



Acknowledgements

Improving the health outcomes of maternal and infant populations is a critical priority in Missouri. The Missouri Perinatal Quality Collaborative serves as a statewide convener, resource, and change agent to support decreased variations in care and outcomes, support optimized use of evidence-based practice, and support clinical-community integration — all noted gaps in achieving equitable and improved health.

These efforts would not be possible without the collective vision and collaboration of the Missouri Department of Health and Senior Services, Missouri Hospital Association, and members of the Missouri Maternal-Child Learning and Action Network. MC LAN members represent a diverse group of stakeholders from clinical backgrounds, professional associations, government agencies, community-based organizations and community representatives who have committed support to reducing maternal morbidity and mortality in Missouri, including the March of Dimes, Missouri Section of the American College of Obstetricians and Gynecologists, Missouri Chapter of the American Academy of Pediatrics, Missouri Primary Care Association, Missouri DHSS, Missouri Department of Social Services MO HealthNet Division, Missouri Foundation for Health, Missouri Chapter of the Association of Women's Health, Obstetric and Neonatal Nurses, Nurse Practitioners in Women's Health Association, Missouri Chapter of the Amniotic Fluid Embolism Foundation, Generate Health, St. Louis Integrated Health Network, Bootheel Perinatal Network, Healthy Blue MO, Home State Health, United Healthcare, Nurture KC, Promise 1000, M-Brace Birthing, SafiMoms365, the Doula Foundation and Simply Strategy. These partners successfully aligned efforts to bring Alliance for Innovation on Maternal Health initiatives to Missouri in 2019 and connect directly to the Missouri Pregnancy-Associated Mortality Review Board which identifies leading causes of morbidity and mortality.

The MO PQC also acknowledges the contributions of AIM, the national, cross-sector commitment designed to lead in developing and implementing patient safety bundles to promote safe care for every U.S. birth. Founded in 2014 through a cooperative agreement funded by the Health Resources and Services Administration, and executed by ACOG, the AIM program provides expert technical support and capacity building to multidisciplinary state-based teams, most often perinatal quality collaboratives, leading targeted rapid-cycle quality improvement via implementation of patient safety bundles. An AIM patient safety bundle is a structured way of improving the process of care and patient outcomes: a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes. Patient safety bundles are developed by expert multidisciplinary working groups, supported by the AIM staff at ACOG. Working groups include representatives appointed by professional member organizations, known experts and researchers specializing in the clinical topic, and patients with lived experience. The bundle development process includes design of measure and metrics for implementation and multiple levels of review from engaged stakeholders.¹

The MO PQC leverages AIM patient safety bundles as one option to support implementation of evidence-based practice and care delivery redesign for birthing units, providers, and communities throughout the state.

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The Evidence

Cesarean birth is a critical obstetric procedure that saves lives when vaginal delivery is not safe for the pregnant person or baby. However, there has been a significant and varying increase in cesarean birth rates, raising concerns about the quality and cost of maternity care.² Between 1998 and 2019, cesarean birth rates in the United States soared from 21.2% to 31.7% of all births, with first-time cesarean deliveries increasing from 18.7% to 25.6%.³

According to the Centers for Disease Control and Prevention, Black birthing people are nearly three times more likely, and American Indian/Alaska Native birthing people are twice as likely to die from pregnancy-related causes compared to white birthing people.³ Increased surgical birth interventions in Black and AI/AN populations contribute to increased rates of mortality. The rate of cesarean sections among Black maternal patients surpasses that of other racial/ethnic groups, and low-risk pregnancies in women of color often result in higher rates of cesarean deliveries, often without determined medical necessity.⁴ A study looking at factors associated with the higher number of cesarean deliveries among Black patients found, that even after adjusting data related to the increased incidence of hypertensive disorders and preterm gestation in Black pregnancies, there is not a clear explanation as to why Black patients have a higher percentage of cesarean deliveries. Anecdotal reports suggest that poor provider-patient interactions, mistaken beliefs about some patient groups and lack of prenatal education concerning the risks of cesarean birth may impact these numbers.⁵ It is imperative to address these disparities by evaluating systems of care, reviewing quality data sets for disparities and identifying interventions to mitigate them.

Cesarean birth in generally low-risk birthing people <u>without medical indication</u> increases the risk for severe maternal morbidity and mortality, including the risk of hemorrhage, uterine rupture, abnormal placentation and cardiac events. Because the rate of vaginal birth after cesarean

remains below 15% in the U.S., the biggest risk of the first cesarean may very well be the likelihood of enduring subsequent cesareans. The risk of uterine rupture, uterine atony, placenta previa, placenta accreta and surgical adhesions increases with each cesarean birth. By the third cesarean, the risk of placenta previa nearly triples, and roughly 40% of people with placenta previa also will have placenta accreta. Psychological stress, anxiety and post-traumatic stress disorder also have been identified as risk factors of cesarean birth. Patients also experience less acute but significant consequences: longer hospital stays, increased pain and fatigue, and slower return to normal activities and productivity. 9,10,11,12

The risks associated with cesarean birth for neonates are equally troubling. Apart from fetuses in breech presentation, neonates experience few benefits from cesarean birth versus vaginal birth. Despite rising cesarean rates in recent decades, cerebral palsy rates have remained unchanged — a signal that cesarean births are not mitigating adverse fetal/neonatal neurologic effects. Hevidence also suggests that babies born by cesarean are actually more likely to experience significant health consequences, including higher rates of serious respiratory complications and increased admission to the neonatal intensive care unit. Cesarean birth historically poses obstacles to early breastfeeding support, delays the initiation of feeding and may impede early skin-to-skin contact, all of which negatively impact the ability to exclusively breastfeed.

The financial impact of cesarean births extends far beyond the procedure itself, affecting insurers, employers, taxpayers, the government and, ultimately, consumers. Research on hospital and provider payments shows that each cesarean delivery costs \$5,000 to \$10,000 more than a vaginal birth. Additionally, individuals who have undergone a previous cesarean often require subsequent cesareans, further escalating costs. These costs do not include subsequent costs incurred through cesarean section risk, including blood clots, infection, pain and scarring, and mental health sequelae.^{16,17}



The following strategies have been identified as key for reducing primary cesarean births that are not medically indicated. 18

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Improv	e the culture of care, awareness and education for cesarean reduction.
	Improve quality of and access to childbirth education. Improve communication through shared decision making at critical points in care. Bridge the provider knowledge and skills gap. Improve support from senior hospital leadership and harness the power of clinical champions. Transition from paying for volume to paying for value.
Suppor	t intended vaginal birth.
	Implement institutional policies that uphold best practices in obstetrics, safely reduce routine interventions in low-risk people and consistently support vaginal birth.
	Implement early labor supportive care policies and establish criteria for active labor admission.
	Improve the support infrastructure and supportive care during labor. Encourage partnerships with doulas and work collaboratively to provide continuous labor support.
	Utilize best practice recommendations for laboring patients with regional anesthesia (epidural, spinal and combined spinal epidural).
	Implement intermittent fetal monitoring policies for low-risk birthing people. Implement current treatment and prevention guidelines for potentially modifiable conditions (such as external cephalic version for breech babies and oral suppressive therapy for patients with a history of genital herpes).

Manage labor abnormalities and safely reduce cesarean births.
 Create highly reliable teams and improve interprofessional communication at critical points in care. Implement standard diagnostic criteria and standard responses to labor challenges and fetal heart rate abnormalities. Utilize operative vaginal delivery in eligible cases (vacuum, forceps). Identify malposition and implement appropriate interventions. Consider alternative coverage programs (laborist models and physician/midwife collaborative practice models). Develop systems that facilitate safe, patient-centered transfer of care between the out-of-hospital birth environment and the hospital. Reduce liability-driven decision making by focusing on quality and safety and support of vaginal birth.
Use data to drive reduction in cesarean births.
 Make data compelling to providers. Assist organizations to understand data associated with their hospital and identify steps to improve care. Assist providers to understand their cesarean rates and be comfortable with the quality of the data. Engage patients, employers and the public in the improvement project.
Integrate midwives and doulas into the birth care team.
 In low-risk pregnancies, midwifery care in labor is associated with decreased intervention and decreased cesarean and operative vaginal births.¹⁹ Doulas have been found to reduce the rates of cesarean birth,²⁰ premature deliveries and the length of labor, while improving breastfeeding success and reducing anxiety and postpartum depression.²¹
Counsel patients who request elective cesarean deliveries.
If the patient's main motivation for an elective cesarean delivery is fear of pain in childbirth, providers should discuss and offer the patient options for analgesia for labor, as well as perinatal childbirth education and emotional support during labor.
☐ In the absence of maternal or fetal indications for cesarean delivery, a plan for
vaginal delivery is safe and appropriate and should be recommended. After exploring the reasons behind the patient's request and discussing risks and
benefits, if a patient decides to pursue cesarean delivery on maternal request: delivery should not be performed before a gestational age of 39 weeks because of the high repeat cesarean delivery rate, patients should be informed of the following risks that increase with each subsequent cesarean delivery: placenta previa placenta accreta spectrum
gravid hysterectomy ²²



Missouri's Call to Action

The Missouri PAMR Board reviews all deaths of women and birthing people while pregnant or within one year of the end of the pregnancy. Pregnancy-associated death is the overarching term used when referring to maternal deaths. Within this broad categorization are more specific terms to describe the cause of death, including pregnancy-related death; pregnancy-associated, but not related (PANR) death; and pregnancy-associated, but unable to determine relatedness.²³ See definitions below.

Pregnancy-related death: Death occurring during or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiological effects of pregnancy²³

PANR: Death during or within one year of pregnancy from a cause that is not related to pregnancy²³ (e.g., pregnant person who dies in a natural disaster)

Pregnancy-associated, but unable to determine relatedness: Cases when the board was unable to determine if a death was pregnancy-related or PANR²³

Maternal morbidity: Any health condition attributed to and/or aggravated by pregnancy and childbirth that negatively impacts women's health short-term or long-term (Updated June 2024).²³

Maternal mortality: The World Health Organization defines a maternal death as "a death while pregnant or within 42 days of the end of the pregnancy from any cause related to or aggravated by pregnancy or its management, but not from accidental or incidental causes." In Missouri, the term maternal mortality is used to describe the death of a person during pregnancy, childbirth and the postpartum period up to 365 days from the end of a pregnancy (Updated June 2024).²³

Cesarean deliveries can be lifesaving, but unnecessary cesarean deliveries can increase unexpected complications, such as infection, organ injury, blood clots or hemorrhage. The low-risk cesarean rate has been increasing across the U.S. and currently is 26.3%.²⁵ In 2022, Missouri's low-risk



cesarean rate was 24.5%, which is the highest it has been since 2018.²⁶ The federal initiative, Healthy People 2030, aims to reduce cesarean births among low-risk birthing people, with the goal of a 23.6% NTSV (Nulliparous, Term, Singleton, Vertex) Cesarean Birth Rate for all primary births.

Despite knowing that women who deliver vaginally after a previous cesarean are less likely to experience birth-related morbidity, such as blood transfusion, ruptured uterus, unplanned hysterectomy and admission to the intensive care unit than women who have repeat cesareans, the vaginal birth after cesarean delivery (VBAC) rate in Missouri is only 15.8%, well below the Healthy People 2020 target of 18.3%.²⁷

Support from a doula has been linked to decreased rates of cesarean sections, vaginal deliveries with instrumentation, and less need for pain medication — further decreasing the odds of infections, blood clots, obstetric hemorrhage and surgical-related adverse events. ^{20,21} With the guidance of a doula, mothers are two times less likely to experience a birth complication and four times less likely to have a baby with low birth weight. ²⁸ And, for those who do require higher birth interventions, doulas can be a helpful emotional support and a trusted information source for the birthing person and their family during these intense, often frightening moments.

Reimbursement for doula care is expected in the coming year for Medicaid beneficiaries through MO HealthNet. Currently, the managed care organizations contracted to provide Medicaid benefits and case management are providing doula reimbursement in lieu of services contract agreements with individual doulas or doula organizations. Based on the evidence in support of doula care to improve maternal and infant birth outcomes, birthing units are encouraged to consider policy and process changes that support doula care throughout the pregnancy, intrapartum and postpartum phases.

The MO PQC encourages all stakeholders in maternal-infant health to take action to reduce severe maternal morbidity and maternal mortality by reducing the numbers of primary cesarean births. While not all cesareans are preventable, implementing strategies to reduce the number of primary cesarean births can help reduce maternal mortality and morbidity in Missouri.



AIM Bundle Components²⁹

An AIM patient safety bundle is a structured way of improving the process of care and patient outcomes: a small, straightforward set of evidence-based practices that, when performed collectively and reliably, have been proven to improve patient outcomes.

Readiness — Every Care Setting

Develop provider, patient, community, and 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.
Consider conducting a <u>Labor Culture Survey</u> to develop a better understanding of the current state and how unit culture may be affecting patient care. Use the results to identify opportunities for staff training, coaching and support.
Develop mechanisms for peer feedback, pairing providers with lower cesarean rates and those with higher rates to facilitate coaching and support.
Develop and document a process for training, recruiting, and incorporating midwives into active clinical practice and team-based care on labor and delivery
units to support low intervention birth. Consider developing processes for incorporating community-based midwives into the care team upon transfer from home birth or birth center to hospital birth
to support continuity of care. Provide resources, support, and opportunities for providers to discuss and openly communicate fears related to legal risk and malpractice concerns and understand strategies to reduce the risk of litigation.

birth the decision and account	e education to pregnant people and families related to their options for labor and aroughout the perinatal cycle, with an emphasis on informed consent and shared in making. All education should be aligned with health literacy, culture, language ressibility needs. A designated support person(s) should be included in all teaching tient permission (or as desired).
	Antepartum and intrapartum education should include the following. — childbirth education, including description of normal labor physiology and process, benefits of spontaneous onset, progress and potential duration
	☐ realistic expectations about the length of the labor process and pain during labor, especially during an induction
	☐ risks and benefits of elective labor induction
	☐ knowledge about the second stage of labor (pushing), approaches to promote progress, including position changes and breathing techniques
	☐ information about labor support, including doula care
_	☐ explanation of pain management options
	Postpartum education should include the following.
	review of warning signs/symptoms and how to seek needed care
	reinforce the importance of postpartum patient follow-up
	summarize delivery events, treatments provided and offer the opportunity
	to debrief on the birth experience
	Work with patients and their support networks, including doulas, on the creation of a flexible birth plan that includes decisions they may need to make during labor
	and delivery. Support patients to create a vaginal birth plan and an alternative
	cesarean birth plan to ensure their wishes are honored as much as possible if a
	cesarean birth becomes necessary. See the Resources section of this document for
	templates and other birth plan resources.
	Translate and contextualize all standard, evidence-based patient education into
	the languages commonly spoken in the populations you serve.

acilitate multidisciplinary education to health care team members on approaches that naximize the likelihood of vaginal birth.
 ☐ The health care team should include the following individuals. ☐ OB-GYNs ☐ family medicine physicians (FP-OB and family practice physicians that provide prenatal and postpartum care) ☐ midwives ☐ physician associates ☐ women's health nurse practitioners ☐ nursing staff ☐ anesthesia providers
doulas
Topics to be addressed include the following.
 □ assessment of labor □ Provide regular staff training and certification in all forms of fetal assessment and interpretation, including electronic monitoring and intermittent auscultation. □ Encourage all OB providers to complete fetal monitoring training upon hire and again every two years. □ methods to promote labor progress □ labor support □ coping mechanisms
☐ pain management (both pharmacologic and nonpharmacologic)
□ shared decision making □ Identify key decision points that may influence risk for a cesarean birth (e.g., method of cervical ripening, admission criteria, use of Pitocin, category II electronic fetal monitoring tracings, failure to
progress) and design shared decision-making guides. Work with patients and their support networks, including doulas, on the creation of a flexible birth plan that includes decisions they may need to make during labor
and delivery. ³⁰ Support patients to create a vaginal birth plan and an alternative cesarean birth plan to ensure that their wishes are honored as much as possible if a cesarean birth becomes necessary. ³¹

	g on trauma-informed care and health care team member biases should be zed for all of the health care team. This training should include the following. Develop a holistic approach that moves beyond annual training, and may include e-modules, grand rounds, skill days, and opportunities for feedback, reflections and discussion. Train all staff (including receptionists) in active listening and trauma-informed care to ensure all patients, regardless of their race, ethnicity, religion, gender expression, sexual orientation, etc., are heard and respected. Identify patients who have a history of trauma, including birth trauma and loss, upon admission. Work with patients and their support person(s) to co-design responsive and supportive care plans. Consider utilizing electronic health record tools and alerts to indicate a history of trauma or PTSD.
☐ Implem for peo	nent standardized admission criteria, triage management, education and support ple presenting in spontaneous labor. Review admission criteria for patients presenting in labor and train triage staff in addressing active labor status. Consider cervical progression (e.g., 6 cm. vs. 4 cm.) as part of admission criteria as well as hospital resources and patient care needs. Design criteria for standardization but also include flexibility for the dynamic nature of childbirth and patient needs. Train clinicians and staff in providing guidance and suggestions for patients and their support person(s) during early labor if they are not ready to be admitted to the labor unit. Develop standardized, evidence-based approaches to induction of labor processes, such as the use of Bishop scores to address cervical readiness, to ensure optimal opportunities for success. Develop standard protocols for safe outpatient induction initiation, including strategies to support cervical ripening. 32

	comfort measures that promote labor progress and prevent dysfunctional labor.
	 □ Standardize movement in labor for all birthing individuals of all body weights/ types and ensure adequate and safe support for staff to enable movement for patients with elevated body mass index (e.g., use of wireless monitoring devices).³³ □ Make available the use of nonpharmacologic labor support techniques, such as hydrotherapy, nitrous oxide, therapeutic rest, and hands-on support with positioning and peanut balls, and provide training for clinicians and staff on the labor unit in how to use these tools.³⁴
	Use standardized methods in the assessment of the fetal heart rate status, including interpretation and documentation, and encourage evidence-based positioning and patient movement in labor.
	 Provide standardized criteria for fetal monitoring (intermittent auscultation, remote monitoring, or continuous monitoring in and out of bed) to promote maximum movement and comfort in combination with safety.³⁵ Develop evidence-based unit standards for interpretation of fetal heart tracings and decision-making guidelines for providers. One example is California Maternal Quality Care Collaborative's Algorithm for Management of Category II Fetal Heart Rate Tracings. Conduct multidisciplinary reviews of fetal heart rate strips to encourage communication between clinicians and promote the use of a common language.^{36,37}
	Implement protocols for timely identification of specific conditions, such as active herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.
	 Develop and implement standard processes for assessing and documenting fetal position between 35 and 37 weeks to proactively diagnose breech presentation. Develop and implement standard processes for identifying active herpes cases and proactively managing throughout pregnancy to allow for the possibility of vaginal delivery.³⁸ Track cases of undiagnosed breech and untreated herpes cases by provider and clinic to identify patterns in missed diagnoses and opportunities for education and training.
	Implement standardized approaches to promote evidence-based interventions for conditions, such as macrosomia, low-lying placenta and oligohydramnios.
	 Consider a second-level review for indications for cesarean birth with limited evidence (e.g., macrosomia).³⁹ Regularly review, update, and provide training for providers on current guidelines related to diagnosis and management of oligohydramnios and low-lying placenta, as well as considerations for decision making for these conditions.^{40,41} Develop a standardized approach and create standard tools (e.g., checklists, educational materials) for diagnosis and management of gestational diabetes to prevent large-for-gestational-age cesarean deliveries.
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☐ Ensure availability and offer a range of standard techniques of pain management and

Response — Every Event

	Ensure availability of clinicians, staff, and resources to maintain appropriate ongoing labor assessment and support, and respond to labor process disruptions and emergencies.
	 Standardize the use of team huddles to review indications for a cesarean birth and identify additional strategies to try before deciding on a cesarean birth.⁴² Encourage care team discussions about progress of labor to take place at the bedside with the entire team. Conduct regular simulations with a multidisciplinary team for scenarios that
	may occur on the labor and delivery unit that could result in a cesarean birth (see the Resources section for examples of simulations). For small facilities without a full in-house surgical team, consider conducting simulations of an emergency cesarean birth to develop comfort and preparedness with situations that may arise.
	Revise hospital policies to ensure that doulas are acknowledged as part of the care team and not considered visitors. 43,44
	Uphold comprehensive standardized induction scheduling with shared decision making, planning and preparation of patients undergoing induction. ⁴⁵
Ш	Utilize standardized evidence-based labor algorithms, policies and techniques, which allow for prompt recognition and treatment of dystocia and are consistent with the diagnosis of labor dystocia criteria.
	Adopt policies that outline standard responses to abnormal fetal heart rate patterns and uterine activity to avoid unnecessary intervention and maintain high-quality neonatal outcomes.
	Regularly review clinical guidelines and <u>algorithms</u> ⁴⁶ related to fetal heart rate abnormalities and ensure that guidelines and protocols are written up in easily accessible locations. ⁴⁷
	Include situations with fetal heart rate abnormalities as part of simulations to allow providers to practice response and decision making in these situations.
	Provide clinician training, skill development, or referral expertise and techniques to lesser the need for abdominal delivery, such as breech version, instrumented delivery and twin delivery protocols.
	Facilitate access to broader training for providers, especially those who work in low-volume facilities, on different techniques for assisted vaginal deliveries, breech and twin deliveries. One example of this training is Advanced Life Support in Obstetrics (ALSO) . Multidisciplinary drills in high-risk, low-volume procedures should cover the following.
	☐ identifying location of operative delivery equipment (e.g., forceps, vacuum extractors)
	☐ practice opportunities for all credentialed clinicians on operative vaginal delivery equipment
	□ process for an external cephalic version□ support of twin birth processes and procedures
	☐ integration of patient-centered, empathetic, trauma-informed care ☐ Identify hospital champions for specific skills and procedures, including foley bulb placement, breech and forceps deliveries, intrapartum fetal head rotation, twin deliveries, and external cephalic version, and engage them in training and
	support for other providers, including residents. Use a data-driven approach to identify champions, keeping in mind that they may not be in leadership roles.
	Look at success rates with various techniques and approaches. Facilitate access to consults for specialized procedures, such as ECV, operative vaginal deliveries, and twin deliveries, and identify referral options if these procedures cannot be offered locally.

Reporting and Systems Learning — Every Unit

Perform regular multidisciplinary reviews of indications for cesarean births to determine alignment with established standards to identify systems issues and variations in provider performance.
 Collect and report out on provider-level cesarean birth rates (physicians and nurses) and provide tools and resources for providers to support them in understanding and reflecting on the data without judgment or blame. Have nurses report out during shift huddles to encourage ownership of quality improvement efforts. Identify and engage clinical champions who have achieved low cesarean birth rates to share best practices, lead trainings, and support and coach other providers.
Develop realistic standards for the organization to achieve and maintain. As feasible, provide comparison data from other hospitals with similar populations to set appropriate benchmarks.
Monitor appropriate metrics and balancing measures, including maternal and newborn outcomes resulting from changes in labor management strategies, with disaggregation by race and ethnicity due to known disparities in rates of cesarean delivery.
Develop methods for collecting feedback from groups that are historically underrepresented in patient surveys, particularly those identifying as Black, Indigenous and People of Color (BIPOC), and provide explanations to patients on how the data will be used.
Use, and review regularly as a clinical team, a balanced set of <u>process measures</u> that include adherence to admission criteria, appropriate management of labor, indication for induction and Bishop score with induction outcomes.
☐ Include balancing measures, such as severe unexpected newborn complications, unplanned NICU admissions, third- and fourth-degree lacerations, and OB hemorrhage, for both birthing people and newborns as a standard measure on system dashboards.
Review all process and outcome data disaggregated by race, ethnicity and language to assess for inequities with unit-specific and leadership teams.
Establish a culture of multidisciplinary planning, huddles and post-event debriefs for implanned cesarean births, which identify success, opportunities for improvement and action planning for future events.
Conduct regular reviews of unplanned cesarean births, including indications for performing the cesarean birth, to identify specific areas for improvement, education and training. Establish standardized briefing documentation to capture
successes and actionable follow-up. Recognize "saves" (NTSV vaginal deliveries) and acknowledge the clinical team who participated to encourage shared learning and positive case reviews. Use a standard process for making clinical and delivery notes in EHR (e.g., dot phrase notes) to accurately capture indications for a cesarean birth and support subsequent data review.

Respectful, Equitable and Supportive Care — Every Unit/Provider/Team Member

	respected members of and contributors to the multidisciplinary care team.	
	respected members of and contributors to the multidisciplinary care team. Review birth plans and preferences with patients and their support networks and adhere to the birth plan as much as possible, discussing openly with patients when plans may need to shift. Use trauma-informed language to discuss potential complications with patients and avoid fearful or threatening language when discussing the option to have a cesarean birth. Engage patients and their families in decision making about their care at every point, from admission through discharge, including during rounds. Keep patients and their families/support person(s) updated throughout their hospital admission about how labor is progressing and inform them about any potential risks or concerns. Involve patients and families/support person(s) in process improvement in inpatient and outpatient settings, and co-design tools and resources. Engage in open, transparent and empathetic communication with pregnant and postpartum people and their identified support network to respond to their concerns. Provide communication in the patient's preferred language and support access to interpretation services; provide educational materials for patients in common languages spoken in your community. Educate clinicians on providing respectful care by engaging in the lifelong learning of cultural humility, understanding that individuals cannot learn all aspects of any culture, including their own.	
	 Provide education during prenatal care about decisions that might need to be made during delivery and provide resources to patients and their support networks on how to advocate for their needs and wishes during labor and delivery. Allow space for patients and their support person(s) to advocate for a delivery that they are comfortable with, not just what is best for providers and the care team. 	
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Resources

Trauma-informed Care

Substance Abuse and Mental Health Services Administration: <u>SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach</u>

Trauma-Informed Care Implementation Resource Center: All Resources

Medical Education Online: Trauma-Informed Care in the Emergency Department: Concepts and Recommendations for Integrating Practices Into Emergency Medicine

Journal of Obstetric, Gynecologic & Neonatal Nursing: National Partnership for Maternal Safety: Consensus Bundle on Support After a Severe Maternal Event

AIM: Patient Support After a Severe Event: The Importance of Providing Trauma-Informed Care

AIM: Implementing a Clinician and Staff Peer Support Program

Patient-facing Education on Inductions, Labor Procedures and Cesarean Birth

National Partnership for Women & Families: What Every Pregnant Woman Needs to Know About Cesarean Birth

March of Dimes: Medical Reasons for Inducing Labor

Consumer Reports Health: Monitoring Your Baby's Heartbeat During Labor

ACOG: If Your Baby Is Breech

Labor Dystocia/Failed Induction Resources

CMQCC: Pre-Cesarean Checklist for Labor Dystocia or Failed Induction

Unit and Physician Education

CMQCC: Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates

Spinning Babies[®] - a physiological approach to preparing for and caring for birth

American Journal of Obstetrics & Gynecology: The Evolution of the Labor Curve and Its Implications for Clinical

Practice: The Relationship Between Cervical Dilation, Station, and Time During Labor

PLOS ONE: Timing of Hospital Admission at First Childbirth: A Prospective Cohort Study

ACOG: <u>Hospital-Based Triage of Obstetric Patients</u>

Simulations

Agency for Healthcare Research and Quality: In Situ Simulation
ACOG: Resource Binder: A Guide to Accompany OB Drill Binders

Fetal Monitoring

AWHONN: Fetal Heart Monitoring Education Programs

American College of Nurse Midwives: <u>Clinical Bulletin No. 18: Induction of Labor CMQCC: Algorithm for the Management of Category II Fetal Heart Tracings</u>

Prenatal Risk Management and Education Services: <u>Intrapartum FHR Monitoring Management Decision Model</u>©

Induction of Labor

ACOG: Labor Induction

ACOG: Committee Opinion No. 831: Medically Indicated Late-Preterm and Early-Term Deliveries

Facilitating Movement During Labor, Pain Management

Evidence Based Birth®: Positions During Labor and Their Effects on Pain Relief

American Journal of Obstetrics & Gynecology MFM: Impact of Therapeutic Rest in Early Labor on Perinatal Outcomes: A Prospective Study

Journal of Perinatal Education: Healthy Birth Practice #2: Walk, Move Around, and Change Positions Throughout Labor
American Journal of Obstetrics & Gynecology: Pharmacologic and Nonpharmacologic Options for Pain Relief During Labor:
An Expert Review

Integrating Midwives and Community Birth Workers

Purchaser Business Group on Health: How to Successfully Integrate Midwives Into Your Practice

Quality Measures

CMQCC: Performance Measures Used to Assess Cesarean Birth

Illinois Perinatal Quality Collaborative: Stratifying Your Maternal Quality Data by Patient Race/Ethnicity, and Other

Demographics to Improve Birth Equity

ILPQC: Process Flow for Collecting Data on Patient Race & Ethnicity

American Hospital Association: A Framework for Stratifying Race, Ethnicity and Language Data

Patient Education and Birth Planning

CMQCC: <u>Birth Preferences Guide</u> CMQCC: <u>My Birth Matters</u> ACOG: <u>Sample Birth Plan Template</u>

ACNM: Normal, Healthy Childbirth for Women & Families: What You Need to Know

National Partnership for Women and Families: <u>Giving Birth</u> ACOG: <u>Medications for Pain Relief During Labor and Delivery</u>

Childbirth Education

Lamaze International
The Bradley Method®
HypnoBirthing® International
Spinning Babies®

Shared Decision Making, Informed Consent

AHRQ: The SHARE Approach: 5 Essential Steps for Shared Decision Making

ACOG: Committee Opinion No. 819: Informed Consent and Shared Decision Making in Obstetrics and Gynecology

Ariadne Labs: TeamBirth

Debriefing, Huddles

ACOG: Obstetric Team Debriefing Form

AHRQ: TeamSTEPPS Pocket Guide to Briefs, Debriefs and Huddles

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