



California Maternal  
Quality Care Collaborative

## Supporting Vaginal Birth and Reducing Primary Cesareans: California-wide Collaborative

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### Why do high rates of Cesarean matter?

- Relentless Rise without Baby or Mother benefit
  - 6% in early 70's, 20% in mid 80's, 33% in 2010
  - CP rates, neonatal seizures unchanged since 1980
  - Overall, no benefit for long-term urinary continence
- Increased maternal and neonatal morbidity
  - Impaired neonatal respiratory function, NICU admits
  - Affects maternal-infant interaction/Breast Feeding
  - Increased maternal PP infections, VTE, transfusions
  - Longer recovery, 2X Post Partum re-admissions
- Prior CS can have major complications
  - Placenta previa and accreta (invasion deep into or thru the uterine wall) → hysterectomy or worse
  - Uterine rupture; abdominal adhesions

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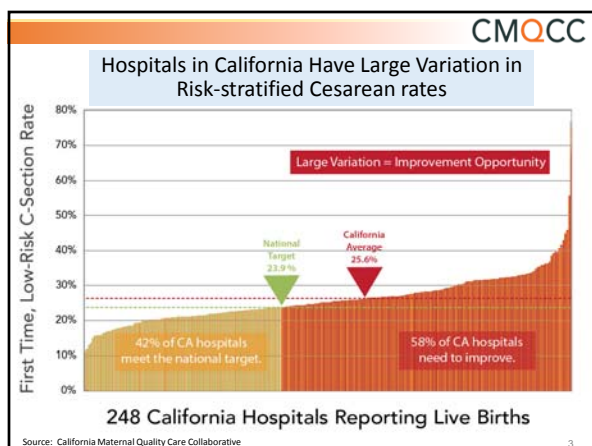
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**CMQCC**

### What Indications Have Driven the **RISE** in CS?

Cesarean Indication	Percent of the Increase in Primary Cesarean Rate Attributable to this Indication
<b>Labor complications</b> (Failure to progress and Fetal concerns)	<b>60%</b>
Breech	No Change
Multiple Gestation	10%
Various Obstetric and Medical Conditions (Placenta Abnormalities, Hypertension, Herpes, etc.)	20%
"Elective" (defined variously, Often: scheduled without "medical indication")	10%

Transforming Maternity Care  
A Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

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**Quality Improvement Focus: How can we prevent the development of Labor Indications for Cesarean?**

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### Importance of the First Birth

If a woman has a Cesarean birth in the first labor, over 90% of ALL subsequent births will be Cesarean births



Which path will she be taken down?

If a woman has a vaginal birth in the first labor, over 90% of ALL subsequent births will be vaginal births

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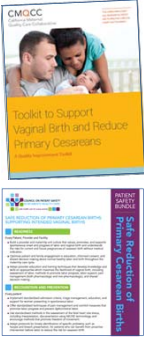
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### CMQCC Toolkit and Collaborative



- Award-winning Multi-disciplinary QI Toolkit
  - Joint effort with leaders from Obstetrics, nursing, midwifery, doulas, hospitals, payers
  - Best practices, policies, protocols, "how-to"
  - Recognition from national ACOG and Lamaze
- Large-scale learning collaborative
  - Over 95 hospitals engaged with a focus on better labor support/management
  - "Reducing the Indications for Cesarean"
  - Strong support from California ACOG, AWHONN, ACNM, Hospital Assoc, Payers and purchasers and many others

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### Patients Have a Central Role: How Can We Partner?

- Critical Importance of Setting Expectations
 

Examples:

  - Prevent early labor admission
  - Promoting walking/Upright positioning
  - Labor induction only when the cervix is ready
- Shared decision making
  - Dependent on childbirth preparation and open communications
  - Lots of misconceptions and misunderstandings;
  - Range in the valuation of "normal birth"
  - Fear of pain and fear for loss of control can be important drivers

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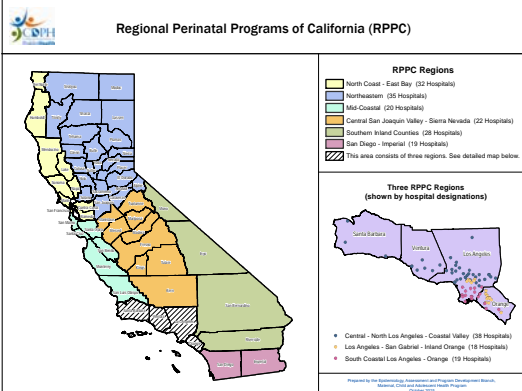
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### Regional Perinatal Programs of California (RPPC)



**RPPC Regions**

- North Coast - East Bay (22 Hospitals)
- Northwestern (25 Hospitals)
- Mid-Coastal (20 Hospitals)
- Central San Joaquin Valley - Sierra Nevada (22 Hospitals)
- Southern Inland Counties (28 Hospitals)
- San Diego - Imperial (19 Hospitals)
- South Coast (19 Hospitals)
- This area consists of three regions. See detailed map below.

**Three RPPC Regions (shown by hospital designations)**

- Central - North Los Angeles - Coastal Valley (28 Hospitals)
- Los Angeles - San Gabriel - Inland Orange (18 Hospitals)
- South Coastal Los Angeles - Orange (19 Hospitals)

Prepared by the Epidemiology, Assessment and Program Development Branch, Maternal, Child and Adolescent Health Program, January 2015

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