CMQCC
California Maternal
Quality Care Collaborative

Moving the Dial--Improving California Maternity Outcomes Together: Examining Maternal Morbidity

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What are We Talking About Today?

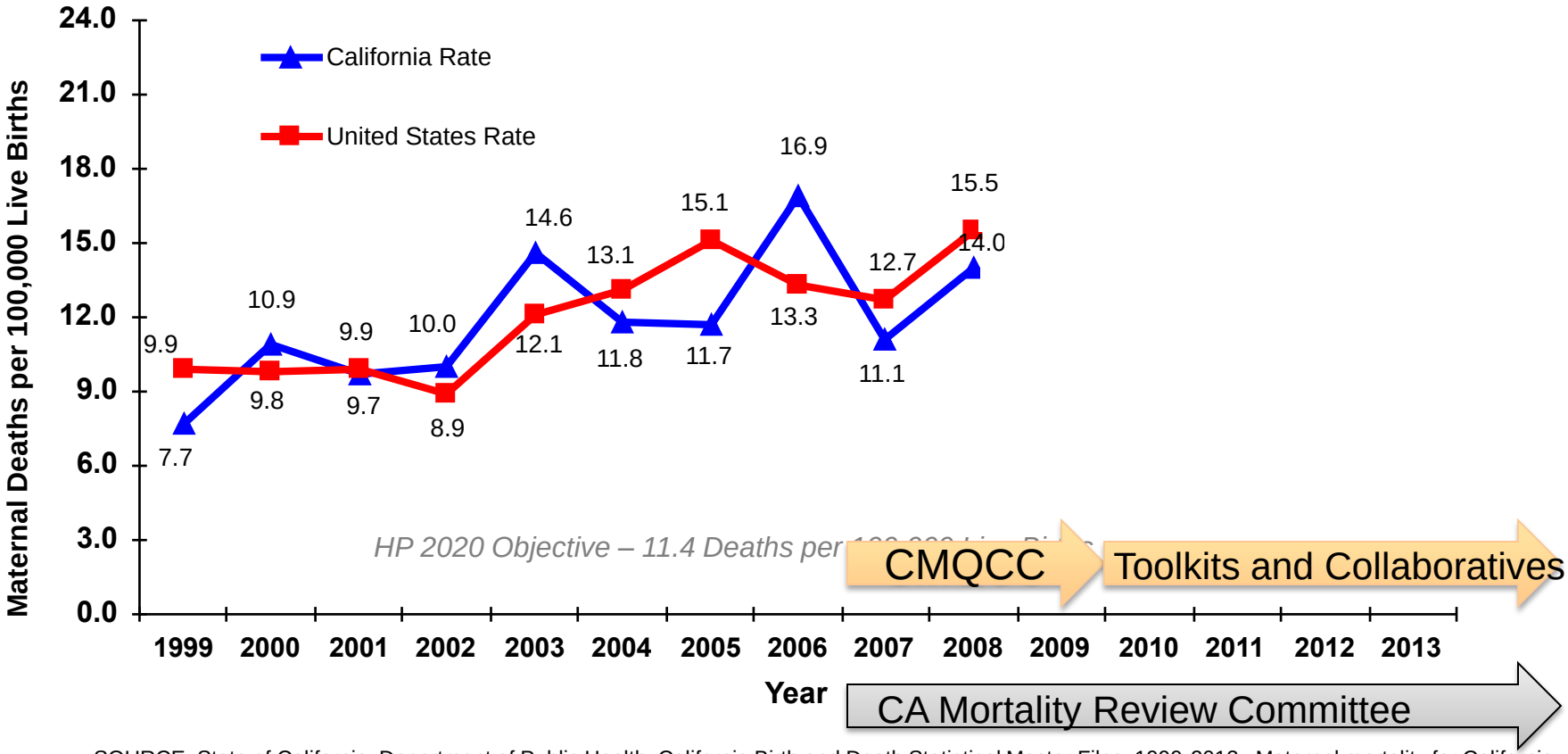
- *Origin Story*
- The rise of maternal mortality in the state of California
- Maternal Data Center
- Severe Maternal Morbidity (SMM)
- Toolkits
- Lessons Learned
- CMQCC Resources

CMQCC Story

- Our mission is to end preventable morbidity, mortality and racial disparities in California maternity care
- Initial Funding from the Dept. of Public Health
  - Rise in maternal mortality—needed study and action
  - Further funding has come from CDC, CDPH, CHCF, RWJ, others
- Multi-organization, multi-disciplinary

Maternal Mortality Rate, California and United States; 1999-2013

California: ~500,000 annual births, 1/8 of all US births



SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2013. Maternal mortality for California (deaths ≤ 42 days postpartum) was calculated using ICD-10 cause of death classification (codes A34, O00-O95,O98-O99). United States data and HP2020 Objective use the same codes. U.S. maternal mortality data is published by the National Center for Health Statistics (NCHS) through 2007 only. U.S. maternal mortality rates from 2008 through 2013 were calculated using CDC Wonder Online Database, accessed at http://wonder.cdc.govon March 11, 2015. Produced by California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, March, 2015.

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

- California Hospital Association (CHA)
- Pacific Business Group on Health (PBGH)
- Integrated Healthcare Association (IHA)

Key Medical and Nursing Leaders

- UCs, Stanford, Kaiser (N&S), 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

- Consumers' Union
- March of Dimes (MOD)
- California HealthCare Foundation (CHCF)
- Cal Hospital Compare
- Amniotic Fluid Embolism Foundation

1 Turning Mortality Reviews Into Action

- Multidisciplinary Review Committee focused on what were the potential improvement opportunities seen in each case
- Foundation for QI Toolkits
- Hemorrhage and hypertension are the most preventable causes of mortality and the drivers for 75% of severe maternal complications
- Maternal mortality has proven to be a great motivator for introducing changes on L&D

Toolkits Inspired by Maternal Mortality Reviews

- Obstetric Hemorrhage
- Preeclampsia
- VTE Prevention
- Cardiovascular Disease
- *Coming Soon!*

  Infection / Sepsis

2 Low-Burden Rapid-Cycle Data

- Data collection burden is the undoing of many QI projects
- Most state data sources are 1-2 years old before they are provided back to hospitals
- Hospitals have little sense of how they compare to others
- Providers have NO sense of how they compare to others
- 213 member hospitals

Rapid-cycle data: metrics available within 45 days after every month

PDD—Discharge Diagnosis File
(ICD9/10 Codes)

Monthly uploads:
mother and infant PDD

Automated Linkage of all 3 files

Birth Certificate
(Clinical Data)

Monthly uploads:
electronic files for
ALL California births

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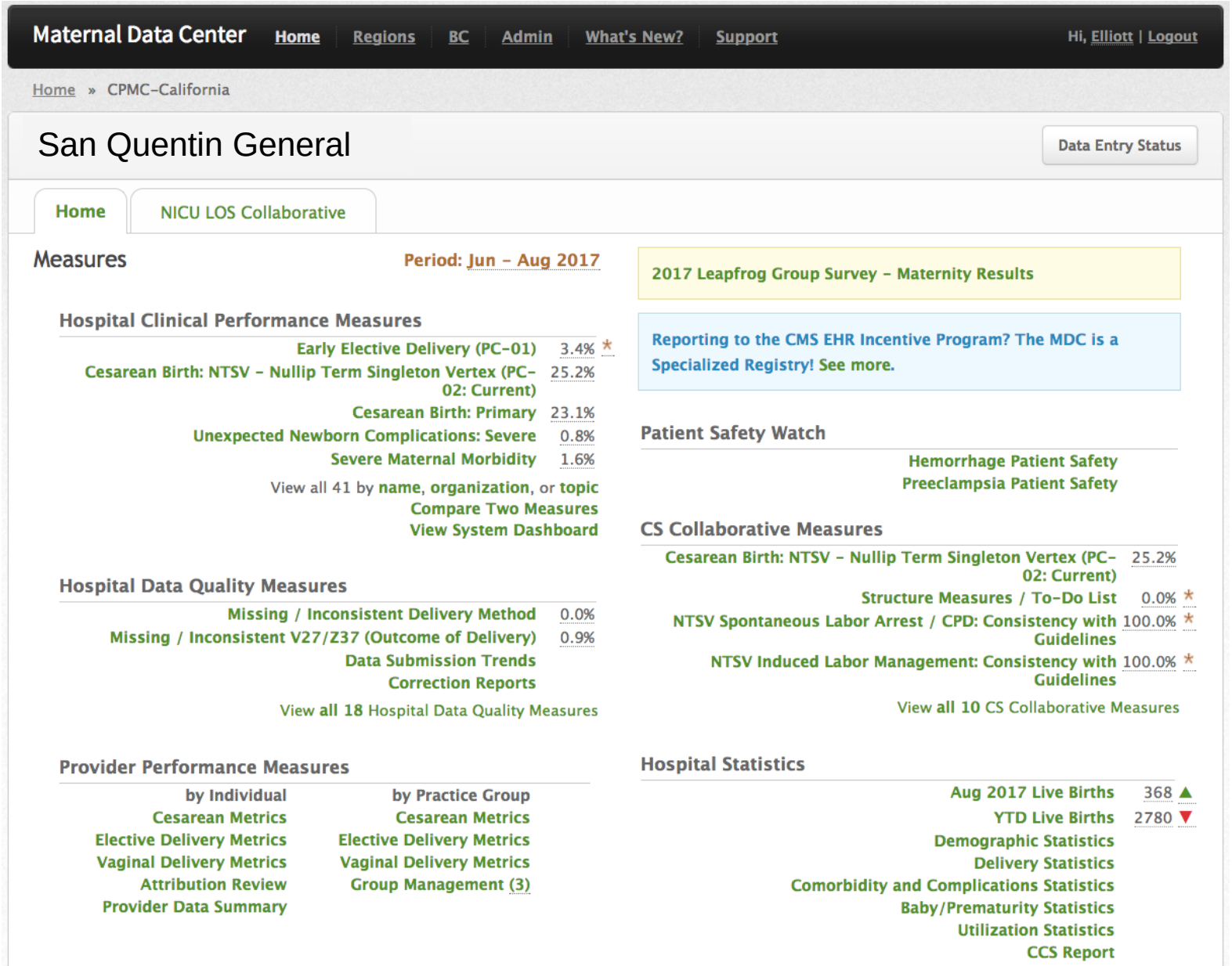
Maternal Data Center

Chart Review
(select metrics/QI projects)

Supplemental files or limited chart reviews

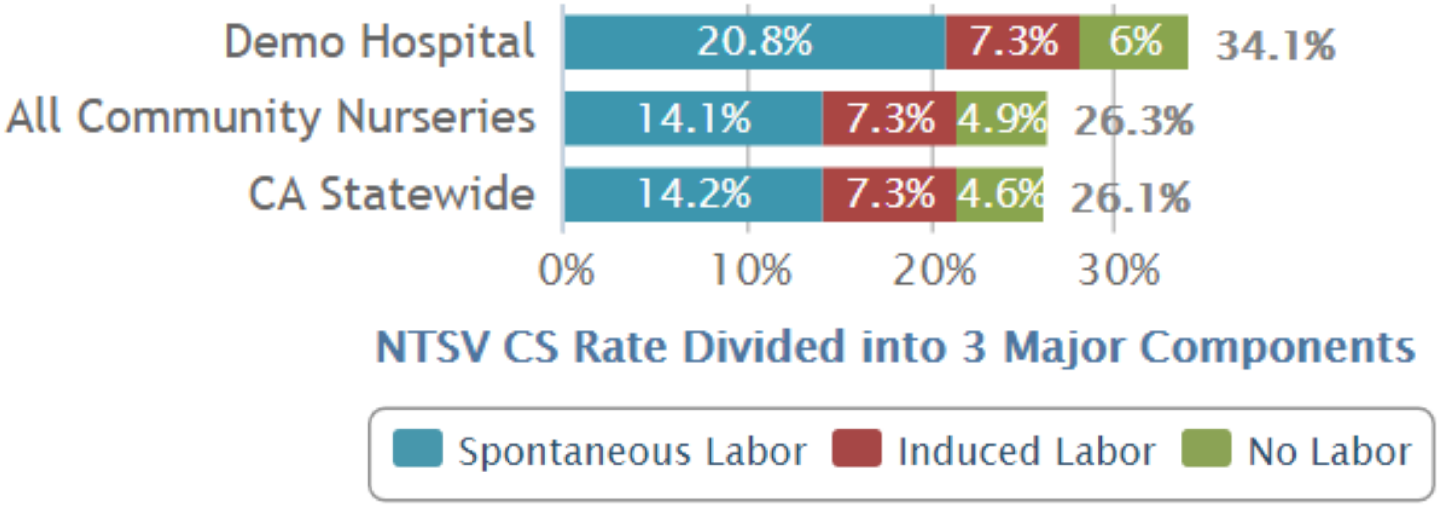
Interactive Analytics Guide QI Practice

Links over 1,000,000 mother/baby records each year


Maternal Data Center
Home
Regions
BC
Admin
What's New?
Support
Hi, Elliott | Logout
Home » CPMC–California
San Quentin General
Data Entry Status
Home
NICU LOS Collaborative
Measures
Period: Jun – Aug 2017
Hospital Clinical Performance Measures
Early Elective Delivery (PC–01) 3.4% *
Cesarean Birth: NTSV – Nullip Term Singleton Vertex (PC–02: Current) 25.2%
Cesarean Birth: Primary 23.1%
Unexpected Newborn Complications: Severe 0.8%
Severe Maternal Morbidity 1.6%
View all 41 by name, organization, or topic
Compare Two Measures
View System Dashboard
Hospital Data Quality Measures
Missing / Inconsistent Delivery Method 0.0%
Missing / Inconsistent V27/Z37 (Outcome of Delivery) 0.9%
Data Submission Trends
Correction Reports
View all 18 Hospital Data Quality Measures
Provider Performance Measures
by Individual
Cesarean Metrics
Elective Delivery Metrics
Vaginal Delivery Metrics
Attribution Review
Provider Data Summary
by Practice Group
Cesarean Metrics
Elective Delivery Metrics
Vaginal Delivery Metrics
Group Management (3)
2017 Leapfrog Group Survey – Maternity Results
Reporting to the CMS EHR Incentive Program? The MDC is a Specialized Registry! See more.
Patient Safety Watch
Hemorrhage Patient Safety
Preeclampsia Patient Safety
CS Collaborative Measures
Cesarean Birth: NTSV – Nullip Term Singleton Vertex (PC–02: Current) 25.2%
Structure Measures / To-Do List 0.0% *
NTSV Spontaneous Labor Arrest / CPD: Consistency with Guidelines 100.0% *
NTSV Induced Labor Management: Consistency with Guidelines 100.0% *
View all 10 CS Collaborative Measures
Hospital Statistics
Aug 2017 Live Births 368 ▲
YTD Live Births 2780 ▼
Demographic Statistics
Delivery Statistics
Comorbidity and Complications Statistics
Baby/Prematurity Statistics
Utilization Statistics
CCS Report

Measure Analysis: Identify "Drivers" of the CS Rate

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



Screen Shot from the CMQCC Maternal Data Center

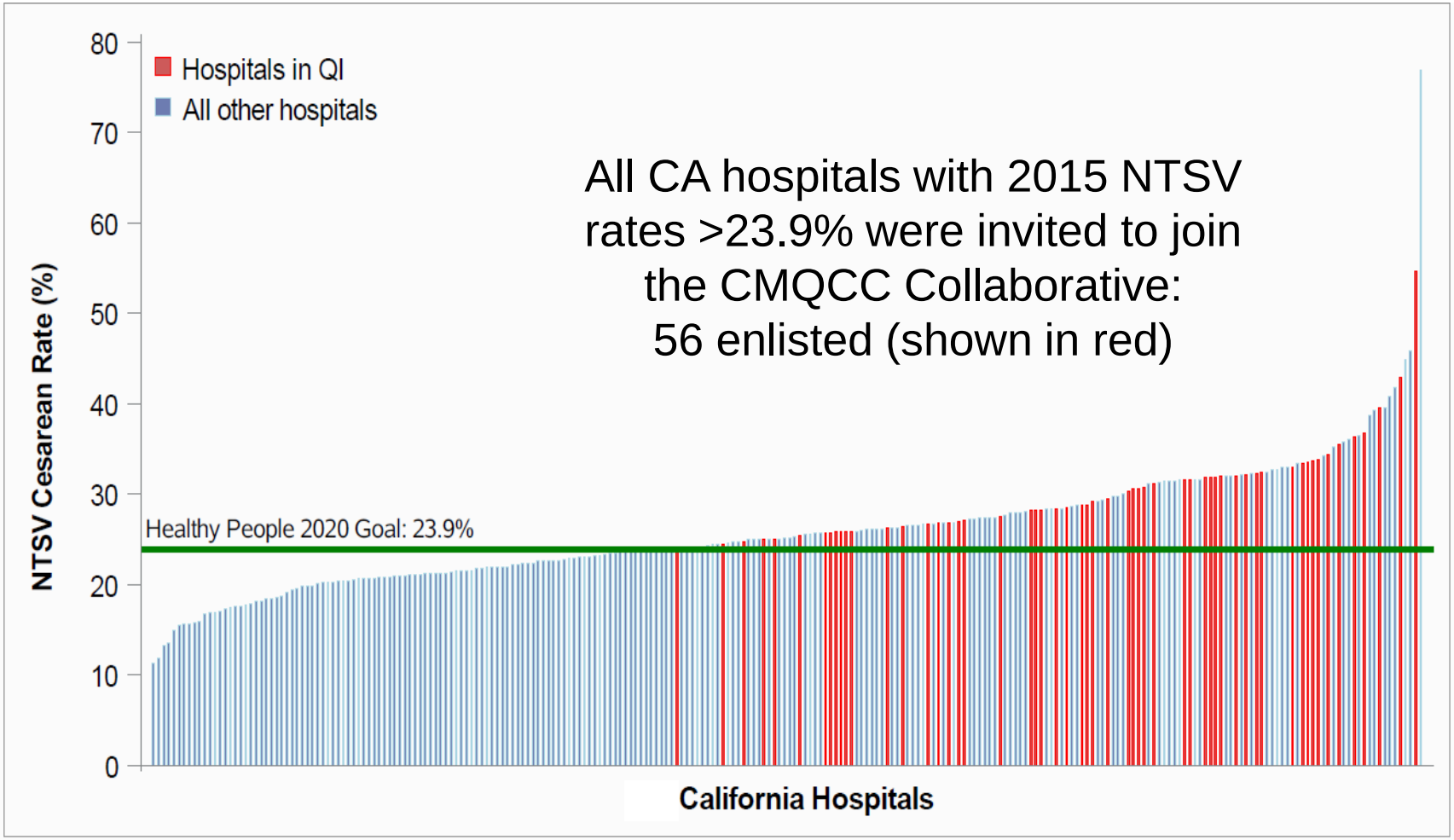
3 All Improvement is Multi-disciplinary

- Teams must involve admin, physicians and nursing at minimum
- Informal leaders often have the best results
- Critical to engage nursing for all projects
- Unit culture drives success

4 It is all about Variation in Practice

- Data show variation in care beyond anything explained by patient characteristics
  - Total Cesarean rate
  - NTSV Cesarean rate
  - Episiotomy rate
  - VBAC rate
  - 3rd/ 4th degree laceration rate
  - Induction rate
  - Severe Maternal Morbidity rate

Variation in NTSV Cesarean Rate among 243 CA Hospitals (2015)



5 The Need for Balancing Measures

- Every QI project needs to have measure(s) or indicator(s) for unexpected harm (safety)
- For maternity care, often need safety metrics for both mother and baby

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Evaluating Severe Maternal Morbidity

Severe Maternal Morbidity (SMM)

- Severe Maternal Morbidity (SMM) - Unanticipated outcomes of the labor and delivery process that result in significant short or long term consequences to a woman's health[1]
- Conditions associated with transfer to intensive care or a higher level of care
- 19 indicators have been identified by the CDC and based on ICD-10 diagnosis codes

CDC SMM Diagnosis Codes:

Acute myocardial infarction

Aneurysm

Acute renal failure

Adult respiratory distress syndrome (ARDS)

Amniotic fluid embolism

Cardiac arrest/ventricular fibrillation

Conversion of cardiac rhythm

Disseminated intravascular coagulation

Eclampsia

Heart failure/arrest during surgery or procedure

Puerperal cerebrovascular disorders

CDC SMM Diagnosis Codes (cont.)

Puerperal cerebrovascular disorders

Pulmonary edema/acute heart failure

Severe anesthesia complications

Sepsis

Shock

Sickle cell disease with crisis

Air and thrombotic embolism

Blood transfusion

Hysterectomy

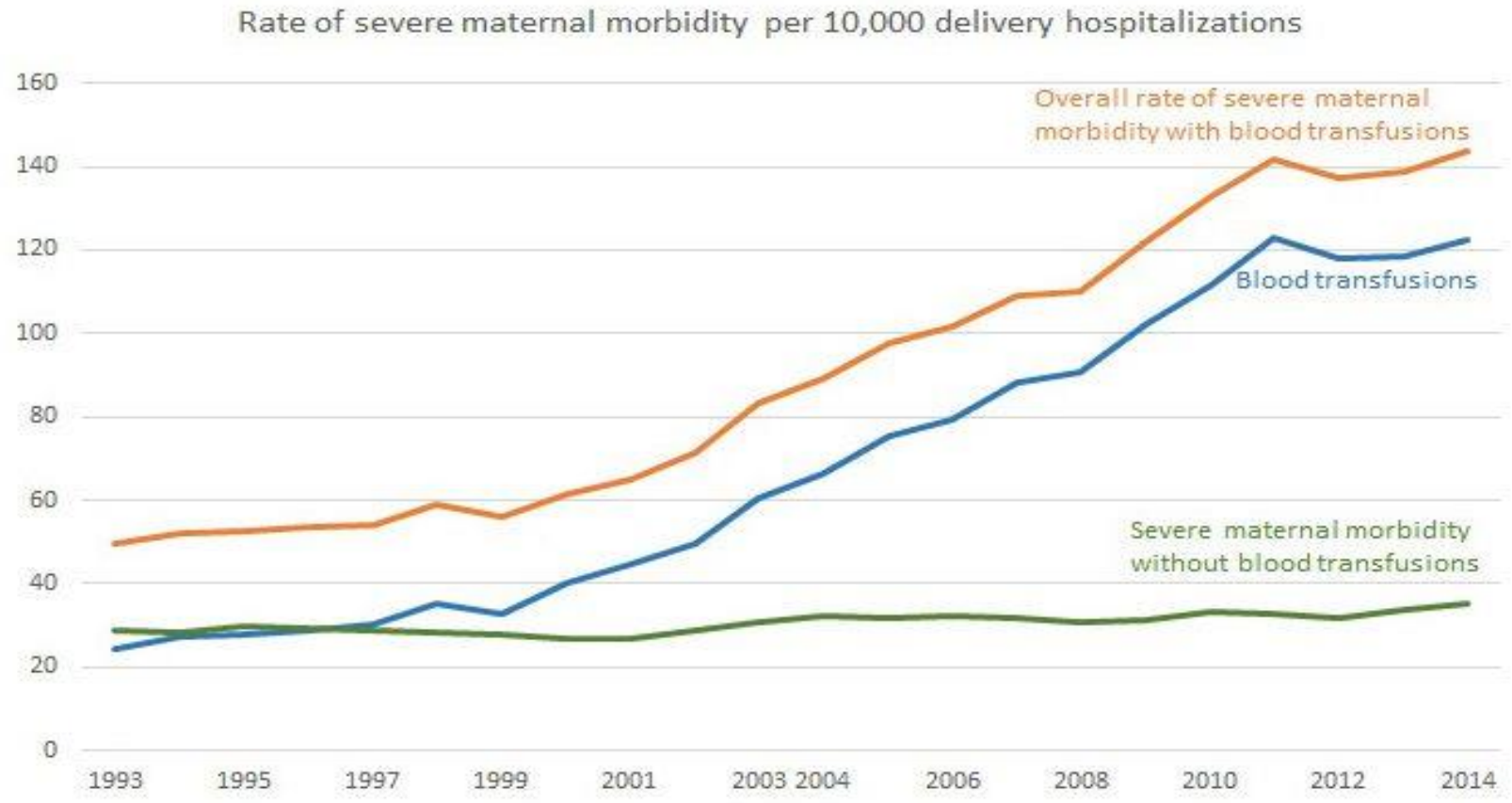
Temporary tracheostomy

Ventilation

CDC-
https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm

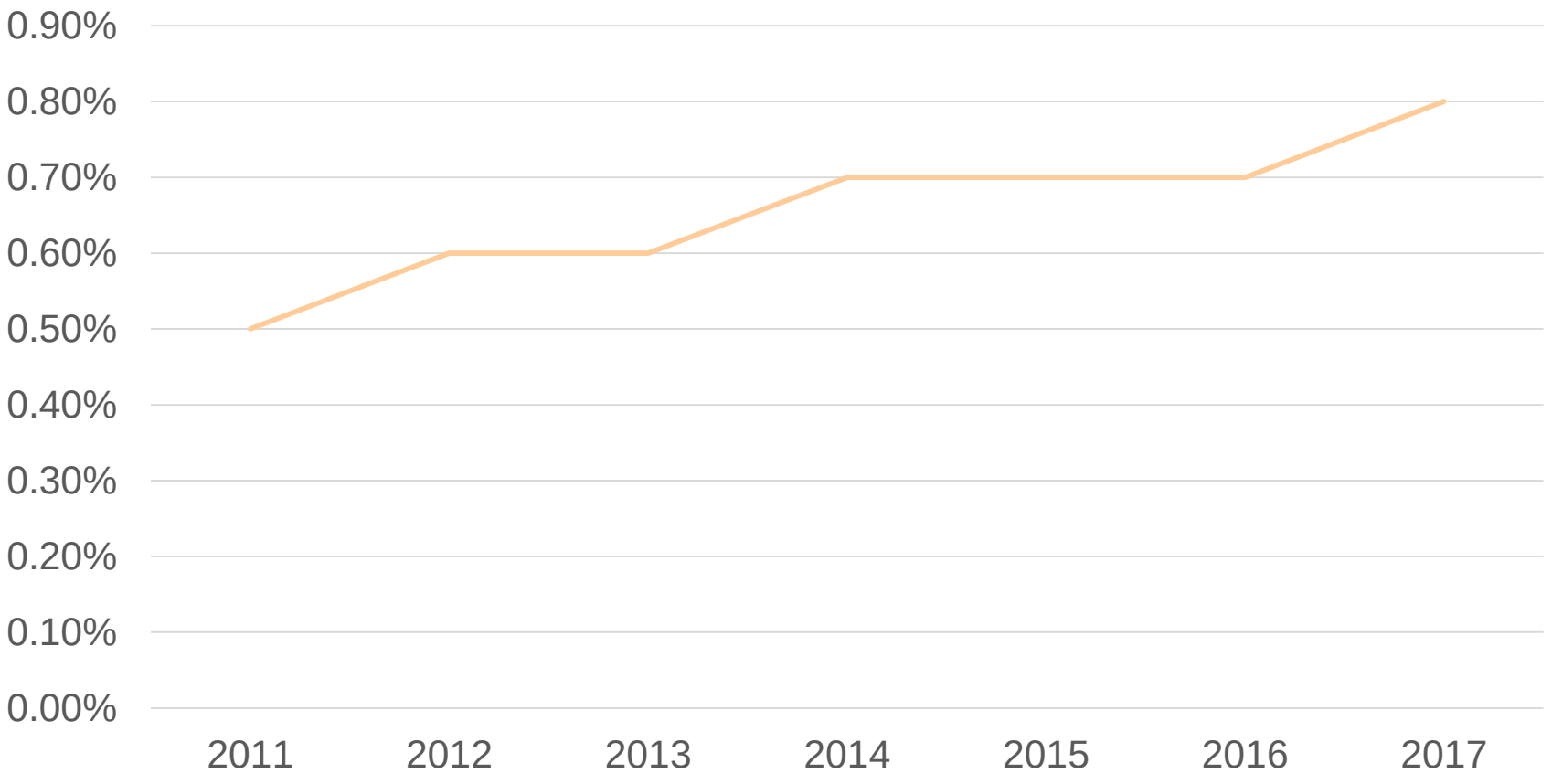
Last updated 2/7/18

Why Focus on SMM?



CDC, Updated 11/27/17

MDC SMM Without Transfusions



Importance of SMM

- Can be considered "near misses"
- If cases are not identified and treated, they have the possibility of escalating to maternal death
- Reviewing incidents of SMM provides a unique opportunity to improve our understanding of the primary contributing factors of these conditions with a potential to improve the health care delivery system[4]

SMM Case Debriefings for Improvement and Sustainability

- Review your hospital data (MDC)
- Track and trend the data routinely – frequency based on delivery volume
- Perform a case review on all fallouts to determine opportunities for improvement

Case Review Process

- Does the case qualify?
- Participants in the review process should include members of the health care team involved in the care of the patient

Case Review Process (cont.)

- Review prenatal record to identify risk factors
- Was patient informed of risk? - Shared Decision Making
- Comprehensive H&P - completed and documented on admission?
- Appropriate personnel/preparation - available as indicated by H&P review/hospital policy?
- Communication - handoffs between caregivers regarding patient Hx, condition changes & delivery summary completed?

Case Review Process (cont.)

- Patient condition - monitored at the correct frequency?
- Patient/family - kept informed of the condition with documentation to support
- Neonatal team - kept informed of the patient condition on admission and throughout the labor process?
- Opportunities for improvement?

Action Steps for Improvement and Sustainability

- Set the expectation for quality sustainability
- Systematic review of bundle compliance for all toolkits at least quarterly. *(MDC assists with data review prompts and cases available for review)*
  - Review SMM trends as an outcome measure for all interventions and sustainability activities
  - Report quality findings to the OB health care team, Quality Department and Administration

Action Steps for Improvement and Sustainability (cont.)

- Establish action plans for any identified opportunities for improvement
- Set stretch (bold) goals
- Small tests of change to evaluate action plans
  - Start with "early wins" and advance to bigger projects as goals are achieved
- Celebrate Successes!

Considerations for Antepartum Approaches for Reducing SMM

- Preconception Planning education for patients focusing on pre-pregnancy control of weight, hypertension, blood sugar management, activity
- Childbirth education to set the expectation for the labor process and reduce the likelihood of primary cesareans
- Open a dialogue regarding alternative birthing options at your facility (VBAC's, midwives, doulas, delayed admissions, intermittent fetal monitoring, etc.)

Communication and Preparation

- The most frequent identified drivers of SMM are transfusions and sepsis
- SMM reduction strategy suggestions focus on communication and preparation
  - Insist on complete prenatal records which focus on risk factors. Add risk factors to hospital problem list.
  - Complete nursing care plans on identified risk factors with preparation plan documented
  - Ensure comprehensive assessments for identified risk factors are completed on admission (hemorrhage risk assessments, lab work analysis, GBS status)

Communication and Preparation

- Ensure systematic and ongoing assessments are completed and documented throughout the labor, delivery and postpartum process
  - Blood loss, time elapsed since rupture of membranes, vital signs including maternal temperature, fetal heart rate
- Have all required personnel and equipment available on the unit/at the bedside when risk factors are identified
  - Anesthesia, Scrub tech, blood products ordered, hemorrhage cart

Summary

- Monitor quality outcomes
- Consider monitoring outcomes using different filters (MDC)
  - By race, NICU level, payer
  - Are you meeting your goals for all of your patients
- Review your SMM measure analysis outcomes to identify trends (MDC)
- Involve your team members in the quality improvement plans to ensure sustainability

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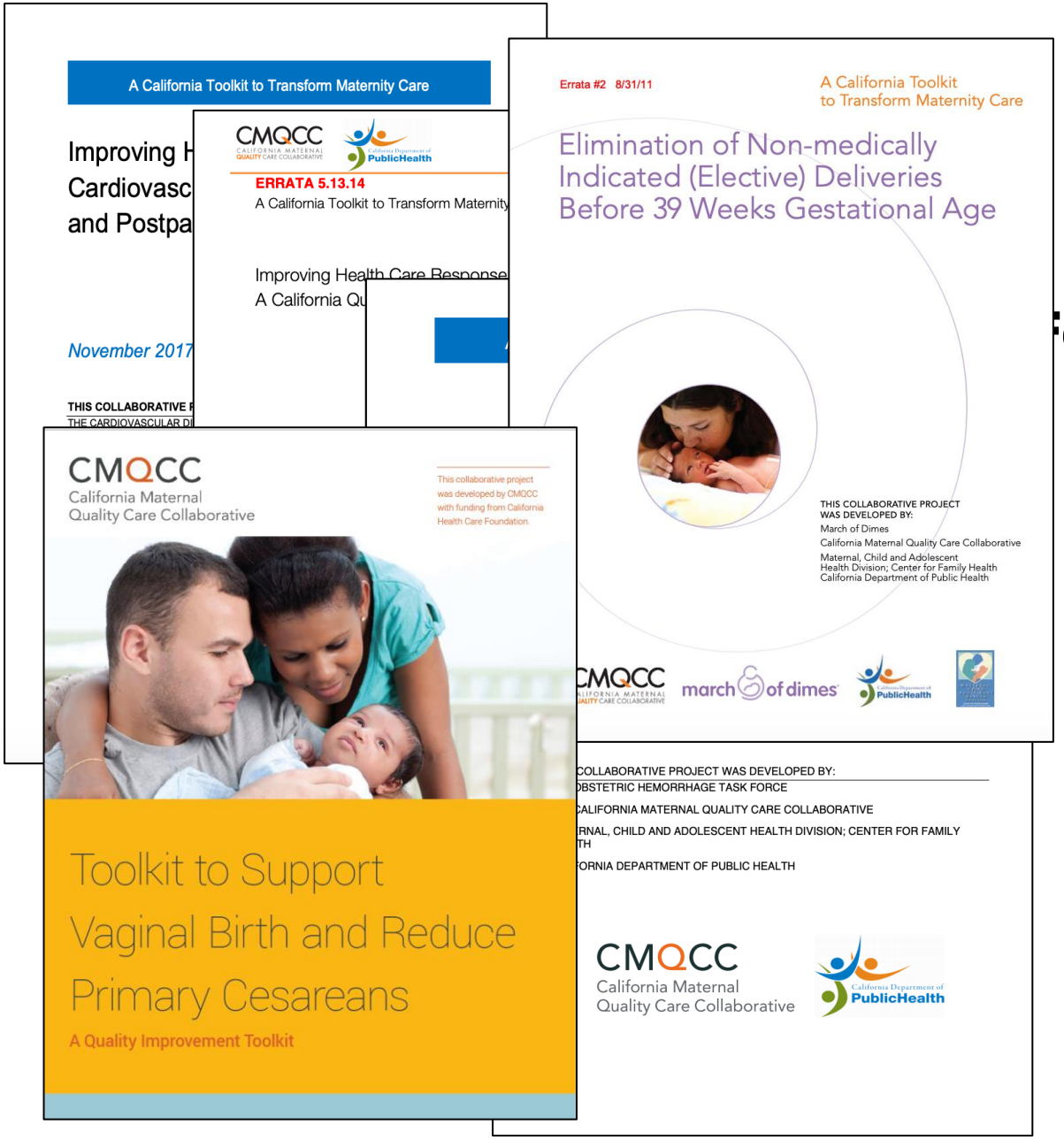
CMQCC Toolkits

CMQCC Maternal Quality Improvement Toolkits

- Aim to improve the health care response to leading causes of preventable death among pregnant and postpartum women
- Include a compendium of best practice tools and articles, care guidelines in multiple formats, hospital-level implementation guide, and professional education slide set.
- Developed in partnership with key experts from across California, representing the diverse professionals and institutions that care for pregnant and postpartum women.

CMQCC Toolkits

- Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age
- Improving Health Care Response to Preeclampsia
- Improving Health Care Response to Obstetric Hemorrhage
- Support Vaginal Birth and Reduce Primary Cesareans,
- Improving Health Care Response to Cardiovascular Disease in Pregnancy and Postpartum
- Improving Health Care Response to Maternal Venous Thromboembolism
- *Coming Soon!* – Maternal Sepsis



For More Information and to Download the Toolkits

- **Visit our website:** www.cmqcc.org
- **Or contact us:** info@cmqcc.org

CA-PAMR Findings
Timing of Diagnosis and Death
2002-2006

- Timing of CVD Diagnosis (n=64)

- Preexisting (prior to pregnancy)
- Prenatal period
- At labor and delivery
- Postpartum period
- Postmortem

- Timing of Death
  - 30% of all CVD deaths were >42 days from birth/fetal demise vs. 7.3% of non CVD pregnancy-related deaths
  - Driven by Cardiomyopathy deaths, with 42.9% deaths >42 days

Hameed A, Lawton E, McCain CL, et al. Pregnancy-Related Cardiovascular Deaths in California: Beyond Peripartum Cardiomyopathy. *American Journal of Obstetrics and Gynecology* 2015; DOI: 10.1016/j.ajog.2015.05.008

Rationale for Toolkit

Cardiovascular Disease is

- **the leading cause of maternal mortality in CA and U.S.**
- **under-recognized in pregnant or postpartum women**
- **higher among African-American women**

- **25% of deaths attributed to cardiovascular disease may have been prevented if the woman's heart disease had been diagnosed earlier.**

- **Pregnancy is a period of frequent interaction with health care providers and offers an opportunity to detect and treat heart disease, improve pregnancy outcomes, and affect future cardiovascular health.**

VTE Risk Assessment:

Standard Practice for all Medical Surgical Patients

- **AHRQ** (The Agency for Healthcare Research and Quality) defined VTE as the "number one patient safety practice" for hospitalized patients
- **Joint Commission** All hospitalized patients to have VTE prophylaxis *or* documentation why no VTE prophylaxis was given – **Quality measure VTE 1**
- **NQF** (National Quality Forum) Safe practices published recommendations:
  - Routine evaluation of hospitalized patients for risk of VTE
  - Use of appropriate prophylaxis

Shojania KG, (Eds.).(2001). "Making healthcare safer; A critical analysis of patient safety practices (Evidence Report/Technology Assessment No. 43)." (AHRQ Publication NO.01-E058).
Joint Commission (2015). Specifications Manual for National Hospital Inpatient Quality Measures v.5.1
National Quality Forum. National Voluntary Consensus Standards for Prevention and Care of Venous Thromboembolism. (2006)

CVD Toolkit Goals

- Encourage obstetric and other healthcare providers to retain a high index of suspicion for CVD, particularly among women with risk factors who present with symptoms in late pregnancy or early postpartum period

- To serve as resource for generalists who provide maternity care to women, with special emphasis on
  - Prenatal visits
  - Postpartum encounters
  - Emergency room visits

CVD Algorithm Validation

- We applied the algorithm to 64 CVD deaths from 2002-2006 CA-PAMR.
- 56 out of 64 (88%) cases of maternal mortality would have been identified.
- Detection increased to 93% when comparison was restricted to 60 cases that were symptomatic.

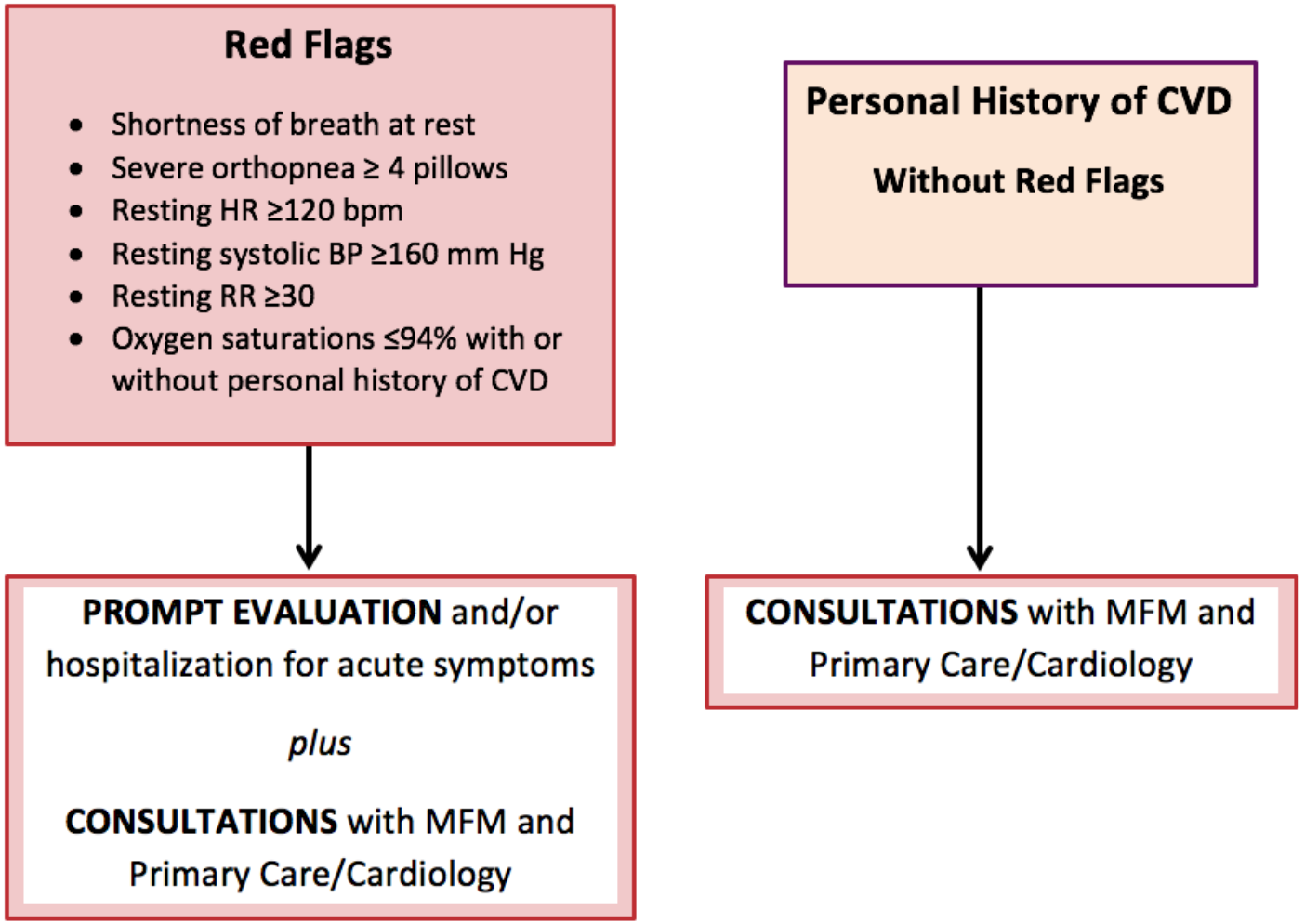
Rationale and Resources are Divided

- Readiness
- Recognition
- Response
- Reporting / Systems Learning

Risk Assessment (Readiness)

- VTE risk assessment tools should be applied to every patient to determine risk for VTE
- Risk assessment based on major guidelines:
  - **NPMS** - National Partnership for Maternal Safety
  - **ACOG** - American College of Obstetricians and Gynecology
  - **ACCP** - American College of Chest Physicians
  - **RCOG** - Royal College Obstetricians and Gynecologists
- Pharmacologic prophylaxis may be with:
  - **Unfractionated heparin (UFH) or**
  - **Low-molecular weight heparin (LMWH)**
    - LMWH is a preferred antepartum medication

CVD Assessment Algorithm
For Pregnant and Postpartum Women (Recognition)



CARDIOVASCULAR DISEASE ASSESSMENT IN PREGNANT and POSTPARTUM WOMEN

(No Red Flags and/or no personal history of CVD, and hemodynamically stable)

SYMPTOMS

*NYHA class > II

Suggestive of Heart Failure:
- Dyspnea
- Mild orthopnea
- Tachypnea
- Asthma unresponsive to therapy

Suggestive of Arrhythmia:
- Palpitations
- Dizziness/syncope

Suggestive of Coronary Artery Disease:
- Chest pain
- Dyspnea

VITAL SIGNS

- Resting HR ≥110 bpm
- Systolic BP ≥140 mm Hg
- RR ≥24
- Oxygen sat ≤96%

RISK FACTORS

- Age ≥40 years
- African American
- Pre-pregnancy obesity (BMI ≥35)
- Pre-existing diabetes
- Hypertension
- Substance use *(nicotine, cocaine, alcohol, methamphetamines)*
- History of chemotherapy

**PHYSICAL EXAM

ABNORMAL FINDINGS

Heart: Loud murmur or

Lung: Basilar crackles

NO

YES

≥ 1 Symptom + ≥ 1 Vital Signs Abnormal + ≥ 1 Risk Factor or

ANY COMBINATION ADDING TO ≥ 4

Consultation indicated:

MFM *and* Primary Care/Cardiology

Obtain: **EKG and BNP**
- **Echocardiogram +/- CXR** if HF or valve disease is suspected, or if the BNP levels are elevated
- 24 hour Holter monitor, if arrhythmia suspected
- Referral to cardiologist for possible treadmill echo vs. CTA vs. alternative testing if postpartum

Consider: **CXR**, **CBC**, Comprehensive metabolic profile, Arterial blood gas, Drug screen, TSH, etc.

Follow-up within one week

Results negative

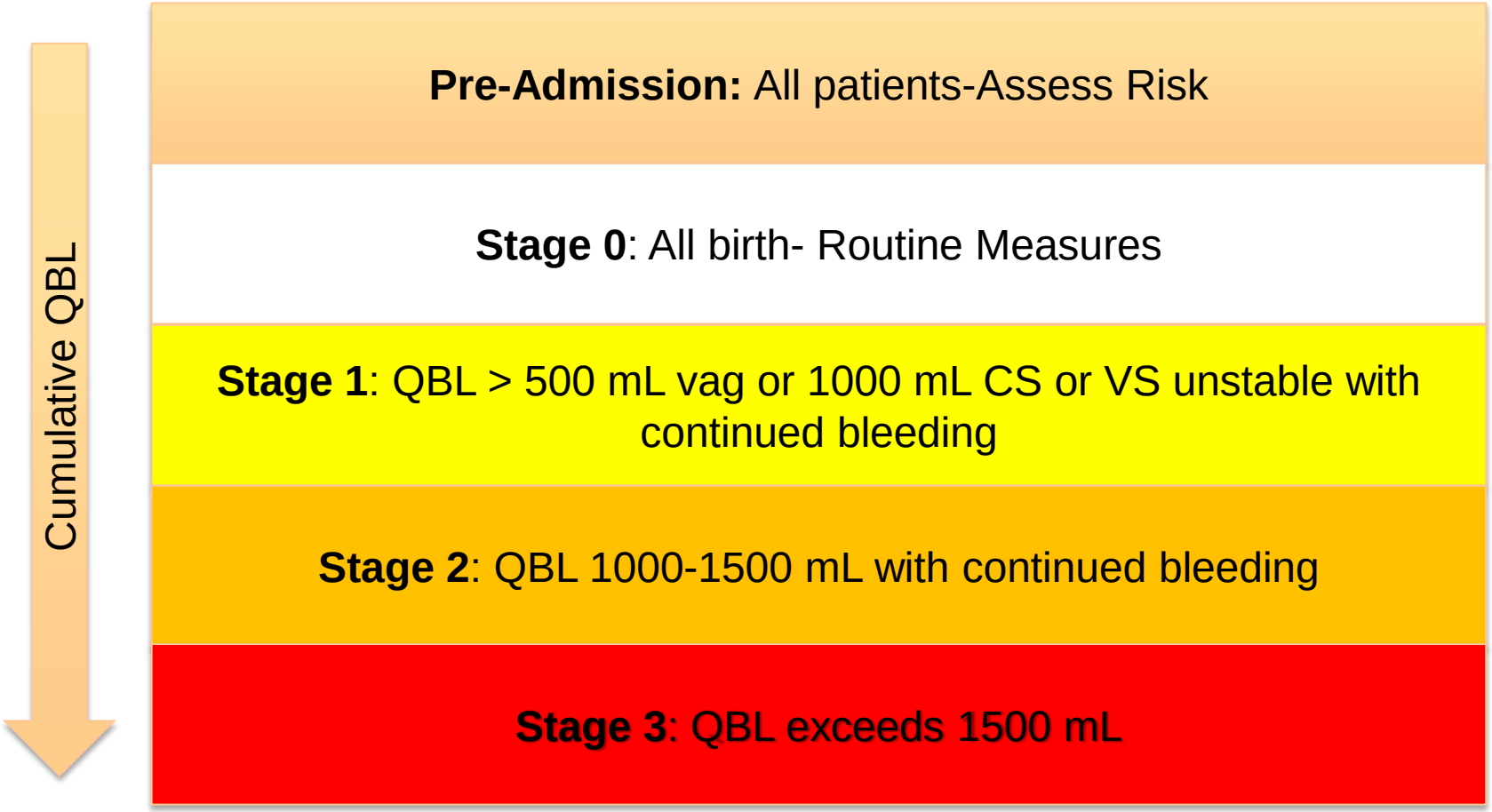
Signs and symptoms resolved

Reassurance and routine follow-up

Results abnormal

CVD highly suspected

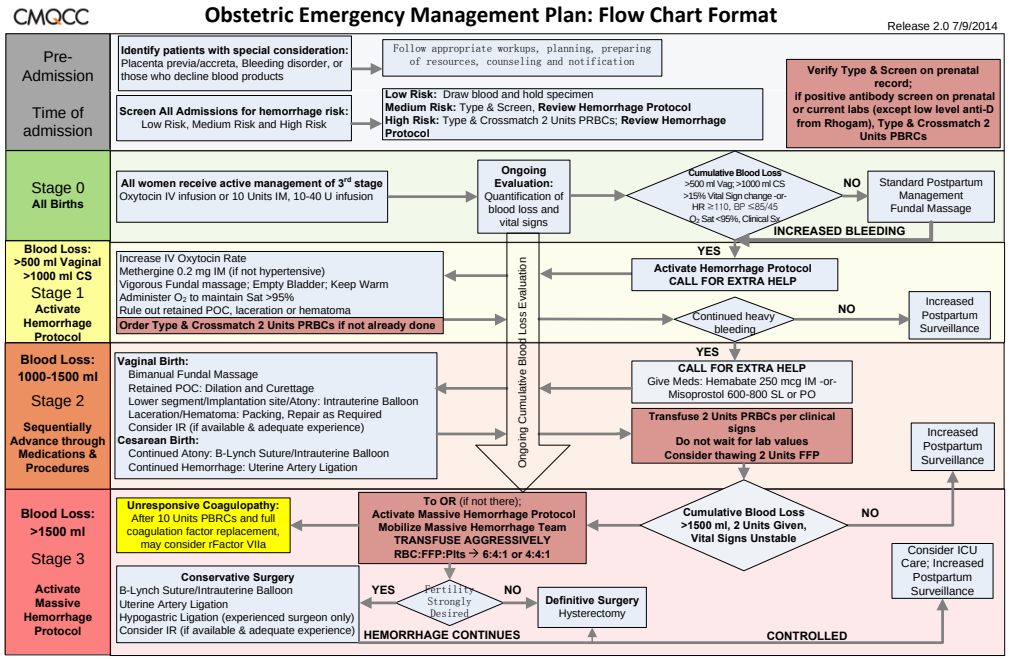
Hemorrhage Guidelines: Staged Responses (Response)



CMQCC OB Hemorrhage Emergency Management Plan

CMQCC Obstetric Hemorrhage Emergency Management Plan: Table Chart Format
version 2.0

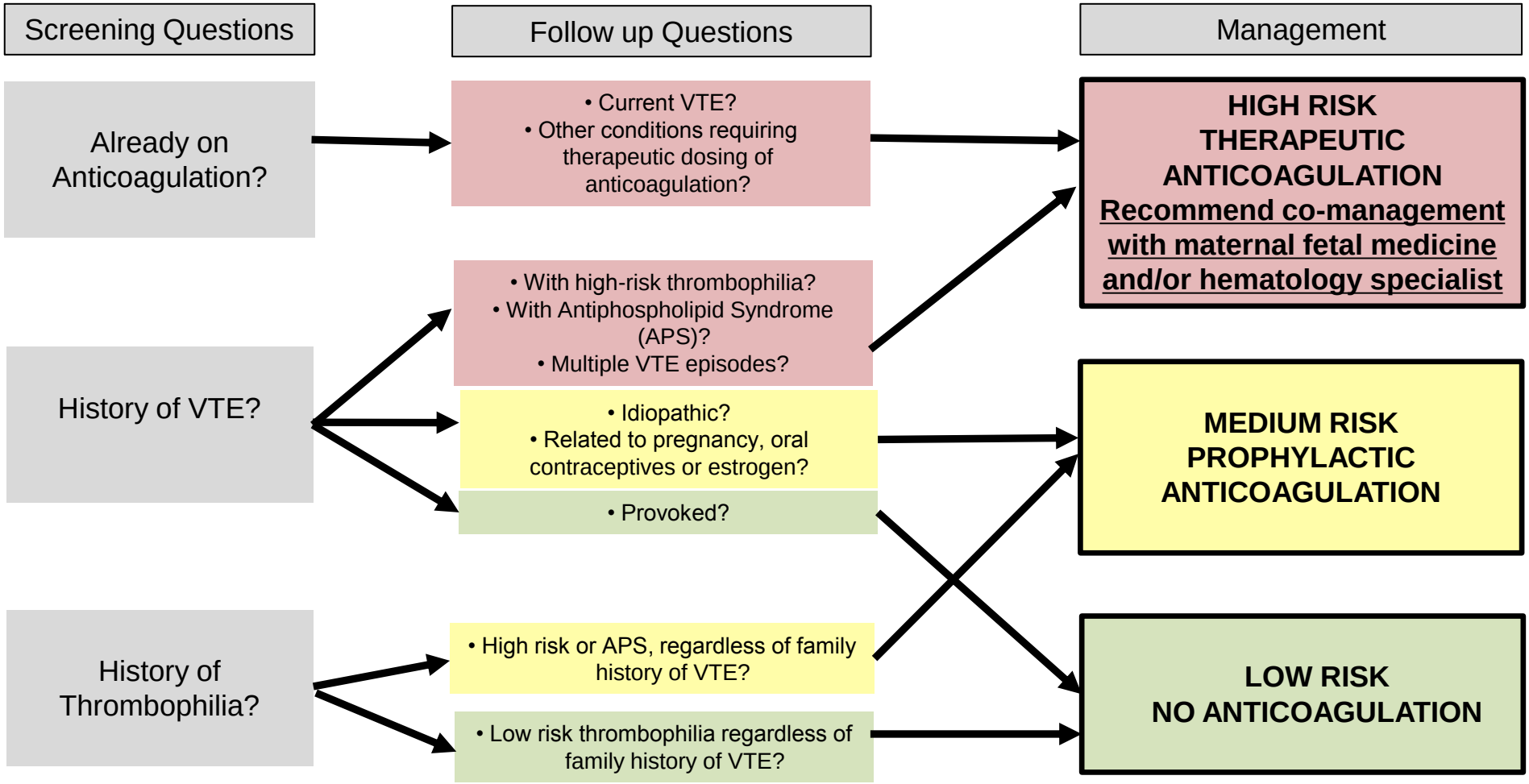
	Assessments	Meds/Procedures	Blood Bank
Stage 0	**Every woman in labor/giving birth**		
Stage 0 focuses on risk assessment and active management of the third stage.	· Assess every woman for **risk factors** for hemorrhage · Measure **cumulative quantitative blood loss** on every birth	**Active Management 3rd Stage:** · **Oxytocin** IV infusion or 10u IM · **Fundal Massage**- vigorous, 15 seconds min.	· If **Medium Risk:** T & Scr · If **High Risk:** T&C 2 U · If **Positive Antibody Screen** (prenatal or current, exclude low level anti-D from RhoGam):T&C 2 U
Stage 1	**Blood loss: > 500ml vaginal or >1000 ml Cesarean, or VS changes (by >15% or HR ³ 110, BP £85/45, O2 sat <95%)**		
Stage 1 is short: activate hemorrhage protocol, initiate preparations and give Methergine IM.	· Activate OB Hemorrhage Protocol and Checklist · Notify Charge nurse, OB/CNM, Anesthesia · VS, O2 Sat q5' · Record **cumulative** blood loss q5-15' · **Weigh** bloody materials · Careful inspection with good exposure of vaginal walls, cervix, uterine cavity, placenta	· **IV Access:** at least 18gauge · Increase IV fluid (LR) and **Oxytocin** rate, and repeat **fundal massage** · **Methergine** 0.2mg IM (if not hypertensive) May repeat if good response to first dose, BUT otherwise **move on** to 2nd level uterotonic drug (see below) · Empty bladder: straight cath or place foley with urimeter	· **T&C 2 Units PRBCs** (if not already done)
Stage 2	**Continued bleeding with total blood loss under 1500ml**		
Stage 2 is focused on sequentially advancing through medications and procedures, mobilizing help and Blood Bank support, and keeping ahead with volume and blood products.	**OB back to bedside** (if not already there) · **Extra help**: 2nd OB, Rapid Response Team (per hospital), assign roles · VS & **cumulative** blood loss q 5-10 min · Weigh bloody materials · **Complete evaluation** of vaginal wall, cervix, placenta, uterine cavity · Send additional labs, including DIC panel · If in Postpartum: Move to L&D/OR · Evaluate for special cases: -Uterine Inversion -Amn. Fluid Embolism	**2nd Level Uterotonic Drugs:** · **Hemabate** 250 mcg IM or · **Misoprostol** 800 mcg SL **2nd IV Access** (at least 18gauge) Bimanual massage **Vaginal Birth:** (typical order) · Move to OR · Repair any tears · D&C: r/o retained placenta · Place intrauterine balloon · Selective Embolization (Interventional Radiology) **Cesarean Birth:** (still intra-op) (typical order) · Inspect broad lig, posterior uterus and retained placenta · B-Lynch Suture · Place intrauterine balloon	· **Notify Blood Bank of OB Hemorrhage** · **Bring 2 Units PRBCs to bedside, transfuse per clinical signs – do not wait for lab values** · Use blood warmer for transfusion · Consider thawing 2 FFP (takes 35+min), use if transfusing > 2u PRBCs · Determine availability of additional RBCs and other Coag products
Stage 3	**Total blood loss over 1500ml, or >2 units PRBCs given or VS unstable or suspicion of DIC**		
Stage 3 is focused on the Massive Transfusion protocol and invasive surgical approaches for control of bleeding.	· **Mobilize team** -Advanced GYN surgeon -2nd Anesthesia Provider -OR staff -Adult Intensivist · **Repeat labs** including coags and ABG's · Central line · Social Worker/ family support	· **Activate Massive Hemorrhage Protocol** · Laparotomy: -B-Lynch Suture -Uterine Artery Ligation -Hysterectomy · Patient support -Fluid warmer -Upper body warming device -Sequential compression stockings	**Transfuse Aggressively** Massive Hemorrhage Pack · Near 1:1 PRBC:FFP · 1 PLT apheresis pack per 4-6 units PRBCs **Unresponsive Coagulopathy:** After 8-10 units PRBCs and full coagulation factor replacement: may consult re rFactor VIIa risk/benefit



California Maternal Quality Care Collaborative (CMQCC), Hemorrhage Taskforce (2009) visit: www.CMQCC.org for details
This project was supported by funds received from the State of California Department of Public Health, Center for Family Health; Maternal, Child and Adolescent Health Division

Every hospital will need to customize the protocol—but the point is every hospital needs one

Algorithm 1: 1st Prenatal Visit Maternal VTE Risk Assessment



Antepartum Outpatient Prophylaxis First Prenatal Visit

Clinical History	Risk Level	Management
• Low risk thrombophilia (isolated) • Low risk thrombophilia with family history of VTE • Prior *provoked* VTE	**LOW**	**No treatment**
• Prior VTE idiopathic • Prior VTE with pregnancy or oral contraceptive • Prior VTE with low risk thrombophilia • Family history of VTE with high risk thrombophilia • High risk or antiphospholipid syndrome (APS)	**MEDIUM**	**Prophylactic dose** LMWH or UFH
• Current VTE or other conditions requiring therapeutic dose of anticoagulation • Multiple prior VTE episodes • Prior VTE with high-risk thrombophilia • Prior VTE with APS	**HIGH**	**Therapeutic dose** LMWH or UFH ***Recommend co- management with maternal-fetal medicine and/or hematology specialist***

Racial Disparities in CVD
Clinical Implications

- **Listen to women.** Take patient complaints seriously, and maintain a high index of suspicion for CVD especially in ALL African-American women.
- Any co-morbidity should further heighten the clinical index of suspicion.
- African-American women with chronic or gestational hypertension, high BMI (>35) who present with symptoms suggestive of CVD or vital signs indicated in the CVD Assessment Algorithm should be evaluated carefully and thoroughly for potential CVD.

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Implementation

Lessons from the Field

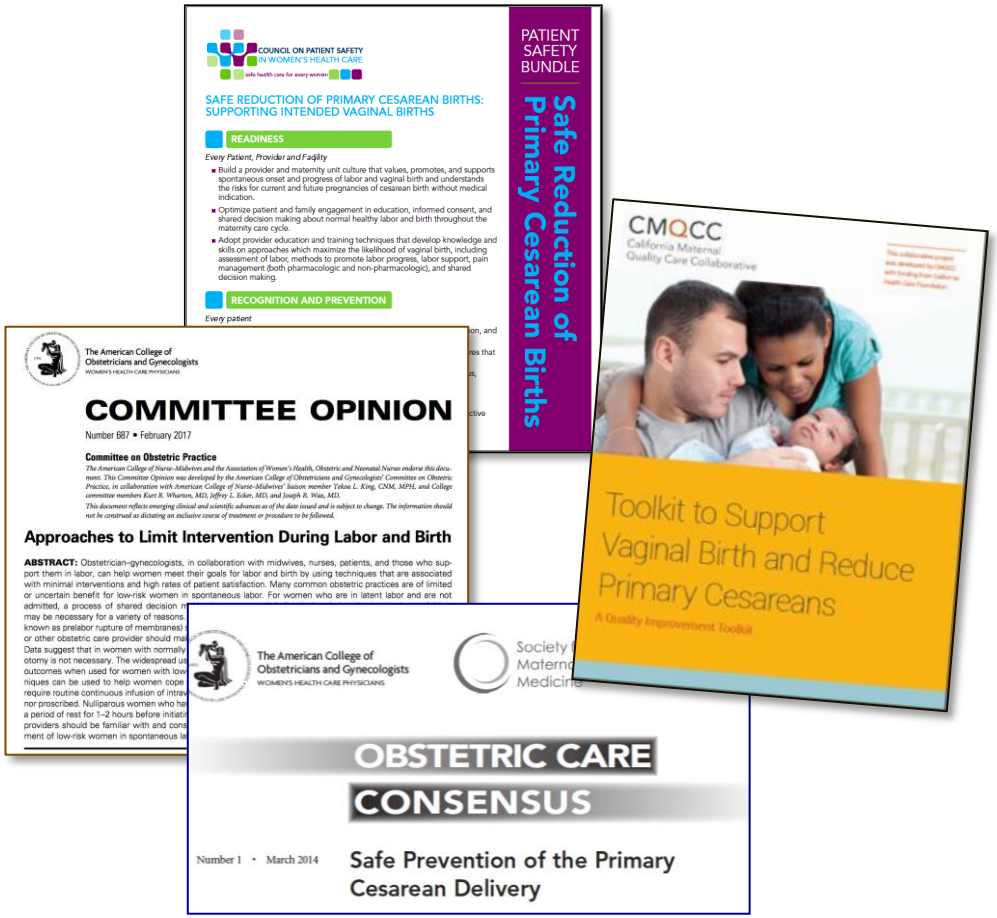
- It takes a broad team
- Easy wins matter
- Goals and timelines are very useful
- It takes time and persistence to get the systems running smoothly
- Must have champions

Disciplines & Departments	Needed?
Obstetrics	Yes
Nursing	
Anesthesia	
Blood Bank	
Laboratory	
Operating Room	
Support personnel	
IT/EMR	
QI	
Others unique to your setting?	

Team Build


NTSV
Initiative
OUR NTSV DATA:
NTSV SUCCESS SHOUT OUTS:
Avoiding c/sections one baby at a time!
September 2018:
MEDICATION
OCTOBER HAS STARTED WITH A BANG!

KEY RESOURCES:



1) AIM Bundles
2) Committee Opinions
3) Consensus Statements
4) Rate transparency (unit/provider)
5) CMQCC Toolkits
6) SHARE
7) Education
8) Patient engagement
9) Unit culture/teamwork

Share Unblinded Data

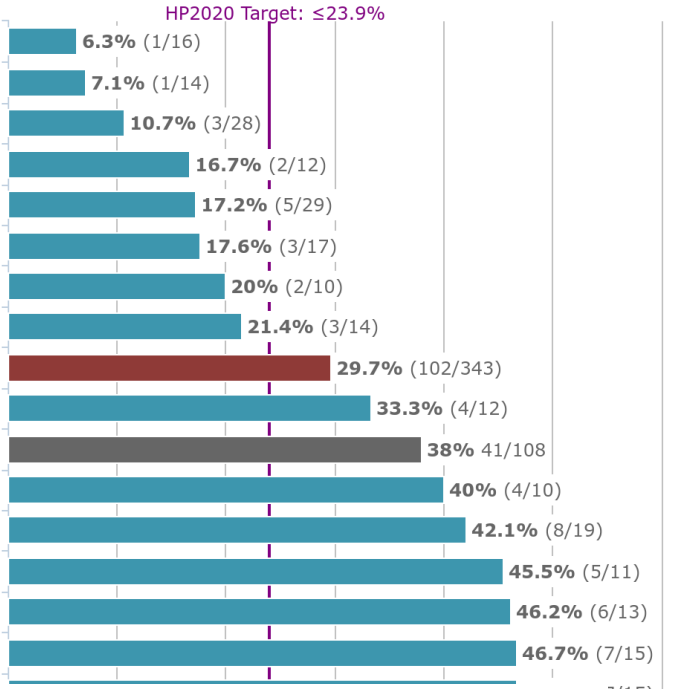
CMQCC
California Maternal
Quality Care Collaborative

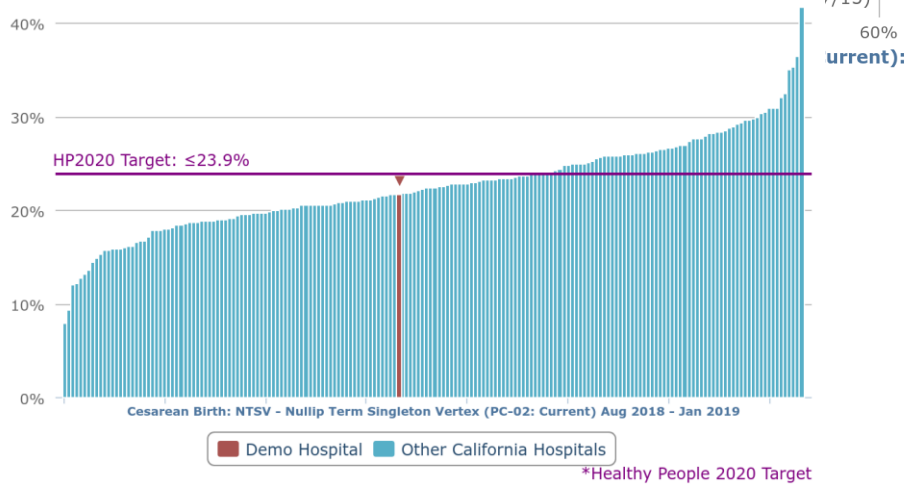
Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates

At Start of Project

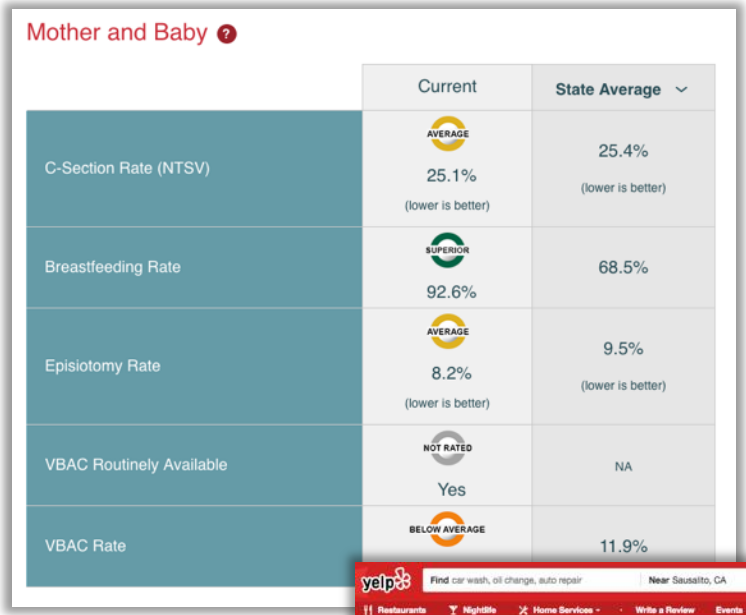
Before the process of unblinding NTSV cesarean rates begins, it is important for teams to have a baseline understanding of their underlying practices. This can be determined through an examination of the drivers for primary cesarean rates, followed by a chart review of a sample to assess how well the providers follow the national ACOG guidelines for Failure to Progress and other key primary cesarean indications. Ongoing monthly review for consistency with guidelines is also quite useful (recognizing that not every case will follow the guidelines perfectly). The Readiness Assessment and Structure Measures Checklist will assist with this baseline review. Success of the project hinges upon system improvements that support providers in reducing individual rates.

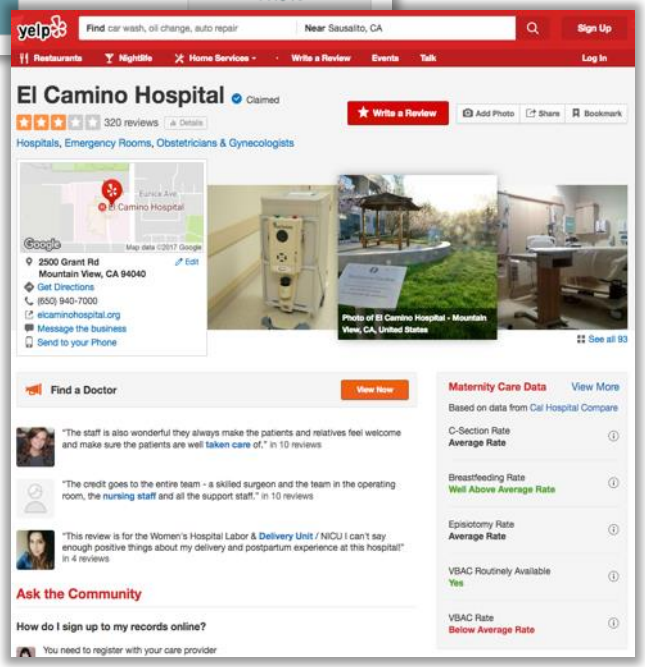
The Readiness Assessment, Structure Measures Checklist (both are found in the Implemer and Chart Audit Tool are all located on the collaborative resources page at https://www.cmqcc.org/projects/toolkit-and-collaborative-support-vaginal-birth-and-redu cesareans/collaborative





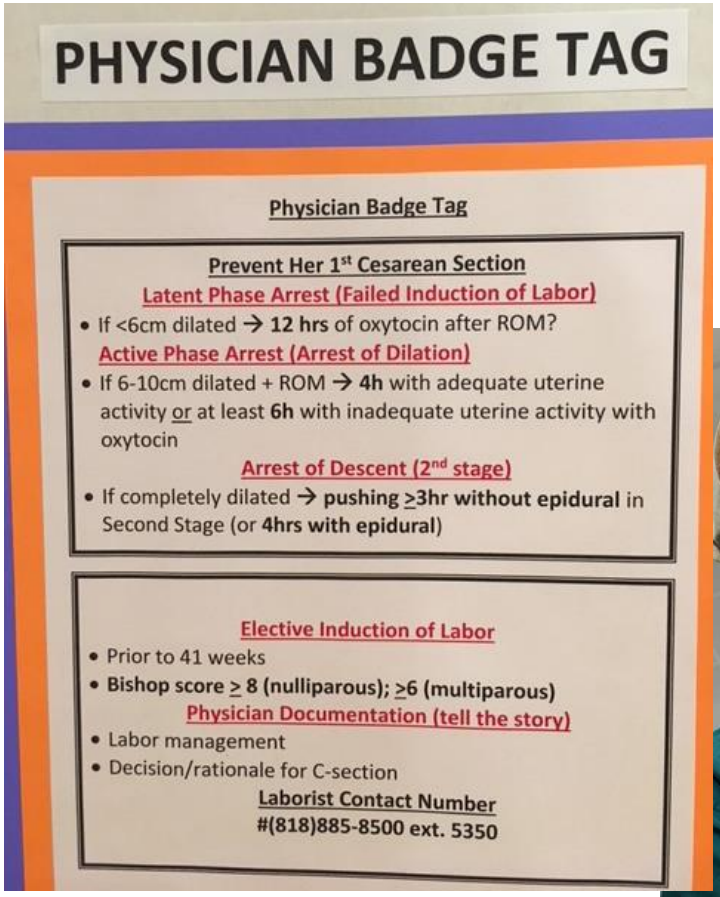
Transparency





- Every Year the CA Secretary of HHS Recognizes Hospitals With NTSV CS Rates <23.9%
- CalHospitalCompare.org
- Yelp
- Joint Commission

Education and Adoption of Guidelines



PHYSICIAN BADGE TAG

Physician Badge Tag

Prevent Her 1st Cesarean Section

Latent Phase Arrest (Failed Induction of Labor)

- If <6cm dilated → **12 hrs** of oxytocin after ROM?

Active Phase Arrest (Arrest of Dilation)

- If 6-10cm dilated + ROM → **4h** with adequate uterine activity or at least **6h** with inadequate uterine activity with oxytocin

Arrest of Descent (2nd stage)

- If completely dilated → **pushing ≥3hr without epidural** in Second Stage (or **4hrs with epidural**)

Elective Induction of Labor

- Prior to 41 weeks
- **Bishop score ≥ 8 (nulliparous); ≥6 (multiparous)**

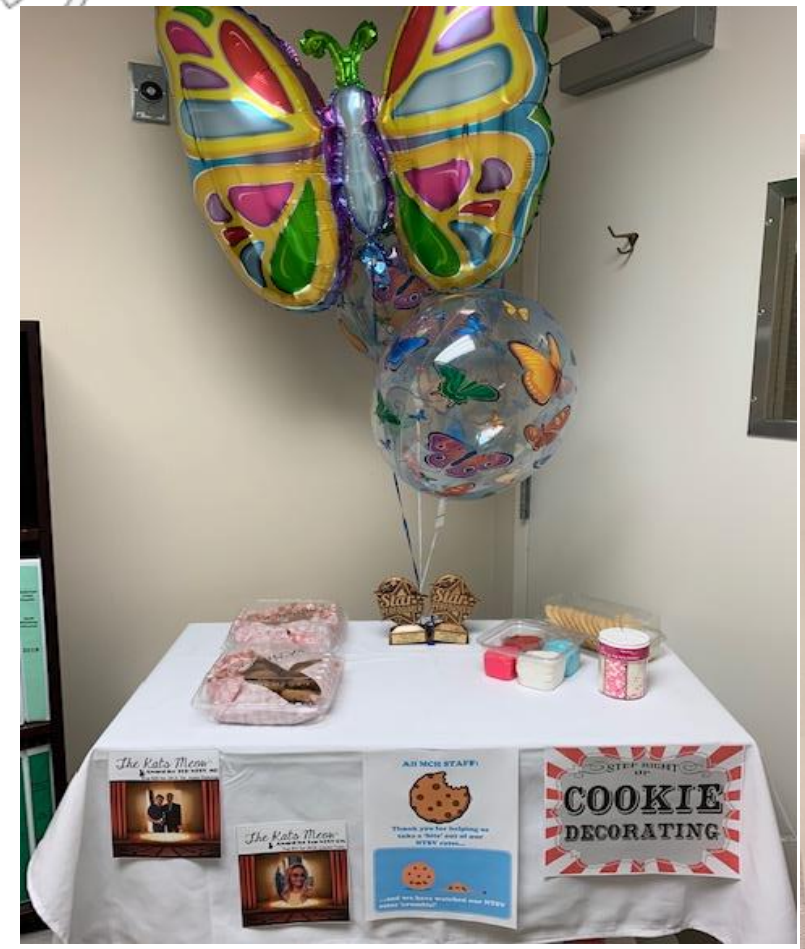
Physician Documentation (tell the story)

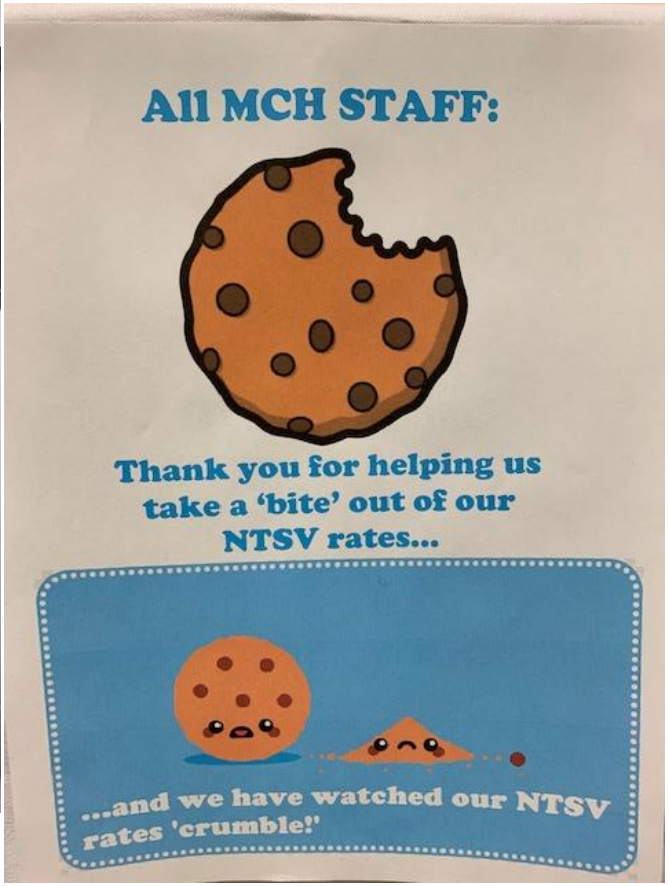
- Labor management
- Decision/rationale for C-section

Laborist Contact Number

#(818)885-8500 ext. 5350

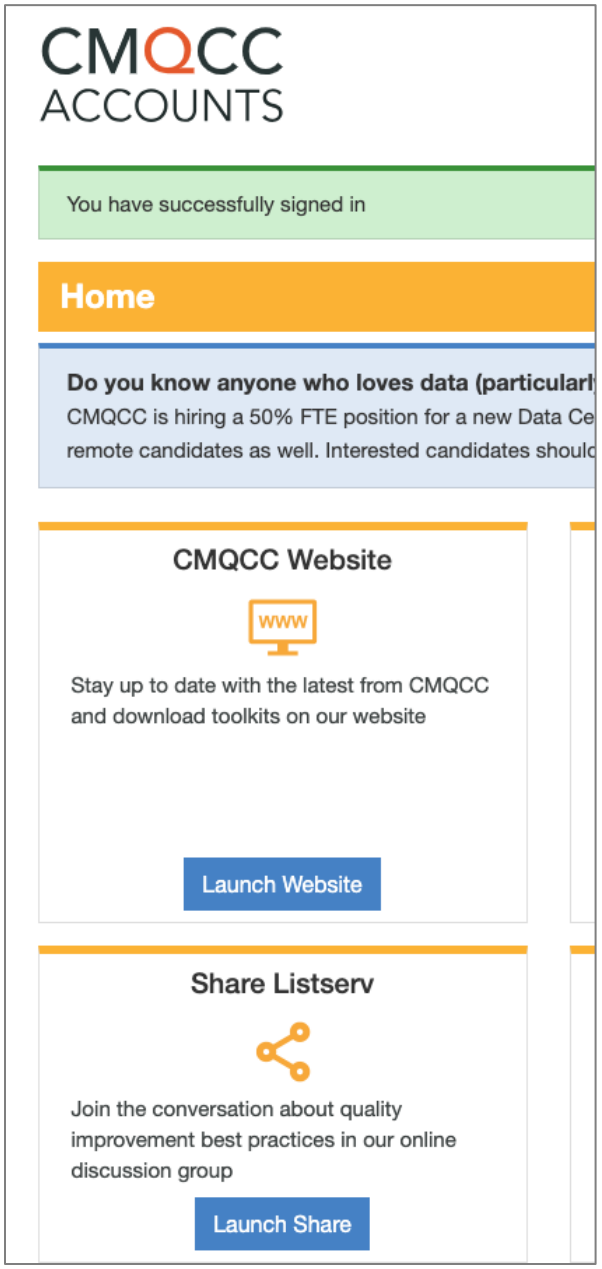
Celebrate Success!!!





Celebrate Success!!!

Share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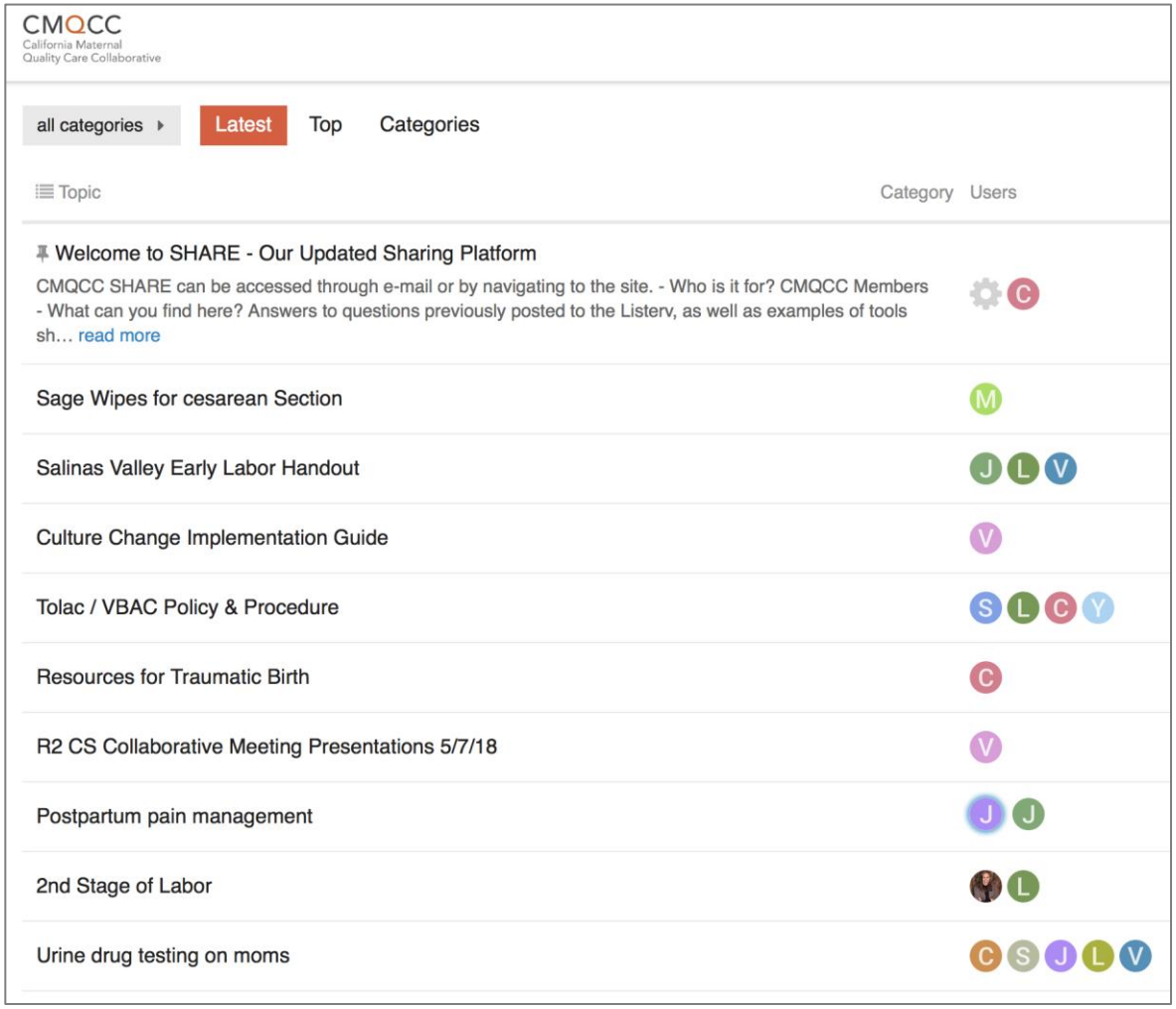
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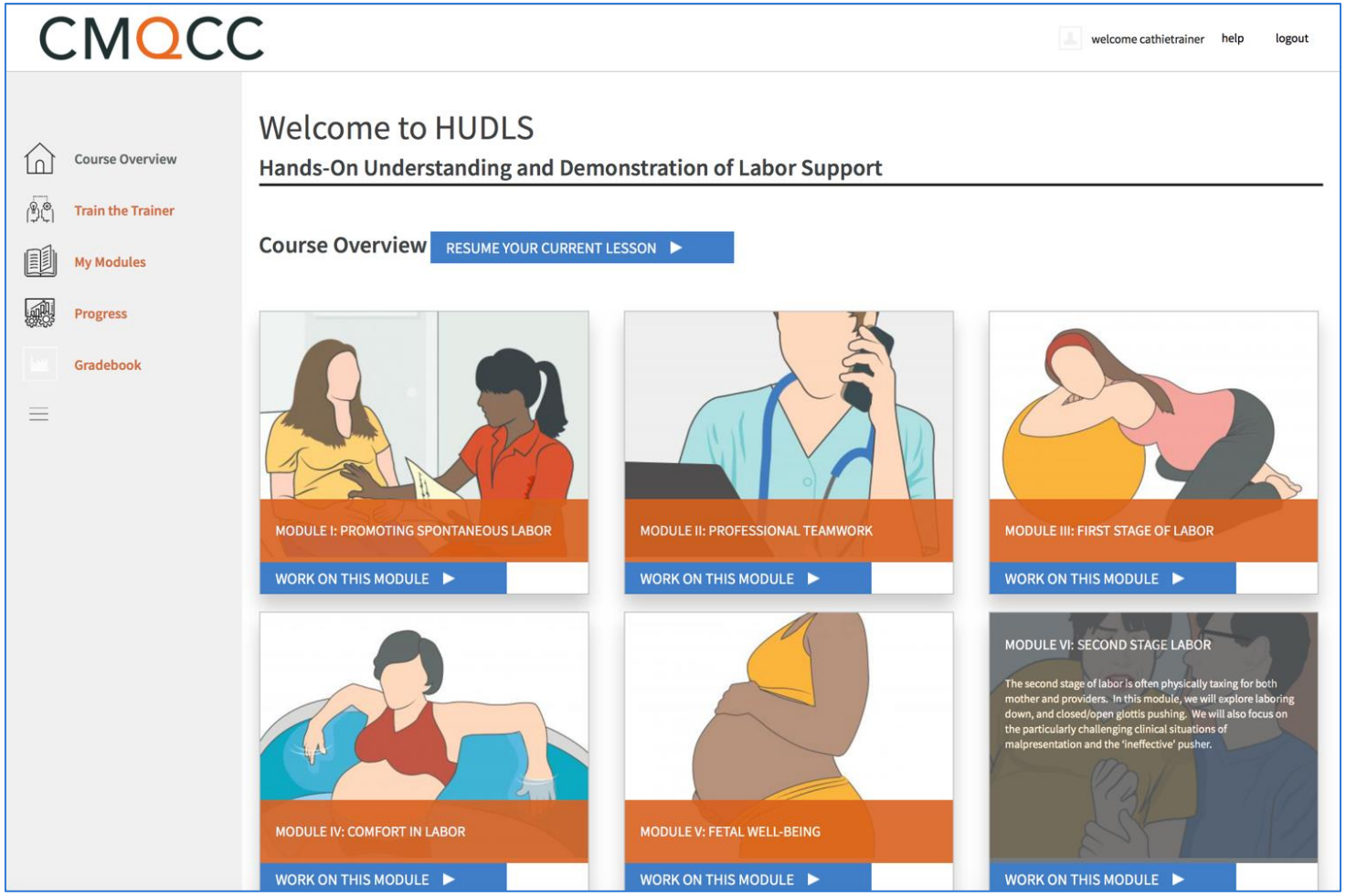
CMQCC SHARE can be accessed through e-mail or by navigating to the site. - Who is it for? CMQCC Members - What can you find here? Answers to questions previously posted to the Listerv, as well as examples of tools sh… read more
Sage Wipes for cesarean Section
Salinas Valley Early Labor Handout
Culture Change Implementation Guide
Tolac / VBAC Policy & Procedure
Resources for Traumatic Birth
R2 CS Collaborative Meeting Presentations 5/7/18
Postpartum pain management
2nd Stage of Labor
Urine drug testing on moms

On-Line Short Modules for Teaching Labor Support



CMQCC QI Academy

- **Goal: facilitate the development of OB quality improvement leaders on every OB unit**
- **Apply QI concepts and techniques to your project**
- **Year long program**
- **Hospital multi-disciplinary teams**
- **National and CA faculty**
- **New cohort every 6 months**
- **CEU/MOC credit for participation in the program**

Sometimes it doesn't quite turn out the way you planned!

Strategies

- Regroup with your team
- Elicit a broader range of support
- Review your data
- Reach out to CMQCC

Questions