Statewide Initiative to Support Vaginal Birth & Reduce Primary Cesareans

Webinar Speakers: Elliott Main, MD
Anne Castles, MA MPH

October 2016
Statewide Initiative to Support Vaginal Birth & Reduce Primary Cesareans: 

*Today’s Objectives*

- Why Focus on Cesareans?
- Understanding Cesarean Measures
- CMQCC Maternal Data Center
- CMQCC Toolkit
- Statewide Collaborative
CMQCC’s Key Stakeholders/Partners

State Agencies
- CA Department of Public Health, MCAH
- Regional Perinatal Programs of California (RPPC)
- DHCS: Medi-Cal
- Office of Vital Records
- Office of Statewide Health Planning and Development (OSHPD)
- Covered California

Membership Associations
- Hospital Quality Institute (HQI)/California Hospital Association (CHA)
- Pacific Business Group on Health (PBGH)
- Integrated Healthcare Association (IHA)

Key Medical and Nursing Leaders
- UC, Kaisers, Sutter, Sharp, Dignity Health, Scripps, Providence, Public hospitals

Professional Groups (California sections of national organizations)
- American College of Obstetrics and Gynecology (ACOG)
- Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN)
- American College of Nurse Midwives (ACNM)
- American Academy of Family Physicians (AAFP)

Public and Consumer Groups
- California HealthCare Foundation (CHCF)
- March of Dimes (MOD)
- California Hospital Accountability and Reporting Taskforce (CHART) / CalHospitalCompare
CMQCC: Major Areas of Activity

Maternal Mortality and Morbidity Reduction

Maternal Data Center

Large-Scale Implementation Projects

Maternity Quality Measures
CMQCC: Leader for Maternity QI Projects

- Statewide multi-disciplinary Taskforces that develop QI toolkits and implementation guides
- Large-scale quality collaboratives in California
- Widespread adoption by other states and national

Elimination of Early Elective Delivery (2010)

Response to OB Hemorrhage (2010; 2nd Ed 2015)

Response to Preeclampsia (2013)
Cesarean Births Have Risen by Over 50% in the Last 15 years

US 2013 = 32.7%
CA 2013 = 33.1%

Even more dramatic is the degree of variation among hospitals and among providers.
Cesarean Delivery Rates Vary Tenfold Among US Hospitals; Reducing Variation May Address Quality And Cost Issues

**ABSTRACT** Cesarean delivery is the most commonly performed surgical procedure in the United States, and cesarean rates are increasing. Working with 2009 data from 593 US hospitals nationwide, we found that cesarean rates varied tenfold across hospitals, from 7.1 percent to 69.9 percent. Even for women with lower-risk pregnancies, in which more limited variation might be expected, cesarean rates varied fifteenfold, from 2.4 percent to 36.5 percent. Thus, vast differences in practice patterns are likely to be driving the costly overuse of cesarean delivery in many US hospitals. Because Medicaid pays for nearly half of US births, government efforts to decrease variation are warranted. We focus on four promising directions for reducing these variations, including better coordinating maternity care, collecting and measuring more data, tying Medicaid payment to quality improvement, and enhancing patient-centered decision making through public reporting.
Why should we care about CS rates?

- Relentless Rise without Baby or Mother benefit
  - 6% in early 70’s, 20% in mid 80’s, 33% in 2010
  - CP rates, neonatal seizures unchanged since 1980
  - Overall, no benefit for long-term urinary continence

- Increased maternal and neonatal morbidity
  - Impaired neonatal respiratory function, NICU admits
  - Affects maternal-infant interaction/Breast Feeding
  - Increased maternal PP infections, VTE, transfusions
  - Longer recovery, 2X PP re-admissions

- Prior CS can have major complications
  - Placenta previa and accreta (invasion deep into or thru the uterine wall) → hysterectomy or worse
  - Uterine rupture; abdominal adhesions
Which CS Rate?

- **Total Cesarean Rate**
  - Includes repeats: very different issues and significant variation of hospital rates of women with prior CS

- **Primary CS Rate and AHRQ TSV CS rate**
  - Better but major variation of hospital rates of nulliparity—the most important driver of different CS rates
  - Term Singleton Vertex is better but still mixes nullips with multips (Note: nullips have 4-8X higher rates than multips)

- **NTSV Cesarean Rate**
  - Nulliparous, Term, Singleton, Vertex
  - Most commonly used
Maldistribution of Nulliparity Among 251 California Hospitals: 2014

Range: 23.2—60.1%
Median: 37.3%
Mean: 39.4%

Urban and teaching hospitals have significantly higher rates of nulliparity.
Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Section Rate: Performance Measure

- Risk Stratified (“standard population”)
  - No further risk-adjustment needed (more discussion later)

- Widely adopted nationally
  - DHHS: Healthy Person 2010 and 2020
  - NQF endorsed, Joint Commission Perinatal Core Measure (PC-02), LeapFrog, CMS e-measure

- >15 years experience

- National data and trends available
NTSV CS Rate Among CA Hospitals: 2015
(Nulliparous Term Singleton Vertex)
(Source: Linked OSHPD-Birth Certificate Data)

National Target = 23.9%

42% of CA hospitals meet national target

Range: 11%—77%
Median: 25.1%
Mean: 25.6%
Collaborative Action: Collective Impact

Multiple Leverage Points are much more effective than one or two alone.

- Data-driven QI Initiative
- Health Plans (multiple strategies)
- Medicaid: Fee For Service and Managed Care
- Purchaser/Employer Engagement
- Public Engagement
- Collected Evidence/QI Tool Kit
- Professional Leadership
- Performance Measures/Public Reporting
- Direct Participation of Pregnant Women

Reduction of Early Elective Deliveries
Collaborative Action: Collective Impact

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- Public Engagement

Reduction of Primary Cesareans
Collaborative Actions: Collective Impact

- **ACOG/AWHONN/ACNM Speaker’s Bureau**
  - Support for grand rounds and “light” QI support
  - All day training on 5/4/2016

- Slide set for Speaker’s Bureau, Collaborative

- **Regional Labor Support Workshops** for labor nurses
  - Lead by CNMs, Doulas and Nurse educators

- **Webinars**
  - Monthly talks by national leaders on key topics on supporting vaginal birth/preventing primary cesareans
  - Archived for later viewing
Collaborative Actions: Collective Impact

- Public Reporting of NTSV CS rates
  - CHART / CalHospitalCompare.org
  - Dept of Insurance/UCSF/Consumers Union
  - Media coverage (LA, SD and Sacramento)
  - Oct 26th: HHS Secretary Dooley Press Conference with CHA and PBGH: “Smart Care” (Overuse Group)

- Public Engagement
  - Consumers Union
  - Social Media strategies
  - Consumer Reports: Education handouts at prenatal care sites—e.g. clinics/WIC
**Hospital Quality Institute notified all hospital CEOs of new release**

<table>
<thead>
<tr>
<th>Mother &amp; Baby</th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C-Section Rate (NTSV)</strong></td>
<td><strong>POOR</strong> 46.50% (lower is better)</td>
<td><strong>BELOW AVERAGE</strong> 32.30% (lower is better)</td>
<td><strong>SUPERIOR</strong> 15.30% (lower is better)</td>
</tr>
<tr>
<td><strong>Breastfeeding Rate</strong></td>
<td><strong>POOR</strong> 32%</td>
<td><strong>POOR</strong> 11.40%</td>
<td><strong>SUPERIOR</strong> 84.70%</td>
</tr>
<tr>
<td><strong>Episiotomy Rate</strong></td>
<td><strong>AVERAGE</strong> 25.40% (lower is better)</td>
<td><strong>POOR</strong> 59.30% (lower is better)</td>
<td><strong>SUPERIOR</strong> 1.60% (lower is better)</td>
</tr>
</tbody>
</table>
Collaborative Actions: Collective Impact

- Does Anyone Care?

- Purchasers/Health Plans
  - Covered California: in their 2017 contracts with Health Plans—For hospitals be included in their Network, they need to have an NTSV rate ≤23.9% by 2019
  - Allowed Exception: if actively working on the topic and showing improvement
  - This has engaged many managed care groups in the State who are now reaching out to hospitals
  - Other large Health Plans are working on their strategies for alignment on this topic
My hospital’s rate is higher than the 23.9% target!

What to do?
Hospital Action Steps: How Can We Help?

- Understand what drives your cesarean birth rate—using rapid-cycle data with standard measures and QI tools
  1. CMQCC Maternal Data Center

- Improve support for labor and vaginal birth—
  2. CMQCC Toolkit on Supporting Vaginal Births and Reducing Cesareans
  3. CMQCC QI Collaborative on Supporting Vaginal Births and Reducing Cesareans
Action Step #1

Join the CMQCC Maternal Data Center!

Anne Castles, MA MPH
Amanda Woods, MA
Using the Maternal Data Center to Drive Improvement

- Monitor hospital performance over time
- Make peer and benchmark comparisons
- Assess provider variation
- Identify QI opportunities
- Risk-Adjustment
Over 200 Hospitals have joined the MDC

Launched 2014
34 Hospitals

Launched 2015
16 Hospitals

Launched 2012
180+ Hospitals
82% of CA Deliveries
CMQCC Maternal Data Center

Low-Burden, High-value

- PDD—Discharge Diagnosis File (ICD9/10 Codes)
  - Monthly uploads: mother and infant PDD (participating hospitals)

- Birth Certificate (Clinical Data)
  - Monthly uploads: electronic files for all CA births

- Chart Review (optional selected metrics/QI projects)
  - Limited manual data entry for these measures

- Automated Linkage of all 3 files

- Interactive Analytics Guide QI Practice

Links over 1,000,000 mother/baby records each year!
Confidential Tool for Each Hospital

Demo Hospital

Measures

Period: Q1 2016

Hospital Clinical Performance Measures

- Early Elective Delivery (PC-01) (HEN) 10.7%
- Cesarean Birth: Low Risk-NTSV (PC-02) 20.3%
- Vaginal Birth After Cesarean (VBAC) Rate, Uncomplicated (AHRQ IQI 22) 6.5%
- Cesarean Birth: Overall 33.5%
- Cesarean Birth: Primary 19.7%
- Failed Induction 16.3%

View all 33 by name, organization, or topic

See your Leapfrog Results in Leapfrog Survey Format

CS Collaborative Measures

- Cesarean Birth: Low Risk-NTSV (PC-02) 20.3%
  - Structure Measures / To-Do List 44.4%
- NTSV Spontaneous Labor Arrest / CPD: Consistency with Guidelines 80.0%
- NTSV Induced Labor Management: Consistency with Guidelines 66.7%

View all 12 CS Collaborative Measures

Hospital Data Quality Measures

- Missing / Inconsistent Delivery Method 1.3%
- Missing / Inconsistent V27/Z37 (Outcome of Delivery) 0.4%
- Data Submission Trends
  - Correction Reports

View all 16 Hospital Data Quality Measures

Hospital Statistics

- Mar 2016 Live Births: 171
- YTD Live Births: 543
- Demographic Statistics
- Delivery Statistics
- Comorbidity and Complications Statistics
- Baby/Prematurity Statistics
- Utilization Statistics
- CCS Report

Provider Performance Measures

- by Individual
  - Cesarean Births
  - Elective Deliveries
  - Vaginal Births
  - Attribution
  - Recommendations
- by Practice Group
  - Cesarean Births
  - Elective Deliveries
  - Vaginal Births
  - Group Management (35)

View Delivery Logbook

First you must authenticate using 2-factor authentication
### Hospital Clinical Performance Measures: By Name

<table>
<thead>
<tr>
<th>Measure</th>
<th>Q1 2014 Rate</th>
<th>Mar 2014 Rate</th>
<th>Jul 2012 - Jun 2013 Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>3rd &amp; 4th Degree Lacerations in Instrument-Assisted Vaginal Deliveries</td>
<td>2.4%</td>
<td>0.0%</td>
<td>13.4%</td>
</tr>
<tr>
<td>3rd &amp; 4th Degree Lacerations in NON-Instrument-Assisted Vaginal</td>
<td>0.3%</td>
<td>1.0%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Deliveries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd &amp; 4th Degree Lacerations in Vaginal Deliveries</td>
<td>0.6%</td>
<td>0.9%</td>
<td>3.4%</td>
</tr>
<tr>
<td>5 Minute APGAR &lt;7 Among All Deliveries &gt;39 weeks (HEN)</td>
<td>0.5%</td>
<td>0.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>5 Minute APGAR &lt;7 in Early Term Newborns (HEN)</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Antenatal Steroids (PC-03)</td>
<td>80.0%</td>
<td>0.0%</td>
<td>N/A</td>
</tr>
<tr>
<td>Appropriate DVT Prophylaxis in Women Undergoing CS</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Birth Trauma - Injury to Neonate (AHRO PSI 17)</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Cesarean Section Rate-Nullip, Term, Singleton, Vertex (PC-02)</td>
<td>34.5%*</td>
<td>30.6%*</td>
<td>28.5%</td>
</tr>
<tr>
<td>Cesarean Section Rate-Nullip, Term, Singleton, Vertex: Age Adjusted</td>
<td>26.7%*</td>
<td>26.9%*</td>
<td>25.9%</td>
</tr>
<tr>
<td>(PC-02)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cesarean Section Rate-Term, Singleton, Vertex (AHRO IQI 21)</td>
<td>33.3%</td>
<td>32.5%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Elective Delivery &lt;39 Weeks (PC-01)</td>
<td>4.4%</td>
<td>5.6%</td>
<td>N/A</td>
</tr>
<tr>
<td>Episiotomy Rate</td>
<td>9.3%*</td>
<td>3.5%*</td>
<td>9.4%</td>
</tr>
<tr>
<td>Exclusive Breastfeeding (PC-05)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Exclusive Breastfeeding with Mother’s Choice (PC-05a)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Failed Induction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Induction Rate</td>
<td>17.7%</td>
<td>21.0%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Newborn Bilirubin Screening Prior to Discharge</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>OB Hemorrhage Risk Assessment on Admission</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Operative Vaginal Delivery</td>
<td>7.6%</td>
<td>5.5%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Preeclampsia ICU Admissions</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Preeclampsia Total ICU Days</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Focus on:** NTSV C-Section
Hospital Performance Over Time

For each hospital quality measure:

- View reports on monthly/quarterly/annual basis
- Easy downloads of the graphics or numerical data
Drill Down Information

- Drill down to case-level information within own hospital account
- Hover boxes show definitions for ICD-10 codes

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C-Section Rate: Low Risk-NTSV (PC-02)

Discharge Dates: 01/01/2015-03/31/2015

**Fallout Cases (57)**

<table>
<thead>
<tr>
<th>Account Number</th>
<th>Delivery Date</th>
<th>Diagnoses</th>
<th>Birth Weight</th>
<th>Gestational Age</th>
<th>Induced</th>
<th>Provider ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1764eb84d7</td>
<td>12/30/2014</td>
<td>661.11, 285.9, 660.71, 648.21, V27.0</td>
<td>3367</td>
<td>40</td>
<td>No</td>
<td>A10040</td>
</tr>
<tr>
<td>4860e5d3e9</td>
<td>01/03/2015</td>
<td>664.10, V27.0</td>
<td>3596</td>
<td>38</td>
<td>No</td>
<td>A10019</td>
</tr>
<tr>
<td>58bb4d6b5e</td>
<td>01/08/2015</td>
<td>665.51, 663.31, V27.0</td>
<td>4109</td>
<td>40+4</td>
<td>No</td>
<td>A10019</td>
</tr>
</tbody>
</table>

Secondary uterine inertia, delivered, with or without mention of antepartum condition.
System-Wide Comparisons

- If part of a multi-hospital system, can view all hospital rates within the system

Cesarean Section Rate-Nullip, Term, Singleton, Vertex (PC-02)

<table>
<thead>
<tr>
<th>Hospital Trend</th>
<th>Benchmark Comparisons</th>
<th>System Comparisons</th>
<th>Payer Comparisons</th>
<th>Provider Comparisons</th>
</tr>
</thead>
</table>

**Apr 2013 - Mar 2014**

Cesareans among live births that are: 1) singleton; 2) vertex; 3) lacking "early onset delivery" ICD-9 code; 4) >=37 weeks GA; 5) to nulliparous women.

- **Springfield General**: 34.5%
- **Maybury Medical Ctr**: 26.4%
- **Twin Peaks Hospital**: 22.1%
- **Hollywood Health Systemwide**: 28.9%
- **California Statewide (Jul 2012 – Jun 2013)**: 28.5%

**Low-Risk First-Birth (NTSV) C/S Rate**
Identify your hospital’s relative performance

- Able to toggle comparison groups (e.g. your state, your NICU level, your region)
- Able to show your hospital alone or all the hospitals in your system
Example View: Provider-level Measure

Cesarean Birth: Low Risk-NTSV (PC-02)

Provider Comparison

Provider Summary for Demo Hospital

By Provider

Description
Cesareans among live births that are: 1) singleton; 2) vertex; 3) lacking "early onset delivery" ICD-9 code; 4) ≥37 weeks GA; 5) to nulliparous women.
Measure Analysis: Identify “Drivers” of the CS Rate

What Drives Our Nulliparous Term Singleton Vertex (NTSV) CS Rate?

- **Demo Hospital**: 20.8% Spontaneous Labor, 7.3% Induced Labor, 6% No Labor, Total 34.1%
- **All Community Nurseries**: 14.1% Spontaneous Labor, 7.3% Induced Labor, 4.9% No Labor, Total 26.3%
- **CA Statewide**: 14.2% Spontaneous Labor, 7.3% Induced Labor, 4.6% No Labor, Total 26.1%

NTSV CS Rate Divided into 3 Major Components:

Screen Shot from the CMQCC Maternal Data Center
Assess Impact of QI Interventions using Control Charts

C-Section Rate: Low Risk-NTSV (PC-02)

Measure
- Hospital Trend
- Control Chart
- Definition
- Measure Analysis

Comparisons
- Peer
- NICU Level
- By Payer
- By Provider
- By Practice Group

Screen Shot from the CMQCC Maternal Data Center
Joining the MDC....as simple as ABC

A. Complete Participation Agreement

B. Submit Patient Discharge Data

\[ Data \text{ your hospital already generates for OSHPD! } \]

C. Participate in training session with CMQCC

Use tool to advance your quality agenda!
Action Step #2

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Editors:
Holly Smith, CNM, MSN, MPH
Nancy Peterson, MSN, RNC-OB
David Lagrew, MD
Elliott Main, MD
The CMQCC Toolkit

- Comprehensive, evidence-based “How-to Guide” to reduce primary cesarean delivery in the NTSV population
- Will be the resource foundation for the CA QI collaborative project
- The principles are generalizable to all women giving birth
- Released on the CMQCC website April 28, 2016
- Has a companion Implementation Guide
The over 50 experts who wrote and advised for the toolkit represent organizations such as:

- American Congress of Obstetricians and Gynecologists (including current District IX Chair)
- American College of Nurse-Midwives
- Association of Women’s Health, Obstetric, and Neonatal Nurses (including current California Chair)
- California Hospital Association/Hospital Quality Institute (including current President/CEO of HQI)
- Childbirth Connection/National Partnership for Women and Families
- Blue Shield of California
- BETA Healthcare Group
- Kaiser Permanente, Sutter Health, MemorialCare Health System, various university health systems, various birth centers, urban and rural hospitals alike
- Doulas of North America, Lamaze International, Coalition for Improving Maternity Services
Key National Foundation Materials

New National Guidelines for Defining Labor Abnormalities and Management Options
May 24, 2016

John Wachtel, MD
Chair: District IX
American Congress of Obstetricians and Gynecologists

Dear Dr. Wachtel:

In representing the American College of Obstetricians and Gynecologists (ACOG), we would like to congratulate you and all the contributors involved in the development of the CMQCC “Toolkit to Support Vaginal Birth and Reduce Primary Cesareans”. We have had the honor to review this comprehensive toolkit and ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate. The toolkit includes a number of resources that could be implemented, and the plan to disseminate the information via speaker training sessions and site visits to encourage implementation are laudable.

Clearly, the rising Cesarean delivery rate, and particularly the primary Cesarean rate, is concerning to all involved in the provision of women’s healthcare, and although here have been a number of efforts nationwide to address this problem, they have been met with mixed success. This excellent resource, and the plan for encouraging awareness and implementation is unquestionably a commendable program to address this issue and should set a benchmark for achieving success in reducing the primary Cesarean delivery rate. We look forward to the program’s implementation, and to hear of the future successes.

Again, we express our sincere gratitude and strong support for everyone who had a part in developing this toolkit. Congratulations, and best wishes moving forward!

Sincerely,

Hal. C. Lawrence III, MD  
Executive Vice President and CEO

Christopher M. Zahn, MD  
Vice President, Practice Activities
We have had the honor to review this comprehensive toolkit and ACOG strongly supports its dissemination and use to address the efforts at reducing the primary Cesarean delivery rate.

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Lamaze International 2016 Annual Conference
October 20-23, 2016 • Hilton West Palm Beach • West Palm Beach, Florida
The Toolkit Mirrors the National Safety Bundle

READINESS
- Improving the Culture of Care, Awareness and Education
  - Education
  - Shared Decisions
  - Support
  - Payment

RECOGNITION
- Supporting Intended Vaginal Birth
  - Early labor supportive care
  - Doulas
  - Care during regional analgesia
  - Intermittent auscultation (fetal monitoring)
  - Modifiable conditions

RESPONSE
- Management of Labor Abnormalities
  - Standard response to abnormal FHR and labor challenges
  - Operative vaginal delivery
  - Safe, efficient out of hospital transfer process

REPORTING/SYSTEMS
- Using Data to Drive Improvement
  - Create awareness
  - Share data
  - Improve data quality
  - Reduce data burden

Each Section: Discussion of Barriers and Strategies, with multiple examples (case studies), diagrams and references
Active Labor Partogram

ACTIVE LABOR PARTOGRAM
Term ≥ 37 Weeks Gestation

NORMAL LABOR PROGRESS
CONSIDER INTERVENTIONS
≥ 95TH PERCENTILE MAKE DELIVERY PLAN

Peanut Ball

- Decrease length of labor
- Decreasing CS rate in patients with epidurals

What does Shared Decision Making Really Mean? ...and how to implement it in OB...

The SHARE Model

S - Seek the patient’s participation
H - Help her explore each option and the corresponding risks and benefits
A - Assess what matters most to her
R - Reach a decision together and arrange for a follow up conversation
E - Evaluate her decision (revisit the decision and assess whether it has been implemented as planned)
**READINESS:** Build a provider and maternity unit culture that values, promotes, and supports intended vaginal birth and optimally engages patients and families

Create a team of providers (e.g. obstetricians, midwives, family practitioners, and anesthesia providers), staff and administrators to lead the effort and cultivate maternity unit buy-in

Develop program for ongoing staff training for labor support techniques including caring for women regional anesthesia

Develop a program positive messaging to women and their families about intended vaginal birth strategies for use throughout pregnancy and birth
RECOGNITION AND PREVENTION: Develop unit-standard approaches for admission, labor support, pain management and freedom of movement

Implement protocols and support tools for women who present in latent (early) labor to safely encourage early labor at home

Implement Policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women
RESPONSE: Develop unit-standard approaches for prompt identification and treatment of abnormal labor and fetal heart patterns

- Implement standard criteria for diagnosis and treatment of labor dystocia, arrest disorders and failed induction
- Implement training/procedures for identification and appropriate interventions for malpositions (e.g. OP/OT)
REPORTING AND SYSTEMS LEARNING: Utilize local data and case reviews to present feedback and benchmarking for providers and to guide unit progress

Share provider level measures with department (may start with blinded data but quickly move to open release)

Perform monthly case reviews to identify consistency with dystocia and induction ACOG/SMFM checklists

Establish a project communications plan (at least monthly education and progress updates)
For a Deeper Dive on the Toolkit!

Webinar:
November 1, 2016: 12-1:30

Presented by:
David Lagrew, MD
Toolkit Co-Author and Editor

Register at www.CMQCC.org
Join the
Supporting Vaginal Birth /Reducing Primary Cesarean Collaborative
CMQCC QI Collaboratives

- Two rounds of participation
  - First round (30) kicked off May 20, Los Angeles
  - Second round kicks off January 2017
- Use the [Mentor Model](#) for collaborative work
- 65 hospitals, *minimum*
  - Already at enrollment target
  - Special attention for higher rate/higher volume facilities
What are the advantages of the Collaborative?

- Use of all of the features of the CMQCC Maternal Data Center
- **Mentor support** from experts for implementation of bundle elements in smaller groups
- Access to national and local experts through grand rounds, in-person and virtual education and **mentor/team monthly calls**
Supporting Vaginal Birth Collaborative Mentor Model

Hospital A

Hospital B

Hospital C

Mentor Physician

Mentor Nurse

YOUR Hospital QI Team

Hospital E

Hospital F
Structure of the Mentor Model

- Monthly web based meetings
- Facilitated by mentors
- Team report outs
- CMQCC Support
What is the Cost to Participate?

- **NO COST** to join collaborative

Hospitals will provide the internal resources necessary for success during the Collaborative by identifying:

- Clinician and Nursing champions
- Time for the Perinatal Quality Improvement team to work on implementation, education and data analysis
Gather Your Perinatal Quality Improvement Team

- Primary Physician champion
- Nursing – CNS, Manager, Bedside RN
- Administration Quality Team Risk Mgr

Improved Maternity Care
Still..... Why Do I Need A Collaborative?

- Peer to peer learning, networking and sharing of best practices are THE BEST WAY to improve further, faster.
- Gives hospitals the ability to translate the knowledge “that” into the knowledge “how”.
- Ability to rapidly spread innovations that work.
- Identify practical advice from peers sharing the same challenges how to implement best practices.
- Ability to integrate reliability and sustainability into improvement work.
Pilot Project: Testing the Approach

- 3 SoCal Hospitals,
  - All with NTSV Rates ~30%
- Maternal Data Center
  - Real time data, un-blinded provider rates, analysis to understand drivers
- Prototype of the toolkit
  - Nursing and physician education and practice changes
- Shared ideas/best practices (mini-collaborative)
- Payer and employer interest
  - One payer negotiated a blended payment
Data-Driven QI: NTSV CS

Pilot Hospital: PBGH / RWJ CS Collaborative

NTSV CS Rate

QI Project Started: Jan 16

National Target for NTSV CS = 23.9%
Data-Driven QI: NTSV CS

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- QI Project Started: Jan 16

NTSV CS Rate:
- 2011: 32.9%
- 2012: 33.6%
- 2013: 31.2%
- Jan-14: 31.8%
- Feb-14: 28.3%
- Mar-14: 24.3%
- Apr-14: 25.0%
- May-14: 25.0%
Data-Driven QI: NTSV CS

Pilot Hospital: PBGH / RWJ CS Collaborative

NTSV CS Rate

QI Project Started: Jan 16

National Target for NTSV CS = 23.9%
NTSV CS Pilot Project
Impressive Results: within 6 months

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Baseline</th>
<th>After QI</th>
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</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td>32.6%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Hospital 2</td>
<td>31.2%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Hospital 3</td>
<td>27.2%</td>
<td>21.9%</td>
</tr>
</tbody>
</table>

24.2% Reduction
22.1% Reduction
19.5% Reduction
Any Downsides? –Balancing Measures

- More vaginal births--Any increase in 3\textsuperscript{rd} or 4\textsuperscript{th} degree lacerations?
  - Zero change from the prior 4 year baseline
- Most important outcome is a healthy baby
  - NQF measure “Unexpected Newborn Complications”
  - Asks whether term babies without preexisting conditions had any major complications during birth or neonatal period
  - No change in the 3 hospitals’ rates
Key Components for Quality Improvement

- Data Monitoring and Evaluation
- Evidence-Based Support Tools
- Engagement of Hospital Clinicians and Administrators

Improved Maternity Care

Your Hospital!
Additional Support Programs

1. **Webinars**
   - Nov 7th—Intermittent Monitoring-Best Practices
   - Jan 24th—Incorporating Doulas in to your hospital practice

2. **Speakers’ Bureau**
   - ACOG/AWHONN Partnership
   - ~20 MD/RN teams trained with slide set
   - Starting now!

3. **Labor Support Workshops**
   - Goal: train trainers to return to their hospitals to train others for labor support techniques
   - In partnership with ACNM, AWHONN and Doulas
   - 6 all-day sessions scheduled all around the state—75 attendees each, nearly oversold (Sept-Dec 2016) More in the new year
4. Examples of Related State Activities
- Covered California Contract Requirements for 2019 includes NTSV CS rate ≤23.9%
- DHCS PRIME hospital project (County, District and University hospitals)

5. New Partners / Recruitment
- Working on alignment with purchasers and payers, Medi-Cal Managed Care plans
- So Cal hospitals with high volume and high rates that are not yet engaged, identified and targeted recruitment underway

6. California Transparency Efforts
- 2015 Hospital-level NTSV rates released by CHART in late October (Preceded by sharing with hospitals)
- Public acknowledgement by Secretary Dooley October 26th of hospitals with rates ≤23.9%
Contacts and Resources

Maternal Data Center
- Anne Castles (acastles@cmqcc.org)
- Amanda Woods (amwoods@cmqcc.org)

Collaborative
- Valerie Cape (vcape@cmqcc.org)

Toolkit
- Nancy Peterson (peterson@cmqcc.org)

Resources @ www.CMQCC.org
- Collaborative FAQs
- MDC Project Description
- Toolkit