Partnership for Patients
Safe Deliveries Roadmap
SPECIAL SESSION Web Conference
September 25, 2013

Advancing Patient Safety in Maternity Care:
A Roadmap from Prenatal to Postpartum

Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
Safe Deliveries Roadmap Project Coordinator

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Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
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Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
Safe Deliveries Roadmap

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Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
FEATURED GUEST

Catherine Spong, MD

Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
The Vision

Washington State Hospital Association
Safe Deliveries Evidenced-Based Roadmap®

Pregnancy
- Fewer infant abnormalities and disabilities
- Less maternal and fetal complications
- More educated patients

Evidenced-Based Care

Delivery
- Less maternal mortality and morbidity
- Fewer early deliveries
- Higher Apgar scores
- Fewer NICU admissions

First Month
- Healthier Mothers and Babies

Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
Participating Hospitals

- Cascade Valley Hospital and Clinics
- Central Washington Hospital
- Coulee Medical Center
- EvergreenHealth
- Group Health Cooperative
- Harrison Medical Center
- Highline Medical Center
- Island Hospital
- Jefferson Healthcare
- Kittitas Valley Healthcare
- Lake Chelan Community Hospital
- Legacy Salmon Creek Medical Center
- Mid Valley Hospital
- MultiCare Auburn Medical Center
- MultiCare Good Samaritan Hospital
- MultiCare Tacoma General Hospital
- Newport Hospital
- Othello Community Hospital
- Overlake Hospital
- PeaceHealth Southwest Medical Center
- PeaceHealth St. Joseph Medical Center
- PeaceHealth Sacred Heart Medical Center, Oregon
- PMH Medical Center
- Providence Holy Family Hospital
- Providence Mt. Carmel Hospital
- Providence Regional Medical Center Everett
- Providence Sacred Heart Medical Center & Children’s Hospital
- Providence St. Mary Medical Center
- Providence St. Peter Hospital
- Pullman Regional Hospital
- Samaritan Healthcare
- Skagit Valley Hospital
- St. Elizabeth Hospital
- St. Francis Hospital
- St. Joseph Medical Center – Franciscan Health System
- Sunnyside Community Hospital & Clinics
- Swedish/Ballard
- Swedish/First Hill
- Swedish/Edmonds
- Swedish/Issaquah
- Three Rivers Hospital
- University of Washington Medical Center
- UW/Northwest Hospital & Medical Center
- UW/Valley Medical Center
- Valley Hospital/Rockwood Health System
- Walla Walla General Hospital
- Whitney General Hospital
- Whitman Hospital and Medical Center
- Yakima Valley Memorial Hospital

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Updates

• LEAPT – Leading Edge Advanced Practice Topics
• Readiness Assessment
• Safe Deliveries Roadmap measures sources
Medicaid Quality Incentive
Safe Deliveries

Elective Deliveries Prior to 39 Weeks
Sustaining measure: percent of patients with Elective Deliveries 37 to less than 39 weeks gestational age

*Data collection period:*
  • July 1, 2013 – December 31, 2013

Induction Appropriateness
Improvement measure: percent of patients undergoing a medical or non medical labor induction with documentation of consent, Bishop Score, and indication

*Data collection period:*
  • September 1, 2013 - December 31, 2013

Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
Meeting Schedule - 2013

• Monthly (webcast)
  • Tuesday, October 22\textsuperscript{nd} 7:00 – 8:00 a.m.
  • Tuesday, November 5\textsuperscript{th} 7:00 – 8:00 a.m.
  • Thursday, December 5\textsuperscript{th} 7:00 – 8:00 a.m.

• Safe Table (in-person)
  • Tuesday, November 19\textsuperscript{th} 9:00 – 2:30 p.m.

2014 meeting webcasts and Safe Table dates coming soon!
Preventing the First Cesarean Delivery

Catherine Y Spong, MD
Director DER, NICHD
National Institutes of Health

Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
Conflict of Interest Statement

I have no conflict of interest related to the content of this presentation
Objectives

- To describe the rationale and background leading to the workshop on preventing the first cesarean
- Review the findings of the workshop
- Discuss the executive summary, recommendations and future needs on prevention of the first cesarean
...the initial purpose was essentially to retrieve the infant from a dead or dying mother;
Above all it was a measure of last resort, and the operation was not intended to preserve the mother's life. It was not until the 19th century that such a possibility really came within the grasp of the medical profession.
Cesarean Delivery
21st century

- Most common major abdominal surgery today
- Variety of obstetrical and medical indications
- “Too posh to push?”
Cesarean Delivery: Public Health Importance

- In USA: ~1 in 3 pregnancies are delivered by Cesarean
  - >1,200,000 cesareans
- Dramatic increase since 1995

Source: Data for 1970-1988 are from the National Hospital Discharge Survey (NHDS). Data for 1989-2003 are from the National Vital Statistics System. For 1989 the estimate of the total cesarean rate from the NHDS was 23.8 percent; the estimate from vital records was 22.8 percent. Data for 2004 are preliminary.
Cesarean vs. Vaginal Delivery

- Generally accepted overall increases in morbidity and mortality with CD
  - 2-fold increase in maternal mortality
  - Greater blood loss
  - Impaired neonatal respiratory function
  - Increased incidence of maternal PP infections
  - Fetal lacerations
  - Affects maternal-infant interaction
  - Longer recovery
  - Rehospitalization

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Hall, 1999; Levine, 2001; Dessole, 2004; Buhimschi, 2006; Lydon-Rochelle, 2000
Multiple Repeat Cesareans

Dose-dependent increase in

- Placenta accreta
- Placenta previa
- Hysterectomy
- Transfusion of $\geq 4$ units
- Maternal ICU admission


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Downstream Consequences of Rising CD Rates

- Decision analysis model
- If primary and repeat cesareans continue to rise at current rates:
- 2020:
  - CS rate of 56.2%
  - Additional 6,236 previas per year
  - Additional 4,504 accretas per year
  - Additional 130 maternal deaths per year
The Healthy People challenge

Healthy People 2010 total VBAC goal

Healthy People 2010 primary Cesarean delivery goal


Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
The Healthy People challenge

Healthy People 2020 P0 Cesarean delivery goal

Healthy People 2020 total VBAC goal


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CD: Why the increase?

- Yale-New Haven hospital, 2003-9
- 32,443 live births
- CD rate increased: 26% - 36.5%
- 50% of the increase – primary CD
  - 16.2% - 21.7%
90% 90% 23.6%

Low risk primipara, 2003

400,000 repeat cesareans for today’s low-risk primiparas

N = 265,423

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Menacker, 2005
The most effective approach to reducing overall cesarean delivery rates is to prevent the first cesarean.
NIH Interest in Cesarean Delivery
NIH Consensus Conference on Cesarean Childbirth, 1980

- September 22-24, 1980
- Focus was on primary CD
- Regarding repeat Cesareans and VBAC trials:

“In hospitals with appropriate facilities, services, and staff for prompt emergency cesarean birth, a proper selection of cases should permit a safe trial of labor and vaginal delivery for women who have had a previous low segment transverse cesarean birth.”
Preventing the First Cesarean Delivery

Summary of a Joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop

Catherine Y. Spong, MD, Vincenzo Berghella, MD, Katharine D. Wenstrom, MD, Brian M. Mercer, MD, and George R. Saade, MD

- What is driving increased cesarean rates?
- Can driving factors be modified?
- Recommendations
Indications Contributing to the Increasing 1° Cesarean Delivery Rate

- Nonreassuring fetal heart tracing (32%)
- Arrest of labor (18%)
- Multiple gestation (16%)
- Preeclampsia (10%)
- Macrosomia (10%)
- Elective (8%)
- Maternal-fetal (5%)
- Obstetric (1%)
## Major Indications for Primary CD

<table>
<thead>
<tr>
<th>Stage</th>
<th>Indication</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prelabor</td>
<td>Malpresentation</td>
<td>10–15*</td>
</tr>
<tr>
<td></td>
<td>Multiple gestation</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Hypertensive disorders</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Macrosomia</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Maternal request</td>
<td>2–8</td>
</tr>
<tr>
<td>In labor</td>
<td>First-stage arrest</td>
<td>15–30*</td>
</tr>
<tr>
<td></td>
<td>Second-stage arrest</td>
<td>10–25</td>
</tr>
<tr>
<td></td>
<td>Failed induction</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Nonreassuring fetal heart rate</td>
<td>10</td>
</tr>
</tbody>
</table>

Some indications may occur both prelabor and in labor.

* Percentage of all cesarean deliveries that have this as a primary indication.

Data from Zhang *et al* *Obstet Gynecol* 2011;118:29-38

*Obstet Gynecol* 2012;120:1181-93
### Potentially Modifiable Obstetric Indications for First CD

<table>
<thead>
<tr>
<th>Indication</th>
<th>Diagnostic Accuracy*</th>
<th>Effect on Prevention of First Cesarean Delivery†</th>
<th>Preventive Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failed induction</td>
<td>Limited</td>
<td>Large</td>
<td>See Table 5 and Figure 1</td>
</tr>
<tr>
<td>Arrest of labor</td>
<td>Limited</td>
<td>Large</td>
<td>See Table 5 and Figure 3</td>
</tr>
<tr>
<td>Multiple gestation</td>
<td>High</td>
<td>Small</td>
<td>Prevent multiple gestations: encourage single embryo transfer</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Safe trial of labor: training for vaginal twin delivery, simulation for cephalic version, or breech extraction of second twin</td>
</tr>
<tr>
<td>Preeclampsia</td>
<td>High</td>
<td>Small</td>
<td>Education: preeclampsia is not an indication for cesarean delivery</td>
</tr>
<tr>
<td>Prior shoulder dystocia</td>
<td>Limited</td>
<td>Small</td>
<td>Improved documentation as to prior shoulder dystocia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Education regarding risk of recurrence based on estimated fetal weight</td>
</tr>
<tr>
<td>Prior myomectomy</td>
<td>Limited</td>
<td>Small</td>
<td>Prior shoulder dystocia is not an absolute indication for cesarean delivery</td>
</tr>
<tr>
<td>Prior third-degree or fourth-degree laceration, prior breakdown of repair, fistula</td>
<td>High</td>
<td>Small</td>
<td>Improved documentation of prior myomectomy</td>
</tr>
<tr>
<td>Marginal and low-lying placentation</td>
<td>High</td>
<td>Small</td>
<td>Education: not an absolute indication for cesarean delivery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Education: limited ability to predict recurrence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Education: attempt at vaginal delivery acceptable as long as placenta is 1 cm or more from internal os³⁸</td>
</tr>
</tbody>
</table>

*Diagnostic Accuracy: Limited = diagnostic accuracy is limited, High = diagnostic accuracy is high
†Effect on Prevention of First Cesarean Delivery: Large = significant effect on prevention, Small = minimal effect on prevention

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*Obstet Gynecol* 2012;120:1181-93
Indications for Inductions

- ACOG practice bulletin mentions 15 medical-obstetric indications
- Logistical and psychological reasons are 2 additional reasons
- Must be 39 weeks if being induced for logistical and psychological reasons

ACOG Practice Bulletin Induction of Labor
2009

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Elective Inductions at Term

- 27 hospitals in 14 states, 2007
- 14,955 term births
- 19% of term births were elective inductions
- Rate of elective induction varied (8-40%)

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Clark SL et al AJOG 2009
4,623 low risk nullips at term

29% elective induction

aOR cesarean delivery 

2.03 (95% CI 1.73 – 2.38)

20% of all primary cesarean deliveries among nulliparous women are related to elective inductions of labor

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Ehrenthal, 2010
To avoid first CD related to induction:

- Focus on elective labor inductions
  - Avoid
  - Recognize association of CD with cervical status
  - Accept that there is no clinically useful prediction model presently available
  - Allow the induction sufficient time to progress

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Potentially Modifiable *Fetal* Indications for First CD

<table>
<thead>
<tr>
<th>Indication</th>
<th>Diagnostic Accuracy</th>
<th>Effect on Prevention of First Cesarean Delivery</th>
<th>Preventive Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malpresentation</td>
<td>High</td>
<td>Large</td>
<td>External cephalic version</td>
</tr>
<tr>
<td>Nonreassuring antepartum or intrapartum fetal surveillance</td>
<td>Moderate</td>
<td>Large</td>
<td>Education regarding correct interpretation and management (Fig. 2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Confirmatory tests (eg, scalp stimulation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intrauterine resuscitative measures (eg, IVF, position change, oxygen, etc)</td>
</tr>
<tr>
<td>Macrosomia</td>
<td>Limited</td>
<td>Small</td>
<td>Screen for and treat diabetes; limit weight gain in pregnancy</td>
</tr>
<tr>
<td>Malformations, eg, NTD, SCT, Moderate EXIT procedure, hydrops</td>
<td>Moderate</td>
<td>Small</td>
<td>Anecdotal for indication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Education: cesarean delivery not indicated for abdominal wall defects</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Multidisciplinary education of subspecialists and counseling of patients</td>
</tr>
</tbody>
</table>

Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13

*Obstet Gynecol* 2012;120:1181-93
### Potentially Modifiable Maternal Indications for First CD

<table>
<thead>
<tr>
<th>Indication</th>
<th>Diagnostic Criteria Accuracy</th>
<th>Effect on Prevention of First Cesarean Delivery</th>
<th>Preventive Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity (BMI greater than or equal to 30 kg/m²)</td>
<td>High</td>
<td>Small</td>
<td>Weight loss preconception, and limited weight gain in pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Education: obesity is not an indication for cesarean delivery and is a poor predictor of cesarean delivery</td>
</tr>
<tr>
<td>Infection (HSV, HCV, HIV)</td>
<td>High</td>
<td>Small</td>
<td>HIV treatment to minimize viral load</td>
</tr>
<tr>
<td>Cardiovascular disease (acute HTN crisis, cardiomyopathy, pulmonary HTN, cerebral aneurysm, CVA)</td>
<td>High</td>
<td>Small</td>
<td>Education: not an independent indication for cesarean delivery</td>
</tr>
<tr>
<td>Inadequate pelvis</td>
<td>Limited</td>
<td>Small</td>
<td>Education: in general, not an indication for cesarean delivery</td>
</tr>
<tr>
<td>Request (no maternal, obstetric, or fetal indication)</td>
<td>Not applicable</td>
<td>Small</td>
<td>Education of patient and provider regarding acute complications and long-term risks, benefits, and effect of cesarean delivery on mother and newborn; specific education on fear of labor</td>
</tr>
</tbody>
</table>

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Definitions:
Failed Induction and Arrest Disorders

Failed induction of labor
Failure to generate regular (e.g., every 3 min) contractions and cervical change after at least 24 h of oxytocin administration, with artificial membrane rupture if feasible.

First-stage arrest
6 cm or greater dilation* with membrane rupture and no cervical change for
4 h or more of adequate contractions (e.g., >200 Montevideo units) or
6 h or more if contractions inadequate

Second-stage arrest
No progress (descent or rotation) for
4 h or more in nulliparous women with an epidural
3 h or more in nulliparous women without an epidural
3 h or more in multiparous women with an epidural
2 h or more in multiparous women without an epidural

* Since women may still be in latent labor, additional time and interventions may be needed in order to diagnose an arrest of active labor before 6 cm dilatation (see Figure 1 for suggested management).
Rethinking Friedman: Contemporary Patterns of Spontaneous Labor

- EMR from 19 US hospitals
- 62,415 women at term, spontaneous labor, vaginal delivery, normal outcomes
- Constructed labor curves using the same methods as Friedman

Zhang, *Obstet Gynecol*, 2010
Average labor curves

Zhang, *Obstet Gynecol*, 2010

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95% similar N&M

Multip. labor speeds up

<table>
<thead>
<tr>
<th>Cervical Dilation (cm)</th>
<th>Parity 0 ( n=25,624 )</th>
<th>Parity 1 ( n=16,755 )</th>
<th>Parity 2+ ( n=16,219 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–4</td>
<td>1.8 (8.1)</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>4–5</td>
<td>1.3 (6.4)</td>
<td>1.4 (7.3)</td>
<td>1.4 (7.0)</td>
</tr>
<tr>
<td>5–6</td>
<td>0.8 (3.2)</td>
<td>0.8 (3.4)</td>
<td>0.8 (3.4)</td>
</tr>
<tr>
<td>6–7</td>
<td>0.6 (2.2)</td>
<td>0.5 (1.9)</td>
<td>0.5 (1.8)</td>
</tr>
<tr>
<td>7–8</td>
<td>0.5 (1.6)</td>
<td>0.4 (1.3)</td>
<td>0.4 (1.2)</td>
</tr>
<tr>
<td>8–9</td>
<td>0.5 (1.4)</td>
<td>0.3 (1.0)</td>
<td>0.3 (0.9)</td>
</tr>
<tr>
<td>9–10</td>
<td>0.5 (1.8)</td>
<td>0.3 (0.9)</td>
<td>0.3 (0.8)</td>
</tr>
<tr>
<td>Second stage with epidural analgesia</td>
<td>1.1 (3.6)</td>
<td>0.4 (2.0)</td>
<td>0.3 (1.6)</td>
</tr>
<tr>
<td>Second stage without epidural analgesia</td>
<td>0.6 (2.8)</td>
<td>0.2 (1.3)</td>
<td>0.1 (1.1)</td>
</tr>
</tbody>
</table>

Data are median (95th percentile).

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Zhang, *Obstet Gynecol*, 2010
95\textsuperscript{th} \%iles of first stage duration in nulliparas, by dilation at admission

- Dilation at admission affects patterns of labor progression
- Protraction/arrest disorders should be diagnosed on upper limits of normal, not averages

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Zhang, *Obstet Gynecol*, 2010
Contemporary labor

- Not what it used to be: labor progresses more slowly
- More measured, nuanced approach to diagnosis of first stage arrest
  - Redefine active phase
  - Redefine arrest
- First stage duration varies with dilation at admission

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Duration of CM change in cervical dilation for nulliparous women with spontaneous labor

<table>
<thead>
<tr>
<th>Cervical Change (cm)</th>
<th>Median (h)</th>
<th>95th Percentile (h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–4</td>
<td>1.8</td>
<td>8.1</td>
</tr>
<tr>
<td>4–5</td>
<td>1.3</td>
<td>6.4</td>
</tr>
<tr>
<td>5–6</td>
<td>0.8</td>
<td>3.2</td>
</tr>
<tr>
<td>6–7</td>
<td>0.6</td>
<td>2.2</td>
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<tr>
<td>7–8</td>
<td>0.5</td>
<td>1.6</td>
</tr>
<tr>
<td>8–9</td>
<td>0.5</td>
<td>1.4</td>
</tr>
<tr>
<td>9–10</td>
<td>0.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Data from Zhang et al Obstet Gynecol 2010;116:1281-7
Obstet Gynecol 2012;120:1181-93
PATIENCE

"A jug fills drop by drop."
-Buddha
Induced labor algorithm

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*Obstet Gynecol* 2012;120:1181-93
Spontaneous labor algorithm

Spontaneous labor*

3–5.9 cm
- No cervical change: Supportive care†
  - Cervical change: Continue labor

At least 6 cm
- No cervical change: Cervical change
  - Rupture of membranes: Continue labor
- Cervical change: No cervical change despite adequate contractions for at least 4 hours
  - Inadequate contractions; no cervical change for at least 6 hours: Consider cesarean delivery

*Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13

Obstet Gynecol 2012;120:1181-93
Key points 1:

- A cesarean delivery that is performed without an accepted indication should be labeled as such, i.e., “nonindicated cesarean delivery.” The term “elective cesarean delivery” should be avoided.

- Labor induction should be performed only for medical indication; if done for nonmedical indications, the gestational age should be 39 weeks or more, and the cervix should be favorable (Bishop score more than 8), especially in the nulliparous patient.
Key points 2:

- The diagnosis of failed induction should only be made after an adequate attempt. Failed induction is defined as failure to generate regular (e.g., every 3 minutes) contractions and cervical change after at least 24 hours of oxytocin administration with artificial membrane rupture if feasible.

- Adequate time for normal latent and active phases of the first stage, and for the second stage, should be allowed unless expeditious delivery is medically indicated (Table 5; Figs. 1 and 3).
Key points 3:

- In the presence of reassuring maternal and fetal status, the diagnosis of arrest of labor should not be made until adequate time has elapsed. This includes greater than 6 cm dilation with membrane rupture and 4 or more hours of adequate contractions (e.g., greater than 200 Montevideo units) or 6 hours or more if contractions inadequate with no cervical change for first-stage arrest. For second-stage arrest, no progress (descent or rotation) for more than 4 hours in nulliparous women with an epidural, more than 3 hours in nulliparous women without an epidural, more than 3 hours in multiparous women with an epidural, and more than 2 hours in multiparous women without an epidural should be considered, with no cesarean delivery for this indication before these time limits (Table 5).
Key points 4:

- Intermittent auscultation, done appropriately, is an acceptable method for labor management in low-risk patients without heart rate abnormalities.

- In the patient with moderate fetal heart rate variability, other findings have little association with neurologic damage or acidosis.

- Medically indicated operative vaginal delivery is an acceptable birth method. Given the current rates, it is critical that training and experience in operative vaginal delivery are augmented and encouraged.
Key points 5:

- Doctors who are salaried and participate in profit-sharing, thus reducing the financial incentive to limit the time spent managing labor, have lower cesarean delivery rates.

- When discussing the first cesarean delivery with a patient, counseling should include its effect on subsequent pregnancy risks such as uterine rupture and placental implantation abnormalities including placenta previa and accreta.
Quality Measures

- Rate of nonmedically indicated cesarean delivery
- Rate of nonmedically indicated induction
- Rate of labor arrest or failed induction diagnosed without meeting accepted criteria
- Rate of cesarean deliveries for nonreassuring fetal heart rate by *Eunice Kennedy Shriver National Institute of Child Health and Human Development* category\(^{14}\)

*For singleton gestation, vertex presentation, at 37 0/7 to 41 6/7 weeks of gestation.*
Strategies to Reduce Cesarean Birth

“No approach dominated as a strategy appropriate to reduce use of cesarean in low-risk women in the United States.”
Additional Recommendations

- Education
  - Accepted indications
  - Long term consequences
- Documentation
- Audit and feedback on non-indicated deliveries
- Clear hospital policies on inductions, definitions

Presented at Washington State Hospital Association Partnership for Patients Safe Table Web Conference, 9/25/13
Considerations

- Workshop: first step to address the issue and raise attention
- Executive summary: starting point
  - Refinement
  - Adaptation to local practice
  - Guidance
- Need evidence that implementation of practices changes outcomes

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First steps:

- Identified as priority issue
- Leaders identified
- Algorithms & checklists modified to your needs
The goal

Healthy mothers, children, and families

Thank you

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Partnership for Patients Safe Table Web Conference, 9/25/13
Questions?

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Safe Deliveries Roadmap Website
http://www.wsha.org/0513.cfm%20

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