



MSPQC

**INITIATIVE TO SUPPORT
VAGINAL BIRTH**

“I-SUPPORT”

TOOLKIT





INITIATIVE TO SUPPORT VAGINAL BIRTH TOOLKIT

HOW TO USE THIS TOOLKIT

This toolkit is organized according to the 4-R's of the AIM Safe Reduction of Primary Cesarean Births Safety Bundle:

- **Readiness**
- **Recognition & Prevention**
- **Response**
- **Reporting/Systems Learning**

The MSPQC Bundle Advisory Team has selected key resources from existing toolkits that may be adopted and adapted by each facility. This is not an exhaustive compilation of tools; it does, however, provide the core components needed for a facility to successfully implement labor management practices that promote vaginal delivery and meet the goals of the MSPQC Initiative to Support Primary Vaginal Births. We fully encourage providers and hospitals to review and utilize the resources from the following organizations in addition to the MSPQC, as they each offer valuable tools and guidance for promoting vaginal births.

In addition to the AIM Safety Bundle, resources within this toolkit are from the California Maternal Quality Collaborative's (CMQCC), Toolkit to Support Vaginal Birth and Reduce Primary Cesareans, Florida's PROVIDE Initiative, and Carolinas Health System.

Key references for this toolkit include:

AIM: <http://www.safehealthcareforeverywoman.org/aim.php>

California Maternal Quality Care Collaborative: <https://www.cmqcc.org/>

Florida Perinatal Quality Collaborative PROVIDE Initiative:
<https://health.usf.edu/publichealth/chiles/fpqc/provide>



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WHAT IS AIM?

The Alliance for Innovation on Maternal Health (AIM) is a national partnership of organizations with a mission to continually improve patient safety in women’s health care through multidisciplinary collaboration that drives culture change. The AIM program is funded through a cooperative agreement with the Maternal and Child Health Bureau/Health Resource Services Administration.

Maternal Safety Bundles

- AIM aligns national, state, and hospital level efforts to improve maternal health and safety
- AIM develops maternal safety bundles and promotes their implementation in all birth facilities to ensure consistent maternity care
 - Maternal Mental Health: Depression and Anxiety
 - Maternal Prevention of Venous Thromboembolism
 - Obstetric Care for Women with Opioid Use Disorder
 - Obstetric Hemorrhage
 - Postpartum Care Basics for Maternal Safety
 - Prevention of Retained Vaginal Sponges After Birth
 - Reduction of Peripartum Racial/Ethnic Disparities
 - Safe Reduction of Primary C/S | Support for Intended Vaginal Birth
 - Severe Hypertension/Preeclampsia
- AIM facilitates multidisciplinary and interagency collaboration between states and hospitals
- AIM supports harmonized data-driven continuous quality improvement processes
- AIM provides evidence-based implementation resources to streamline bundle implementation

Core AIM Partners Include:



American College of Nurse Midwives



The American College of Obstetricians and Gynecologists



Association of Maternal & Child Health Programs



American Society for Healthcare Risk Management



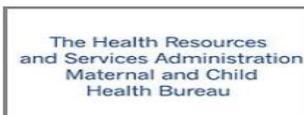
Association of State and Territorial Health Officials



Association of Women’s Health Obstetric and Neonatal Nurses



California Maternal Quality Care Collaborative



HRSA Maternal and Child Health Bureau



Society for Maternal Fetal Medicine



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Project Overview

This document is an outline of the pilot for the Mississippi Perinatal Quality Collaborative and Blue Cross & Blue Shield of Mississippi, *Initiative to Support Primary Vaginal Births* (I-Support). The goal of the initiative is to support Network Hospitals in implementing evidence-based practices that promote vaginal birth and the safe reduction of primary cesarean births among low risk women. While cesarean births can be undeniably life-saving and necessary, the progressively increasing rates of cesarean births and significant variation across care settings has been cause for national attention. Mississippi has one of the highest rates of cesarean births and improving these rates, where possible, can translate to reduced morbidity for mothers in our state.

This initiative was developed in alignment with the Alliance for Innovation on Maternal Health (AIM) Safe Reduction in Primary Cesarean Births Safety Bundle, the California Maternity Quality Care Collaborative (CMQCC) Toolkit to Support Vaginal Birth and Reduce Primary Cesareans and the Florida Perinatal Quality Collaborative PROVIDE toolkit, that each provide best practices shown to promote vaginal delivery and safely reduce cesarean delivery in low-risk, first time mothers.

Following the 12 month pilot, lessons learned from participating hospitals will help to improve and refine the I-Support initiative before implementation across all Mississippi facilities. Your involvement and input are critically important to the success of this initiative and are deeply appreciated.

Participation

Participation in the initiative will require the development of a Project Team, a group of key stakeholders from the healthcare team that will be actively engaged in leading and supporting the initiative. Below is a list of recommended roles of the Project Team and associated responsibilities:

Project Lead. *The Network Hospital official making the commitment for Network Hospital participation, will be the Hospital Team Leader for the initiative, and the main contact. This person should have influence to drive change, ultimate project oversight, and management to ensure implementation objectives and timelines are met*

OB Physician Lead. *Must be a leader willing to engage colleagues on this issue and attend your Hospital team's meetings on this initiative*

Nurse Lead. *Must be a leader willing to engage colleagues on this issue and attend your Hospital team's meetings on this initiative.*

Data Lead. *Will be responsible for submitting quarterly data to the AIM Data Portal*

Hospital Administrator. *Is responsible for full administrative support for this initiative*



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Information Technology Lead. *Is responsible for EMR integration of recommended tools (i.e. order sets)*

Mississippi Perinatal Quality Collaborative (MSPQC) and Blue Cross & Blue Shield of Mississippi (BCBSMS) Initiative Support Team. *The Initiative to Support Primary Vaginal Births (I-Support) is a collaborative effort led by MSPQC and BCBSMS driven by a shared goal of improving the health status of mothers and babies in Mississippi. The implementation of the AIM Safety Bundles is a key component of the BCBSMS Maternity Quality Model. Network Hospitals' progress with implementing the Bundle Components will be monitored by BCBSMS through progress updates entered in the AIM Data Portal by Network Hospital teams and the quarterly Maternity Quality Model Performance Review. MSPQC and BCBSMS will be a part of the multidisciplinary Initiative Support Team that will provide guidance, feedback, and educational opportunities to participating hospitals on executing improvement strategies via collaborative coaching calls, learning session webinars, and in-person trainings.*

Implementation

Implementation of AIM Safety Bundle components will be accomplished in 3 Phases throughout the initiative. Hospital teams are welcomed and encouraged to utilize available resources to move at a faster pace or expand upon the proposed activities.

Below is a description of the 3 Phases of Implementation and key roles and responsibilities.

Phase 1- Readiness (implement in 3-6 months)

Team Preparation and Education

Initiative kick off is planned for November 2019. Network Hospital teams and providers will be invited to participate in an initial group meeting to allow time for healthcare teams to discuss the current state of practice within their facilities, share perceived challenges and collaborate on recommendations related to promoting safe primary vaginal births. Network Hospitals will be asked to complete a baseline readiness survey to establish processess/practices already in place related to Bundle components.

During Phase 1, an onsite meeting at your Network Hospital with the Initiative Support Team will be scheduled to

Expected participation by the following key stakeholder(s):

- Project Lead
- OB Physician Lead and other OB Providers from your Network Hospital
- Nursing Lead
- Data Lead

Expected responsibilities:

- Attend MSPQC kick-off group meeting in Jackson, MS on 11/14/19
- Completion of readiness assessment



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- Attend Phase 1 onsite meeting with the Initiative Support Team

Education of best practices (ACOG/SMFM guidelines)

AIM E-modules will be the didactic method for education of best practices for all nurses and providers. This will be monitored through progress updates entered in the AIM Data Portal by the Data Lead. Additional educational opportunities will be provided through active learning seminars that focus on labor support education for Network Providers and Nursing Staff.

Expected participation by the following key stakeholder(s):

- OB Physician Lead and other OB Providers from your Network Hospital
- Nursing Lead and Women's Services Staff
- Data Lead

Expected responsibilities:

- Complete designated online AIM E-modules
- Attend active learning seminars with monthly team sharing
- Enter progress updates on completed education into the AIM Data Portal

Phase 2- Recognition & Reporting (suggestion to implement in months 3-9)

Data sharing of provider rates

Throughout the initiative BCBSMS will share unblinded Provider rates for the BCBSMS population in a claim-based report for all affiliated OBGYN Clinics from each Pilot Initiative Network Hospital. Hospital teams will be asked to share provider rates for their entire delivering population if they are not already doing so.

MSPQC will share global outcome measures for participating hospitals including overall cesarean rates, NTSV rates, severe maternal morbidity rates and neonatal morbidity and mortality rates. Neonatal morbidity and mortality rates will serve as a balancing measure, to ensure that rates of unexpected poor neonatal outcomes do not rise during the course of the initiative.

Expected participation by the following key stakeholder(s):

- Nursing Lead
- OB Physician Lead and other OB Providers from your Network Hospital
- BCBSMS

Expected responsibilities:

- BCBSMS shares Provider rates for each affiliated OBGYN Clinic for your Network Hospital
- Designated person from the Hospital tracks and shares all-payor Provider rates from your Network Hospital
- All Providers from your Network Hospital review their rates



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Multidisciplinary Case Reviews and Audits

Case Reviews are a key component of the AIM Safety Bundle. Initial case reviews will be facilitated by the Initiative Support Team in onsite Network Hospital meetings. The Initiative Support Team can also serve as a resource for helping Network Hospital teams establish a process to perform Case Reviews as needed. Case Reviews that are multidisciplinary will allow educational opportunities to be identified and aid in recognizing practice variations that impact delivery outcomes. The AIM Safety Bundle Multidisciplinary Case Reviews focus on cesarean deliveries resulting from common medical indications. Examples are *Dystocia/Failure to Progress*, *Failed Induction and Fetal Concern*. Monthly chart audits on 1 or more of these focus areas should guide which deliveries are discussed in the Multidisciplinary Case Review based on which indication is noted to be the primary driver of cesarean delivery in your facility.

Expected participation by the following key stakeholder(s):

- Data Lead
- Nurse Lead
- OB Physician Lead and other OB Providers from your Network Hospital
- Other key stakeholders involved in the management of the patient

Expected responsibilities:

- Complete 10 chart audits per month on 1 (or more if you choose) of the the 3 primary indication areas (Dystocia/Failure to Progress, Induction or Fetal Concern)
- Attend Phase 2 in-person meeting on-site with the Initiative Support Team
- Participate in quarterly Case Reviews
- Update the AIM Data Portal on a quarterly basis with your data collected in Case Reviews

Phase 3- Response (suggestion to implement in months 9-12)

Policy/Protocol Changes

Education on best practices (phase 1) and identifying care opportunities in Case Reviews and data review (phase 2) will guide Network Hospital teams in reviewing and revising policies and protocols accordingly. Integration of policy and protocol changes into the Electronic Medical Record is expected. The Initiative Support Team will conduct at least one onsite meeting with your team to support the policy review process. At the meeting we will share policies and protocols implemented at other facilities that were successful in initiating quality improvement programs related to supporting intended vaginal deliveries. Examples are algorithms for Pitocin Management from the California Perinatal Quality Collaborative and the Carolinas HealthCare System Policy and Clinical Guideline on Labor Management in the Nulliparous Patient.

Expected participation by the following key stakeholder(s):

- Nurse Lead
- OB Physician Lead and/or other OB Providers from your Network Hospital
- Other key stakeholders involved in the management of the patient
- Information Technology Lead



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Expected responsibilities:

- Policy/Protocol Development and Review
- Attend Phase 3 onsite meeting with the Initiative Support Team

Key Tasks and Timeline

Tasks	Key Stakeholder	Timeframe
Participate in the MSPQC Orientation Webinar on the <i>Initiative to Support Primary Vaginal Births</i> to learn about the initiative and orient your Hospital Project Team in preparation for participation	At minimum OB Physician Lead and Nurse Lead	October 2019
Engage your Network Hospital Leadership Team to confirm participation in the Initiative	Administration, Physician Lead, Nurse Lead	October 2019
Submit Hospital Commitment and Data Agreement	Designated Project Lead	October - November 2019
Attend In-person Initiative Kick Off Meeting and complete a Pre-Implementation Network Hospital Readiness Assessment (at least 2 team members per Network Hospital)	At minimum OB Physician Lead and Nurse Lead	November 2019
Establish a schedule for routine touchpoints throughout the Initiative for your Hospital Project Team to discuss implementation progress and opportunities for improvement (suggested monthly)	Designated Project Lead	December 2019
Introduce Initiative in your Network Hospital with an educational session, department meeting, or other event/announcement	Project Lead, Administrative Lead, OB Physician Lead, Nurse Lead	January 2020
Attend Phase 1 in-person meeting with Initiative Support Team	Project Team	February 2020
Attend MSPQC/BCBSMS AIM Safety Bundle Regional meeting in your area (focus will be active learning opportunities related to the supporting vaginal deliveries and collaborative learning)	OB Physicians, Nurses	April 2020
Complete AIM e-module education	OB Physicians, Nurses	January – June 2020
Attend Phase 2 in-person meeting with Initiative Support Team	Project Team	June 2020



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Establish and implement process for Case Reviews and Chart Audits	Project Team	June – September 2020
Attend Phase 3 in-person meeting with Initiative Support Team	Project Team	September 2020
MSPQC Annual Meeting-Members from the Hospital Project Team are asked to participate in a panel discussion to share successes/challenges with Bundle implementation	Project Team	November 2020
Develop new policies and protocols and review/revise existing ones	Project Team	September – December 2020
Hold regular Hospital Project Team meetings in your Network Hospital to share Provider rates based on all deliveries, review progress, discuss key components for each Phase, and establish processes to implement key components and measure outcomes (Plan, Do, Study, Act cycles are recommended)	Project Team	January – December 2020
Attend MSPQC monthly Initiative webinar meetings for collaboration and advice (includes sharing successes/challenges of Bundle implementation)	Project Team	January – December 2020
Submit quarterly updates on Bundle Implementation to the AIM Data Portal	Data Lead	January – December 2020
Complete Post-Initiative Implementation Hospital Assessment	Project Lead	December 2020

In-Person Meetings

Representatives (at least two, preferably the Nurse Lead and Provider Lead) from all Pilot Initiative Network Hospitals will be asked to participate in the following in-person meetings to learn and collaborate:

1. The Initiative Kick-Off group meeting in Jackson, MS to learn and collaborate with other Pilot Initiative Network Hospitals on best-practices related to promoting primary vaginal births and complete a baseline readiness assessment
2. Phase 1 on-site meeting at your Network Hospital with the Initiative Support Team to review your Hospital's baseline readiness assessment and discuss identified opportunities
3. Phase 2 on-site meeting at your Network Hospital with the Initiative Support Team to review progress and facilitate the process for Multidisciplinary Case Reviews
4. Phase 3 on-site meeting at your Network Hospital with the Initiative Support Team to review progress and share existing evidenced based practices and protocols to aid in your Hospital's policy development and review process



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5. MSPQC Annual Meeting where Hospital Project Teams from all Pilot Initiative Hospitals will share their successes and challenges in a panel discussion



Readiness

There are three domains of Readiness to be addressed by every facility to ensure a culture that promotes and supports intended primary vaginal births in the absence of medical indication.

Recommendations for Every Patient, Provider and Facility:

- 1. 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**
- 2. Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle**
- 3. 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/Prevention & Reporting

There are six domains of Recognition/Prevention & Reporting that should be implemented in every facility to maximize clinical planning for labor management and support and use data to drive improvement.

Recommendations for Every Patient in Every Birth Facility:

- 1. Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor**
- 2. Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor**
- 3. 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**
- 4. 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**
- 5. 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**
- 6. Track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management**



Response/Systems Learning

There are five domains of Response/Systems Learning that should be implemented in every facility for every patient to appropriately manage labor abnormalities.

Recommendations for Every Patient with Every Labor Challenge in Every Birth Facility:

- 1. Have available an in-house maternity care provider or alternative coverage which guarantees timely and effective responses to labor problems**
- 2. Uphold standardized induction scheduling to ensure proper selection and preparation of women undergoing induction**
- 3. Utilize standardized evidence-based labor algorithms, policies, and techniques, which allow for prompt recognition and treatment of dystocia**
- 4. Adopt policies that outline standard responses to abnormal fetal heart rate patterns and uterine activity**
- 5. Make available special expertise and techniques to lessen the need for abdominal delivery, such as breech version, instrumented delivery and twin delivery protocols**