td>LDR Director, LDR OR Manager, Charge RN, Scheduler</td>
</tr>
<tr>
<td>1.2 Procedure Start Time: When Anesthesiologist releases patient to Surgical Team. Pre-incision verification (time out) will occur: correct patient, correct site, correct surgery, and correct position.</td>
<td></td>
</tr>
<tr>
<td>1.3 Incision Time: When surgeon makes the Incision / starts the surgery.</td>
<td></td>
</tr>
<tr>
<td>1.4 Procedure End Time: Surgeon has finished the procedure.</td>
<td></td>
</tr>
<tr>
<td>1.5 Out of Room Time: Patient exits the O.R. suite.</td>
<td></td>
</tr>
<tr>
<td>1.6 Late Start:</td>
<td></td>
</tr>
<tr>
<td>1.6.1 If the patient enters the OR by or before the scheduled start time, the case is considered “on time” and “no delay” is recorded on the Intraoperative Record. If the patient enters the OR past the scheduled time, the case is considered a “late start” and a delay code must be recorded on the Intraoperative Record.</td>
<td></td>
</tr>
<tr>
<td>1.7 Urgent/Emergent</td>
<td></td>
</tr>
<tr>
<td>1.7.1 Emergency Cases: Life threatening conditions requiring immediate attention that takes precedence over other cases. Emergencies will be performed in an available operating room during regular hours or may bump scheduled cases if all existing rooms are in use.</td>
<td></td>
</tr>
<tr>
<td>1.7.2 Urgent Cases: In house referrals or patients admitted to the hospital that requires surgical intervention within 24 hours.</td>
<td></td>
</tr>
<tr>
<td>1.7.3 Turnover Time: The time from when the current patient leaves the room until the next patient enters the room. Turn over time reports are generated for to-follow cases by the same surgeon.</td>
<td></td>
</tr>
<tr>
<td>1.7.4 Clean Up Time: Scheduling will allow adequate time between scheduled cases for cleaning and prepping. The OR clean up time is 30 minutes.</td>
<td></td>
</tr>
<tr>
<td>2.0 SURGERY CASE / INDUCTION SCHEDULING:</td>
<td></td>
</tr>
<tr>
<td>2.1 All cases are scheduled through the Labor and Delivery Scheduling Line.</td>
<td>Physician, Scheduler, LDR Charge Nurse</td>
</tr>
<tr>
<td>2.1.1 OB Physician Office will fax the Hoag Scheduling Request/Order to LDR Scheduling</td>
<td></td>
</tr>
<tr>
<td>2.1.2 Forms will not be accepted and requested date will not be granted if:</td>
<td></td>
</tr>
<tr>
<td>2.1.2.1 The form has been faxed before 0900</td>
<td></td>
</tr>
<tr>
<td>2.1.2.2 The form has been received 8 weeks prior to the requested surgery</td>
<td></td>
</tr>
</tbody>
</table>

Effective Date: 04/07/15
## Appendix T

### Model Policies

#### PROCEDURE

**Category:** Patient Care Services  
**Effective Date:** [Footer]

**Owner:** Labor and Delivery OR Manager

**Title:** Cesarean Delivery / Induction of Labor Scheduling

<table>
<thead>
<tr>
<th>Description</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>date for cesareans/ 1 week prior to the requested induction date for vaginal delivery</td>
<td></td>
</tr>
<tr>
<td>2.1.3 Orders are not present in SCM at the time of scheduling.</td>
<td></td>
</tr>
<tr>
<td>Women who have medical indications for delivery have priority over women having elective cesarean deliveries and inductions of labor. These decisions are at the discretion of the LDR charge nurse in consultation with the designated physician leader.</td>
<td></td>
</tr>
<tr>
<td>All scheduled deliveries must have the appropriate form completed and signed by physician to begin the scheduling process.</td>
<td></td>
</tr>
<tr>
<td>2.2.1 Cesarean Deliveries: Cesarean Delivery Scheduling Request/Order form (PS 7598).</td>
<td></td>
</tr>
<tr>
<td>2.2.1.1 For primary, elective cesarean deliveries, a complete/signed “Understanding the Risks” patient education checklist must also be received in order for the case to be scheduled.</td>
<td></td>
</tr>
<tr>
<td>2.2.2 Inductions of labor: Induction of Labor Scheduling Request form (PS 5529).</td>
<td></td>
</tr>
<tr>
<td>2.2.2.1 For elective inductions, a completed/signed “Induction Education” patient education must also be received in order for the case to be scheduled.</td>
<td></td>
</tr>
<tr>
<td>Cases will be entered into Surgical Information System (SIS) by the LDR Scheduling Clerical Coordinator as tentative.</td>
<td></td>
</tr>
<tr>
<td>A Hoag Physician Leader (Chief of Maternal Fetal Medicine, Laborist, Department Head, etc.) will review the Scheduling Request/Order form within 24 hours.</td>
<td></td>
</tr>
<tr>
<td>2.4.1 Approval from the Hoag Physician Leader:</td>
<td></td>
</tr>
<tr>
<td>2.4.1.1 The case will proceed as scheduled. No further action taken.</td>
<td></td>
</tr>
<tr>
<td>2.4.2 Further information needed:</td>
<td></td>
</tr>
<tr>
<td>2.4.2.1 The Hoag Physician Leader will complete a request for further information to be faxed to physician office.</td>
<td></td>
</tr>
<tr>
<td>2.4.3 Declines scheduling request:</td>
<td></td>
</tr>
<tr>
<td>2.4.3.1 The Hoag Physician Leader will communicate the cancellation with Clerical Coordinators for removal of schedule.</td>
<td></td>
</tr>
<tr>
<td>2.4.3.2 LDR Scheduling will call the OB Physician’s office to inform them of the cancellation of the case.</td>
<td></td>
</tr>
<tr>
<td>Computerized Elective Scheduling (captured in SIS)</td>
<td>Scheduler, LDR OR Manager</td>
</tr>
<tr>
<td>2.5.1 In order to ensure correct patient identification the following information is needed in order to schedule surgery:</td>
<td></td>
</tr>
<tr>
<td>2.5.1.1 Social Security Number or Medical Record Number</td>
<td></td>
</tr>
<tr>
<td>2.5.1.2 Patient Name (Last, First, Middle Initial)</td>
<td></td>
</tr>
<tr>
<td>2.5.1.3 Date of Birth</td>
<td></td>
</tr>
<tr>
<td>2.5.1.4 Patient Gender</td>
<td></td>
</tr>
<tr>
<td>2.5.2 If patient is in Affinity, download the above information and continue with the following information.</td>
<td></td>
</tr>
<tr>
<td>2.5.2.1 Patient Home and/or Work Phone Number</td>
<td></td>
</tr>
<tr>
<td>2.5.2.2 Patient In-House Room Number</td>
<td></td>
</tr>
<tr>
<td>2.5.2.3 Surgeon Name</td>
<td></td>
</tr>
<tr>
<td>2.5.2.4 Assistant Surgeon</td>
<td></td>
</tr>
</tbody>
</table>

**Effective Date:** 04/07/15
## PROCEDURE

### Category: Patient Care Services

**Owner:** Labor and Delivery OR Manager  
**Effective Date:** See footer  
**Title:** Cesarean Delivery / Induction of Labor Scheduling

<table>
<thead>
<tr>
<th>Description</th>
<th>Responsible Person</th>
</tr>
</thead>
</table>
| 2.5.2.5 Surgical Procedure  
2.5.2.6 Pre-Op Diagnosis  
2.5.2.7 Special Needs / Equipment needed  
2.5.2.8 Anesthesia Type  
2.5.2.9 Admit Type | LDR OR Manager, Physician Leader |

### 2.6 Time Availability:

<table>
<thead>
<tr>
<th>Day</th>
<th>Team A</th>
<th>Team B</th>
<th>Induction</th>
</tr>
</thead>
</table>
| Monday, Tuesday, Thursday, & Friday | 0715  
0900  
1030  
1200  
1330 | 0730  
0030  
2 slots  
0400  
2 slots  
0900  
2 slots | 0030 – 2 slots  
0400 – 2 slots  
0900 – 2 slots |
| Wednesday | 0830  
1000  
1130  
1300  
1430 | 0900 | |
| Weekends and Holidays | No scheduled time available | 0830  
1130 | |

### 2.7 Add on Cases

2.7.1 Surgeons or their offices call Labor and Delivery to schedule add-on cases. (After the schedule closes for the next day and scheduling for the day of surgery), all non-urgent/emergent add-on cases are considered first call/ first serve but will be triaged by the LDR Charge Nurse for time assignment and or available space.

2.7.2 Add-on cases are logged on the Add-on list with specific information requested: Patient and surgeon name, procedure. Appropriate ancillary departments are notified as needed. Add-on cases are entered in SIS system by Clerical Coordinator.

2.7.3 Anesthesia department will assign an Anesthesiologist to add-on cases  
2.7.3.1 If case has no Anesthesiologist assigned it will automatically be assigned the LDR Unit Anesthesiologist

2.7.4 All Urgent –emergent add-on cases are coordinated by charge nurse  
2.7.4.1 Any special requests, such as anesthesia support, or other special equipment need to be communicated to the charge nurse immediately so the items can be obtained

### 2.8 Bumping:

2.8.1 If the surgeon determines the surgery cannot wait until there is availability of OR-room, the surgeon will contact the OR Manager or the LDR Charge Nurse and discuss the need to bump another case.  
2.8.1.1 It is the responsibility of the surgeon to contact the surgeon whose

**Effective Date:** 04/07/15
## PROCEDURE

**Category:** Patient Care Services  
**Effective Date:** See footer

**Owner:** Labor and Delivery OR Manager  
**Title:** Cesarean Delivery / Induction of Labor Scheduling

<table>
<thead>
<tr>
<th>Description</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>procedure he/she will bump and discuss the situation with the surgeon.</td>
<td></td>
</tr>
</tbody>
</table>

**Reference:**

**Review and/or input for this procedure was given by the following:**
WHI ACO Pilot Committee  
WHI Leadership  
WHI OB Core 12/2014

**Revision Designation:** B – significant revisions

**Effective Date:** 04/07/15
### INDUCTION OF LABOR (IOL) SCHEDULING REQUEST

**HOAG MEMORIAL HOSPITAL PRESBYTERIAN**

The Prenatal Record MUST be on file in Labor and Delivery or Faxed with this completed form.

<table>
<thead>
<tr>
<th>Check if this is an update to a currently scheduled case</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Elective ☐ Non-Elective Date Submitted</td>
</tr>
</tbody>
</table>

**Requested Induction Date:**

**Requesting OB:**

**Alternate time availabilities:**

**Pediatrician:**

**Dating:** EDC (month/day/year):

**Gestational age at desired date of IOL:** weeks days

**IOL Diagnosis:**

| Latex Allergy: ☐ Yes ☐ No |

**PATIENT DEMOGRAPHIC INFORMATION:**

**Patient Name:**

**DOB:** SSN: MR#:

**Address:**

<table>
<thead>
<tr>
<th>Home #: Work #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cell #: Other #:</td>
</tr>
</tbody>
</table>

**Office contact:**

| Phone #: Fax #: |

| ☐ Induction Order in CPOE (Sign & Hold) |

**Special instructions:**

**To Be Completed by Physician Office Staff:**

**A.M./P.M.**

**[Date] [Time] [Physician Signature – Required]**

**To Be Completed By Hoag Hospital LDR Scheduling:**

**Confirmation Code:**

**IOL Date:** IOL Time:

---

**FAX FORM TO LDR**

**INDUCTION OF LABOR SCHEDULING REQUEST**

**PS 5529**

**Rev 09/14/15**

---

[2291]
Appendix T
Model Policies

Induction of Labor:

Gravity: _______ Parity: _______

**Indication:** (check all appropriate indications below)

**Level 1**
- Chorioamnionitis
- Diabetes Uncontrolled
- Fetal hydrops/somnification
- Gestational/hypertension
- IUGR less than 5%
- Maternal medical conditions (specify): ___________
- Multiple gestation: _______
- Non-reassuring fetal testing
- Oligohydramnios
- Preeclampsia/HELLP
- PROM

**Level 2**
- ≥ 41 weeks gestation / Post-term pregnancy
- Gestational diabetes
- IUGR – reassuring testing
- Fetal demise

**Level 3**
- Distance from hospital
- History of rapid labor
- Maternal request
- Prior C/S
  - Patient desires VBAC
  - Psychological factors (specify): _______
- > 39 weeks with a favorable cervix
- Other indication: _______________

**Confirmation of gestational age:**

LMP: ___________

EDC determined by: (check all that apply)

- Ultrasound obtained at < 20 weeks on (date): ___________ (gestational age): ______ weeks confirms gestational age
- Known date of conception on (date): ___________ associated with infertility treatment

If EDC was not determined by above methods, then identify documentation of fetal maturity:

- Amniocentesis performed on: ___________ Results: ___________
- *Provide explanation if scheduling at < 39 weeks: _______________

**Bishop Score**

<table>
<thead>
<tr>
<th>Dilation (cm)</th>
<th>Effacement (%)</th>
<th>Station (cm)</th>
<th>Cervical Consistency</th>
<th>Cervical Position</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>closed</td>
<td>0-30</td>
<td>-3</td>
<td>Firm</td>
<td>Posterior</td>
<td>0</td>
</tr>
<tr>
<td>1-2</td>
<td>40-50</td>
<td>-2</td>
<td>Medium</td>
<td>Mideine</td>
<td>1</td>
</tr>
<tr>
<td>3-4</td>
<td>60-70</td>
<td>-1</td>
<td>Soft</td>
<td>Anterior</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>≥ 80</td>
<td>0</td>
<td>Firm</td>
<td>Medium</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medium</td>
<td>Soft</td>
<td></td>
</tr>
</tbody>
</table>

A Bishop Score ≥ 5 is required for elective induction of multiparous patients.

**Physician Signature:** ___________ Date/Time: ___________

To be completed by Chief of Maternal Fetal Medicine or OB Hospitalist

**Procedure Scheduling Determination:**
- Schedule: Medically indicated and necessitates delivery < 39 weeks gestation
- Schedule: Gestation ≥ 39 weeks on scheduled date

Completed by: ___________ Date/Time: ___________

**Bishop Score on Admission**

<table>
<thead>
<tr>
<th>Dilation (cm)</th>
<th>Effacement (%)</th>
<th>Station (cm)</th>
<th>Cervical Consistency</th>
<th>Cervical Position</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>closed</td>
<td>0-30</td>
<td>-3</td>
<td>Firm</td>
<td>Posterior</td>
<td>0</td>
</tr>
<tr>
<td>1-2</td>
<td>40-50</td>
<td>-2</td>
<td>Medium</td>
<td>Mideine</td>
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</tr>
<tr>
<td>3-4</td>
<td>60-70</td>
<td>-1</td>
<td>Soft</td>
<td>Anterior</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>≥ 80</td>
<td>0</td>
<td>Firm</td>
<td>Medium</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medium</td>
<td>Soft</td>
<td></td>
</tr>
</tbody>
</table>

**Exam done by:**

- Difference in Bishop score greater than or equal to 4
- Cervical ripening ordered
- Patient discharged and rescheduled

**FAX FORM TO LDR**

**INDUCTION OF LABOR SCHEDULING REQUEST**

PS 5529 Rev 09/14/15

Name Label: ___________
Induction Education for Patients

Induction of labor is the use of medication or other interventions to get labor started. There are a number of medical reasons for which labor induction is indicated. An elective induction is done when a patient and her clinician decide to induce for non-medical reasons. In a first delivery, elective induction is not scheduled before 41 weeks of pregnancy. For women who have already delivered a baby, elective induction is not performed prior to 39 completed weeks of pregnancy. The most common ways of starting contractions are by breaking your bag of water and use of medications.

There are a number of physical and social reasons that a patient and her clinician may choose elective induction. Patients should have a clear understanding of the pros and cons of inducing labor before considering labor induction.

ELECTIVE INDUCTION OF LABOR MAY:
- Increase the duration of labor and hospital stay
- Increase the need for pain medication and/or epidural
- Decrease the patient’s ability to move about the labor room
- Increase the chance of cesarean delivery

For more information about induction please go to:

Please understand that your scheduled time is a request. You may not be able to come in on the day and time that you are scheduled if we have high patient volume and room is not available.

Call Labor and Delivery at 949/764-5789 before coming to the hospital to determine availability for induction. If there is no availability at that time, the charge nurse will provide you follow up instructions. You will be contacted by our Labor and Delivery staff regarding your delivery plans.

Continue your normal routine while waiting to be admitted to the hospital, to include eating and drinking as usual.

I have read and understand the above information and have had the opportunity to ask questions.

<table>
<thead>
<tr>
<th>PATIENT SIGNATURE</th>
<th>PATIENT NAME</th>
<th>DATE</th>
</tr>
</thead>
</table>

MARIN GENERAL HOSPITAL
DEPARTMENT OF NURSING
WOMEN’S, INFANTS’ AND CHILDREN’S CARE SERVICES

POLICY FOR THE PAIN MANAGEMENT OF THE OB PATIENT DURING THE INTRAPARTUM PERIOD

I. POLICY
It is the policy of Marin General Hospital (MGH) to assure that an obstetric patient be given accurate and current information regarding nonpharmacologic and pharmacologic interventions that are available to them when they are in labor.

II. PURPOSE
The purpose of this policy is to ensure that patients are supported in their pain management decisions by the Obstetric (OB) Registered Nurses (RN) caring for them in labor. Health care providers including nurses are crucial resources for childbearing families. In order to assist women in the decision for relief of labor discomforts, Obstetric Registered Nurses must be knowledgeable regarding the risks and benefits of all medications used in labor and also be able to support them in non pharmacological methods.

III. GENERAL INFORMATION
Labor pain differs from acute or chronic pain in that it is an expectation of the process. Increasing intensity and frequency often heralds progress and is interpreted as a positive sign, rather than a sign that something is wrong. Labor pain has many psychological associations that cause women to actually choose to experience pain rather than control it. The preparation for the labor process as well as the emotional support received during labor aid in decreasing maternal anxiety thereby decreasing or altering her perception of pain.

The laboring patient's description of the pain intensity of her contractions is whatever she says it is, regardless of the intensity of uterine contractions (UC's) as palpated by the nurse.

Pain relief needs to be addressed with use of non-pharmacological interventions any time during labor that pharmacological interventions are contraindicated. Nonpharmaceutical interventions are an effective alternative to pharmacological interventions and can be used anytime per patient preference.
## ASSESSMENT

1. Assess each patient upon arrival to the unit for the following:
   a. Onset, frequency, and duration of UCs.
   b. A Labor Pain and Coping Assessment shall be performed initially on admission using the Labor Pain and Coping Scale (LPCS):
      1. Unaware, talking, sleeping
      2. Aware of Contractions, discomfort using breathing and relaxation techniques, comfort relaxation techniques, comfort measures and minimal coaching
      3. Requires coaching, pain medication and pain management interventions
      4. Intense coaching, inadequate pain relief
   c. Description of pain (to rule out pain from other causes than labor, i.e. abruption, uterine rupture, etc.).
   d. Interventions for pain management used by patient at home.
   e. Effectiveness of interventions will be assessed 30 minutes after intervention is given.
   f. If patient has had any childbirth preparation classes.
   g. Patient's plan for pain management during labor.

2. Pain assessment in Labor is ongoing because it is not expected to diminish or go away. Following the LPCS assessment on admission, a pain/coping assessment shall be performed with complete set of vital signs (every 2-4 hours) before and after medication/intervention is requested and received or as patient conditions warrants. Frequency of assessment may be modified by agreement between the patient and the nurse.
### PLANNED STEPS

1. Assess patient's level of pain and need for intervention.
2. Use any of the following support measures as non-pharmacological methods of pain management.
   a. Dim lights in room
   b. Quiet atmosphere
   c. Support people in room as desired by patient
   d. Instruction/coaching in slow, relaxed breathing or effective breathing pattern of patient's choice.
   e. Instructions/support of relaxation techniques such as
      1. Massage
      2. Visualization
      3. Meditation
      4. Music
      5. Distraction Strategies
      6. Cutaneous stimulations (transcutaneous electrical nerve stimulation [TENS], acupuncture, acupuncture)
      7. Hypnosis/self-hypnosis
   f. Hydrotherapy-shower or tub, it not contraindicated (Refer to Hydrotherapy Policy #3050.41).
   g. K-pad for heat per MD order or cold pack.
   h. Counter pressure
   i. Sterile water injections as counter irritant for back labor. (Refer to Intradermal Sacral Sterile Water Injections Policy & Procedure #3050.22).
3. Notify MD/Certified Nurse Midwife (CNM) if non-pharmacological methods ineffective or patient requesting additional pain relief.
4. Provide pharmacological interventions per MD/CNM orders with explanation to patient/support person.

### PATIENT EDUCATION

1. Give appropriate age specific explanation of LPCS assessment.
2. Explain process of labor as needed to decrease patient's anxiety, taking into consideration the following:
   a. Patient's questions
   b. Patient's previous knowledge of labor process
   c. Patient's age
   d. Multiparity
   e. Stage and progress of labor
3. If patient has had no childbirth preparation,
   a. Instruct patient and support person in simple breathing and relaxation techniques.
   b. Provide coaching/support until patient is able to use techniques effectively.
4. If patient has had previous childbirth preparation,
   a. Provide support/encouragement for effective breathing and relaxation techniques by patient.
   b. Provide coaching/support until patient is able to use techniques effectively.
### PATIENT EDUCATION (Continued)

5. Assess pain intensity of UC’s as described by patient (using LPCS coping scale) with vital signs every 2-4 hours or more often if progress of labor changes and/or the patient's condition changes. After epidural anesthesia, assess pain level every 1 hour.

6. Assess effectiveness of each intervention. (Non-pharmacological or pharmacological) by reassessing the patient's pain intensity per pain scale.

### REASSESSMENT

Pain level is reassessed with vital signs and before and within 30 minutes after pain medication intervention is administered for effectiveness. Notify MD if:

1. Respiratory rate <10 or Blood Pressure (BP) < 90/50
2. Inadequate analgesia
3. Side effects (i.e. nausea, itching, hypotension)

### DOCUMENTATION

1. On Labor and Delivery (L&D) Flowsheet, OB Interdisciplinary Plan of Care (IPOC), document:
   a. Baseline UC’s/pain assessment/Patient's acceptable level of pain
   b. Patient's description of intensity of pain using Labor Pain Coping Scale, (LPCS) And mild, moderate or severe per patient’s perception in regards to “uterine contraction assessment”.
   c. Patient's plan for pain management during labor.
   d. Interventions for pain management used by patient at home.
   e. Effectiveness of interventions (per pain scale- assessed 30 minutes after intervention).
   f. If patient has had any childbirth preparation classes.
   g. Any additional cultural/psychosocial information effecting pain.
   h. Patient's pain /coping assessment using LPCS scale. Document in the pain assessment section underneath the Vital Signs at least every 4 hrs and 30 minutes after intervention.
   i. Interventions utilized.
   j. Effectiveness of interventions.
   k. Education given to patient and/or support person.
   l. Document any medication given on L&D flowsheet.

### IV. AGE SPECIFIC CONSIDERATIONS

N/A

### V. EQUIPMENT

Medication as prescribed by MD/CNM
Syringe/needle
Intravenous (IV) Solution
IV Tubing
Angio Catheter
References


References


References


References


References


References


References


