

Essential & Optional Strategies for Safely Lowering the NTSV Cesarean Rate

This checklist, abstracted from the OBI 2023 Site Visit Summary Report, is designed to help quality improvement (QI) champions link barriers/facilitators to QI strategies that will promote successful clinical practice change efforts to safely lower the NTSV cesarean rate.

Essential Strategies Safely Lowering the NTSV Cesarean Rate



Optimize Your Team

- Identify a multidisciplinary champion team (physician, RN/CNM, CDA)
- Build a coalition
- Secure administrative awareness, buy-in & needed resources



Plan

- Review baseline performance data
- Assess for readiness & identify barriers/facilitators
- Tailor strategies
- Develop a QI blueprint
- Obtain stakeholder feedback about blueprint
- Conduct consensus discussions
- Develop/adapt policies & protocols
- Plan education & training activities
- Establish a communications plan
- Change electronic medical record (EMR) options to support QI
- Involve patients in QI Planning
- Plan for outcome evaluation



Engage

- Provide dynamic, interprofessional training activities
- Disseminate educational materials
- Conduct ongoing training
- Remind clinicians
- Organize clinicians & staff team meetings
- Relentlessly communicate to engage frontline workers
- Prepare patients to be active participants



Reflect & Evaluate

- Evaluate the QI effort
- Audit and provide feedback
- Facilitate the relay of clinical data to clinicians (NTSV Case Reviews)
- Obtain and use patient/family and clinician feedback
- Communicate with stakeholders to sustain gains

Optional Strategies for Tailoring

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| <input type="checkbox"/> Facilitation | <input type="checkbox"/> Promote network weaving | <input type="checkbox"/> Assess & redefine workflow | <input type="checkbox"/> Engage community resources |
| <input type="checkbox"/> Engage local opinion leaders | <input type="checkbox"/> Peer mentorship | <input type="checkbox"/> Visit other sites | <input type="checkbox"/> Access new funding |
| <input type="checkbox"/> Change physical structure & equipment | <input type="checkbox"/> Alter incentives/allowance structures | <input type="checkbox"/> Conduct cyclical small tests of change | <input type="checkbox"/> Promote adaptability |
| | | | <input type="checkbox"/> Stage implementation scale-up |



Table 1. Description of Essential Strategies For Safely Lowering the NTSV Cesarean Rate

<p>Optimize Your Team</p>	
<ul style="list-style-type: none"> • Identify champion(s): Secure a highly effective multidisciplinary team (including physician, nurse/midwife, and CDA) who meet regularly and dedicate themselves to supporting new practices and overcoming indifference or resistance • Build a coalition: Recruit partners in the QI effort, (ideally with representation of clinicians affected by the changes and administrators who can influence the changes), and define roles/responsibilities and meeting cadence • Secure administrative buy-in: Secure awareness and needed support/resources from institutional and unit leaders 	
<p>Plan</p>	
<ul style="list-style-type: none"> • Review baseline performance data: Collect and analyze data (e.g., rate of NTSV cesareans, overall and by indication) demonstrating a gap between current performance and goal, identify your key opportunities (i.e., drivers of the gap), and set time-bound, ambitious goals (e.g., related to cesarean rate, dystocia compliance, Category II management, and % NTSV cesareans for various indications) • Assess for readiness and identify barriers and facilitators: Determine your unit’s readiness for change, barriers that may impede QI, and strengths that can be used in the QI effort; consider provider attitudes and beliefs and points of resistance, knowledge and skill gaps that education and training must address, and patient needs and preferences • Tailor strategies: Select QI strategies to address barriers and leverage facilitators • Develop a QI blueprint: Develop a description of the 1) aim/purpose of the implementation; 2) scope of the change (e.g., units and individuals affected); 3) barriers, facilitators, and strategies; 4) timeline and milestones; 5) evaluation measures • Obtain stakeholder feedback about the QI blueprint: Formally and informally solicit stakeholder (e.g., frontline workers, patients) input to refine the QI blueprint • Conduct consensus discussions: Include stakeholders in discussions about how the QI effort addresses an important problem and will benefit patients and achieve consensus about what clinical behavior(s) need to change • Develop policies and protocols**: Optimize evidence-based, patient-centered policies to support right-sizing the NTSV cesarean rate (e.g., policies related to comfort measures and ambulation in labor, induction management, pitocin dosing, outpatient cervical ripening, fetal assessment approaches [e.g., intermittent auscultation]) 	

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Plan 
<ul style="list-style-type: none"> • Plan education & training activities**: Prepare content and schedule activities to train all members of the maternity care team together (i.e., in shared, interprofessional activities), as well as patients and their supporters • Establish a project communications plan**: <ul style="list-style-type: none"> ◦ Determine how you will convey WHY change is needed and what clinical behaviors need to change (i.e., WHO needs to do WHAT differently WHEN, and HOW?) ◦ Determine how you will proactively address likely points of resistance ◦ Identify multi-media communication channels and frequency of communications • Change electronic health record (EHR) systems: Change EHRs (e.g., incorporating standardized order sets, dot phrases, best practice alerts, patient educational materials, structured flowcharts) to facilitate better patient care or assessment of clinical outcomes • Involve patients in QI planning*: Solicit and use patient feedback to help plan QI activities • Plan for outcome evaluation: Identify relevant outcomes, measures, and data sources
Engage 
<ul style="list-style-type: none"> • Provide dynamic, interprofessional training activities: Use a variety of interactive methods (e.g., standing learning systems, Grand Rounds, unit huddles) to teach stakeholders about the desired changes, with the goal of changing clinical behavior; shared, multi-disciplinary training (with physicians, nurses, residents attending together) may be particularly helpful • Develop and disseminate educational materials: Develop and disseminate materials that make it easier for clinicians to learn about and know how to deliver the desired clinical practice • Conduct ongoing training: Offer follow-up training, advanced training, booster training, purposefully spaced training, training to competence, structured supervision, and onboarding for new staff • Remind clinicians: Develop reminder systems to help clinicians recall information and/or prompt them to use desired best practices (e.g., reminder card with ACOG/SMFM dystocia criteria on computers; unit posters with Cat II algorithm)

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Engage 
<ul style="list-style-type: none"> • Organize clinician & staff meetings: Support the teams implementing the innovation & protect time at recurring meetings to reflect on their efforts & share lessons learned • Relentlessly communicate*: Use robust formal & informal communication channels to keep all frontlines individuals informed of QI initiative progress • Prepare patients to be active participants: Prepare patients to be active in their care, ask questions, & inquire about care guidelines & available evidence-based treatment options
Reflect & Evaluate 
<ul style="list-style-type: none"> • Evaluate the QI effort: Monitor progress and adjust clinical practices and QI strategies to mitigate resistance, catalyze change, and continuously improve the quality of care • Audit and provide feedback: Collect clinical performance data and give it to clinicians and administrators to monitor, evaluate, and modify provider behavior (e.g., track clinician-level NTSV cesarean rates, provide feedback to each clinician on their rates, share comparative clinician-level data [blinded or unblinded] with the unit) • Facilitate relay of clinical data to providers: Provide as close to real-time data as possible about key process and outcome measures, using multiple channels of communication, in a way that promotes use of desired clinical behaviors • Obtain and use patient and family feedback*: Develop strategies to increase patient and family feedback on the QI effort (e.g., attending coalition meetings, sharing their personal story with clinicians) • Communicate with stakeholders to sustain gains: Communicate data to demonstrate the continued impact of the clinical practice changes, emphasizing ongoing benefit, cost-effectiveness, or return on investment of the effort

Definitions adapted from Powell, B.J., et al. [A refined compilation of implementation strategies: results from the Expert Recommendations for Implementing Change \(ERIC\) project.](#) *Implementation Sci* 10, 21 (2015).

*ERIC strategies rarely observed at OBI hospitals, but likely to be helpful based on observed barriers

**Strategies not in ERIC compilation but observed in use at sites with low cesarean rates

Table 2. Description of Optional Strategies for Safely Lowering the NTSV Cesarean Rate

<p>Facilitation</p>	<p>A process of interactive problem-solving and support in the context of a recognized need for improvement and a supportive interpersonal relationship with your OBI Outreach and Engagement Nurse. Barriers Addressed: All</p>
<p>Engage Local Opinion Leaders</p>	<p>Activate individuals recognized as “influential” on your unit to motivate colleagues to adopt desired clinical behavior changes; dampen resistance among opinion leaders, if needed. Barriers Addressed: Frontline individual factors, Engaging</p>
<p>Change Physical Structure & Equipment</p>	<p>Adapt the physical structure/equipment to promote quality improvement (e.g., co-location of residents & nurses to support joint strip review, addition of remote fetal monitors to facilitate movement). Barriers Addressed: Structural characteristics, Available resources, Workflow incompatibility</p>
<p>Access New Funding</p>	<p>Access money to facilitate improvement, including resources to secure unit supplies (e.g., birthing balls), offer employee trainings, or incentivize participation in QI activities. Barriers Addressed: Structural characteristics, QI team, Engaging</p>
<p>Promote Network Weaving</p>	<p>Cultivate high-quality working relationships within and across organizational units to promote information sharing, collaborative problem-solving, and a shared vision related to implementing the innovation. Barriers Addressed: Relationships, Teaming</p>
<p>Peer Mentorship</p>	<p>Capture local knowledge from other sites on how clinicians made something work in their setting and then share it with other sites. Barriers Addressed: All</p>
<p>Alter Incentive/ Allowance Structures</p>	<p>Actions to incentivize or reward the adoption and implementation of the desired clinical behavior. Barriers Addressed: Frontline individual factors</p>

Table 2. Description of Optional Strategies for Safely Lowering the NTSV Cesarean Rate

<p>Promote Adaptability</p>	<p>Identify the ways a clinical innovation can be tailored to meet local needs and clarify which elements of the innovation must be maintained to preserve fidelity. Barriers Addressed: Frontline individual factors</p>
<p>Assess & Redefine Workflow*</p>	<p>Map current work processes and plan for desired work processes, identifying changes necessary to routinize the clinical innovation. Barriers Addressed: Frontline individual factors, Workflow incompatibility, Engaging</p>
<p>Visit Other Sites*</p>	<p>Visit (or conduct virtual meetings with) sites where a similar implementation effort has been considered successful. Barriers Addressed: All</p>
<p>Conduct Cyclical Small Tests of Change*</p>	<p>Implement changes in a cyclical fashion using small tests of change before taking changes system-wide. Tests of change benefit from systematic measurement, and results of the tests of change are studied for insights on how to do better. This process continues serially over time, and refinement is added with each cycle. Barriers Addressed: Engaging</p>
<p>Stage Implementation Scale Up*</p>	<p>Phase implementation efforts by starting with small pilots or demonstration projects and gradually move to a system-wide rollout. Barriers Addressed: Engaging</p>
<p>Engage Community Resources*</p>	<p>Utilize health departments, non-profits, resources for addressing social determinants of health, and reproductive justice experts. Barriers Addressed: Patient factors, Frontline individual factors</p>

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