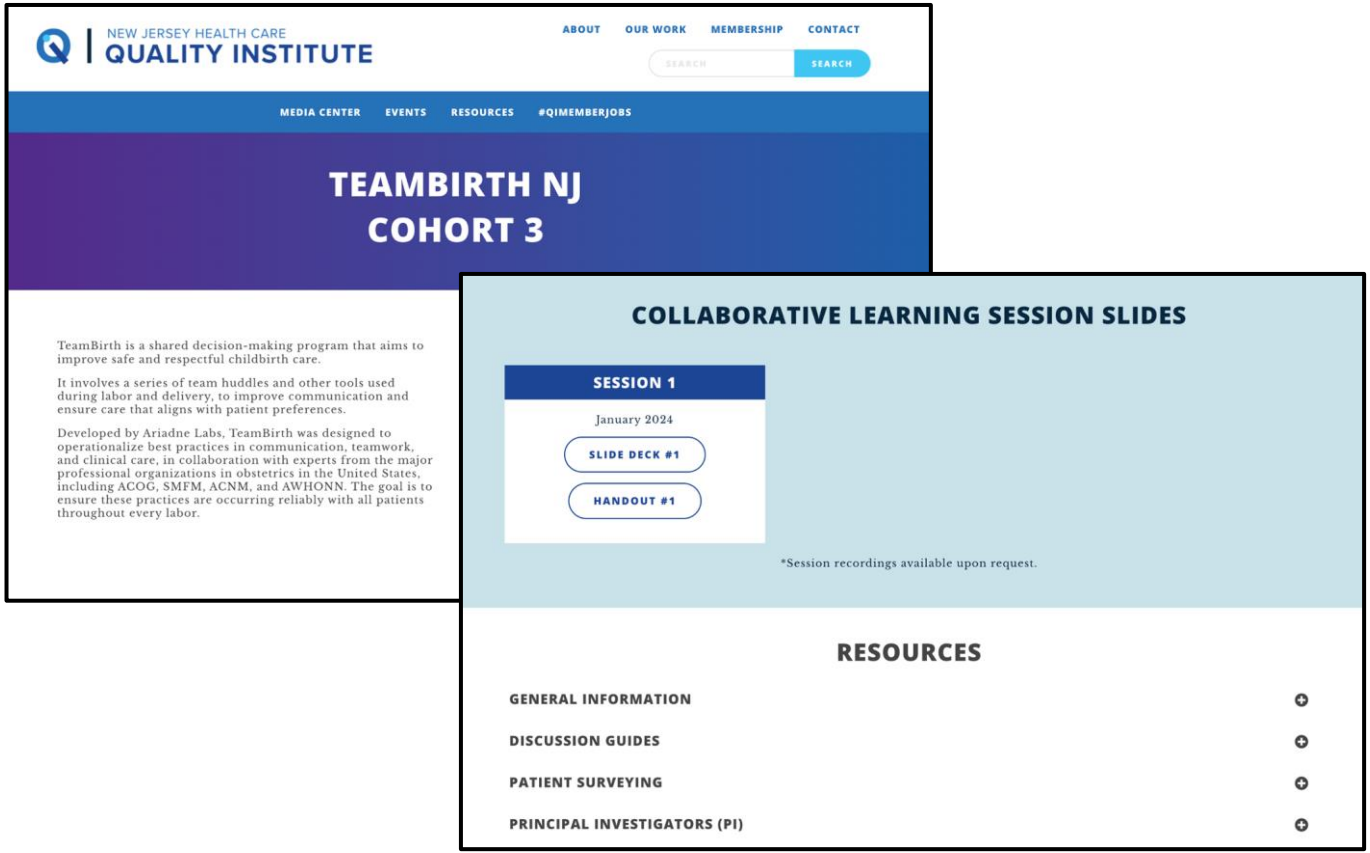
TeamBirth: Process Innovation for Clinical Safety, Effective Communication, and Dignity in Childbirth

June 25, 2024

Collaborative Session Agenda

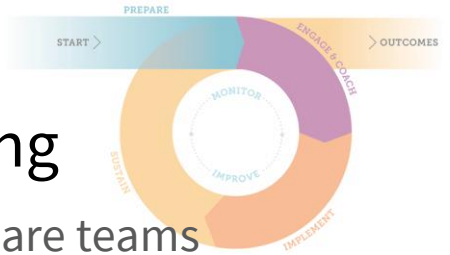
TeamBirth Implementation	○ Announcements ○ Implementation Pathway & Timeline ○ Current core activities: **Patient surveying, socialization, testing** ○ Upcoming core activities: **Promoting champions, providing training**
TeamBirth Core Knowledge & Skills	○ Review: **Next Huddle & When to Huddle** ○ Learn: **Discussion Guides** ○ Discuss: **Testing & Training Strategy** ○ Looking Ahead: **Launch**
Looking Ahead	○ Takeaways From Today ○ Action Items & Next Steps



Password protected site - www.njhcqi.org/teambirthnj-cohort3 ; password: Cohort32024!
Public TeamBirth NJ website: www.njhcqi.org/our-work/qualityimprovement/

Surveying

TeamBirth Patient Survey



Your Measurement Strategy: Patient Surveying

TeamBirth implementation requires input from patients and care teams

	Patient Survey
WHO	Patients who delivered at your hospital
WHAT	~20 questions that include: Self- reported huddles in labor and postpartum, experience of autonomy in decision making, demographics, additional comments
WHY	To collect first hand experiences of patients throughout implementation in order to inform opportunities for improvement and demonstrate TeamBirth impact
WHERE	Inpatient postpartum units
HOW	Survey distribution to patients after birth
WHEN	***Baseline: July through mid-September*** ***Post-go live: Mid-September onward***

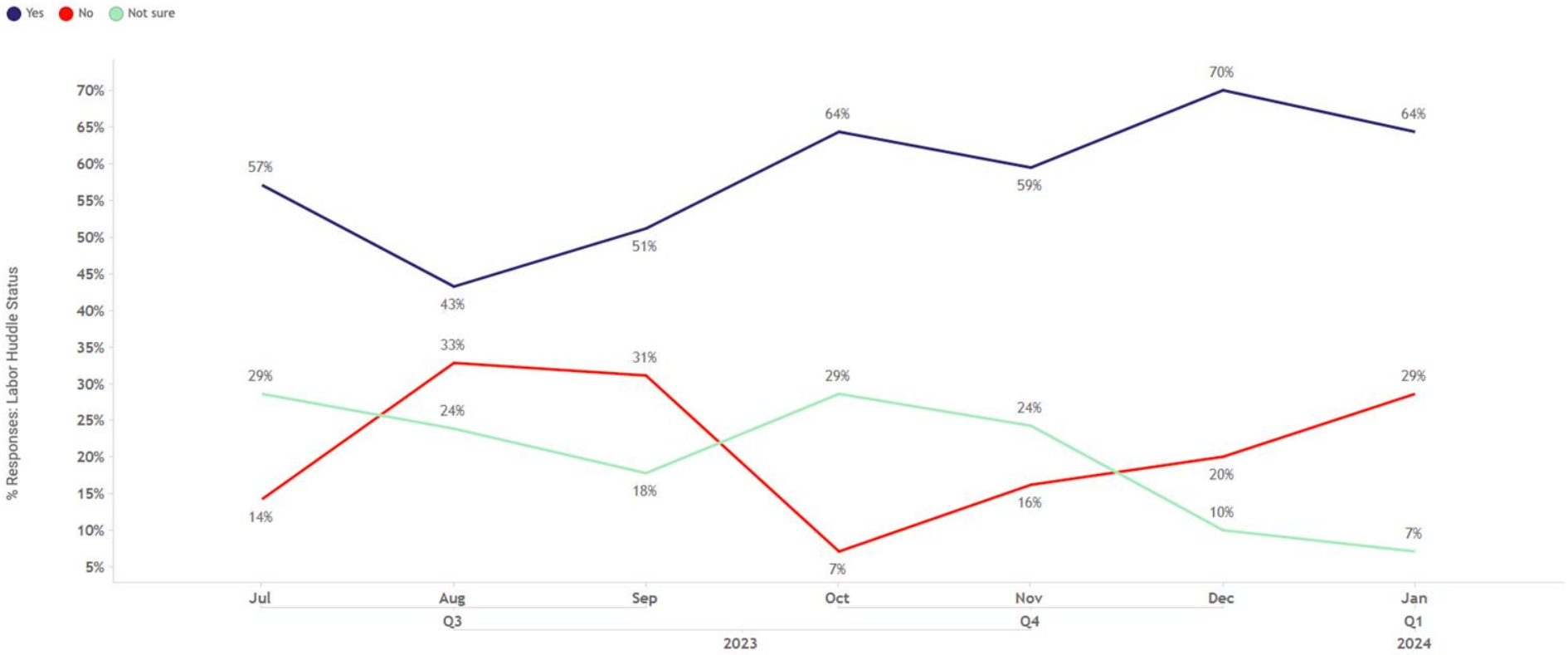
Patient Survey

Collecting patient demographics

Age	**Miles Traveled to Hospital**
Race	**Is this your first baby?**
Ethnicity	**Delivery Method**
Education	**Was labor induced?**
Health Insurance Type	**High risk pregnancy or medical complication experience?**

Patient Survey: Questions on TeamBirth Process

TeamBirth Experience: % of Patients with and without a Labor Huddle



Patient Survey: Patient Experience

Mother's Autonomy in Decision Making Scale (MADM)

My clinical team asked me how involved in decision making I wanted to be.

My clinical team told me there are different options for my maternity care.

My clinical team explained the advantages and disadvantages of the maternity care options.

My clinical team helped me understand all the information.

I was given enough time to thoroughly consider the different maternity care options.

I was able to choose what I considered to be the best care options.

My clinical team respected that choice.

Answered using a 6 point Likert scale:

Completely Disagree	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Completely Agree	Prefer Not to Answer

Patient Surveying Process

Your process for surveying will include:

Survey Preparation	Data Collection	Analysis & Review	Share Results
• Print Survey • Train staff to message survey to patients	• Distribute surveys • Collect Responses	• Enter data into Qualtrics • Implementation Team data review	• Share findings with clinical teams

Teams will discuss and plan for the details of your unique patient survey strategy in Coaching Calls

Testing & Training

Develop your training strategy

HOW

Key Milestones

- ❑ Training videos and resources uploaded to your learning management system
  - Ensure content is ready in time to train Champions
- ❑ Train all clinicians who may be part of the direct care team (e.g. nurses, midwives, physicians)
- ❑ Establish a process with champions for ongoing coaching to reinforce skills and behaviors from the trainings
- ❑ Create a system for tracking training completion to promote buy-in and accountability for participating

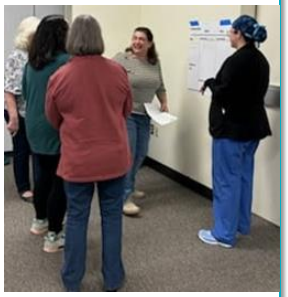
Train Staff & Providers

Socialization - Get the word out!

- Infographics
  - Large poster size
  - Small pocket size
- TeamBirth information board
- TeamBirth “roadshows”
- TB info on meeting agendas
- Swag with QR code & TB info
- Online groups, social media

Approaches to Training

- Scenario station for training
- TeamBirth education board
- Off-unit events:
  - OB clinics
  - SIM lab
- TeamBirth “roadshows”
- Office hours
- Multidisciplinary training - on the fly, come (or call in!) off-shift, combo
- Repurpose staff meetings, rounds, previously scheduled training



ARIADNE LABS

Provide Training

Ensure everyone has the knowledge and skills AND the opportunity to apply them

CORE Training Components	
Knowledge (Didactic) TeamBirth Videos	**Application (Action)** Huddle Practice

Adaptation for your context

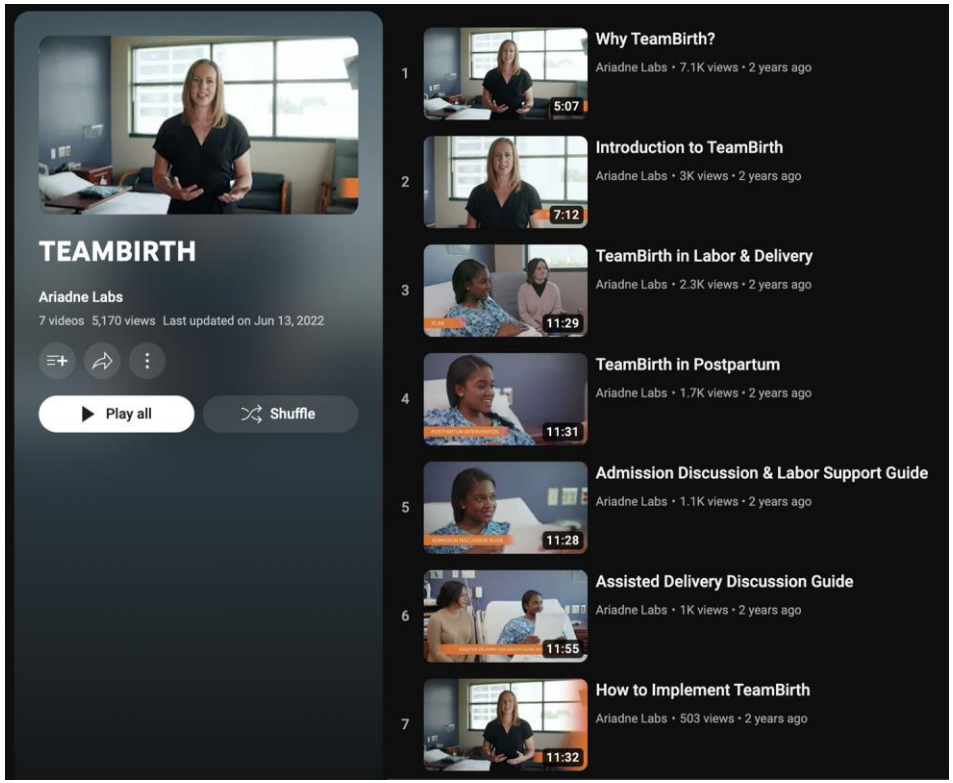
- Assign videos in online learning management system
- Distribute QR codes for YouTube links
- Give your own live presentation of TeamBirth video content
- Supplement videos with TeamBirth resources like the infographics

- Role play huddle simulation in multidisciplinary groups
- Tabletop scenario practice
- Demos
- SIMs
- Combine with skills day

Who should watch which video?

Implementation Team	Videos 1-7
OB Providers & Midwives	Videos 1-6
Anesthesiologists/CRNAs	Videos 1, 2, 6
Labor and Delivery Nurses	Videos 1-3, 5-6
Postpartum Nurses, Newborn Providers, Lactation Specialists	Videos 1-2, 4
LDRP Nurses, Doulas, CBEs	Videos 1-6

Why TeamBirth is for everyone! Use early and often for socialization.



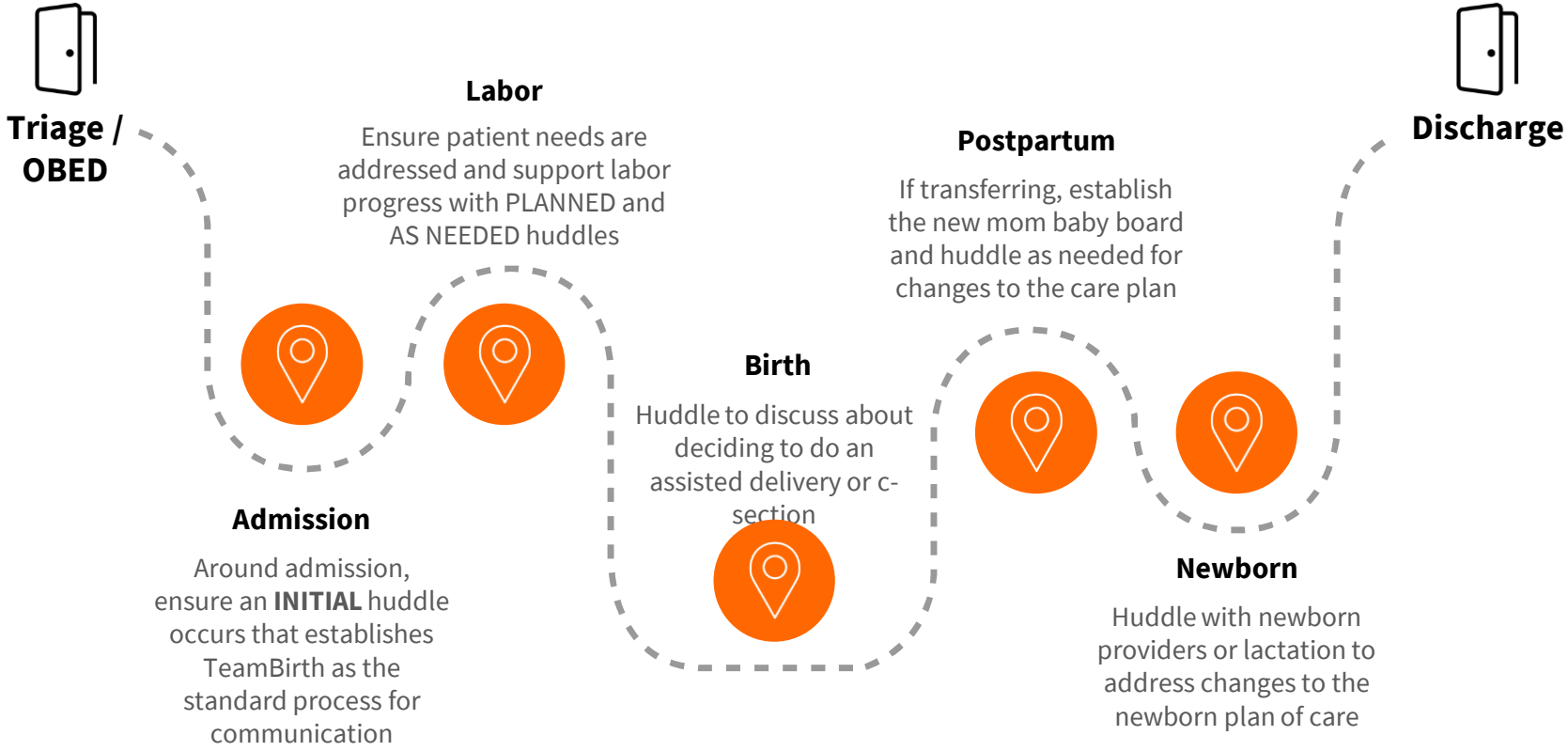
TeamBirth knowledge & skills

- When to Huddle

- Discussion Guides
  - Admission Decision Guide
  - Labor Support Guide
  - Assisted Delivery Discussion Guide

Door to Door TeamBirth

These **key moments** describe how TeamBirth is put in practice throughout the birthing journey.



TEAMBIRTH

WHEN TO HUDDLE

HUDDLE OPPORTUNITIES

ARIADNE LABS
DELIVERY DECISIONS INITIATIVE

REMEMBER

- Gather all members of the direct care team, including the patient and their support people
- Hold huddle in person when possible, but can also be conducted over phone when needed
- Any member of the team may call for a huddle and/or lead the conversation
- Designate a facilitator to prompt the huddle, lead discussion, and ensure all team members have the opportunity to participate

INITIAL

INITIAL
PLANNED

- Admission
- Induction
- High Risk/Antepartum
- OBED
- Planned C-Section
- Transfer In (from community or other facility)
- Postpartum Readmission

KEY DECISIONS & CHANGES TO CARE PLAN

ONGOING
PLANNED OR AS NEEDED

- Labor Progress
  - Interventions: AROM, augment, vacuum, forceps, or C-section
- Category 2 tracing
  - Interventions: internal monitoring, assisted birth
- Hemorrhage
- Hypertension
- Post OB emergency
- Opioid Use
- Pain Control Options

Newborn specific:

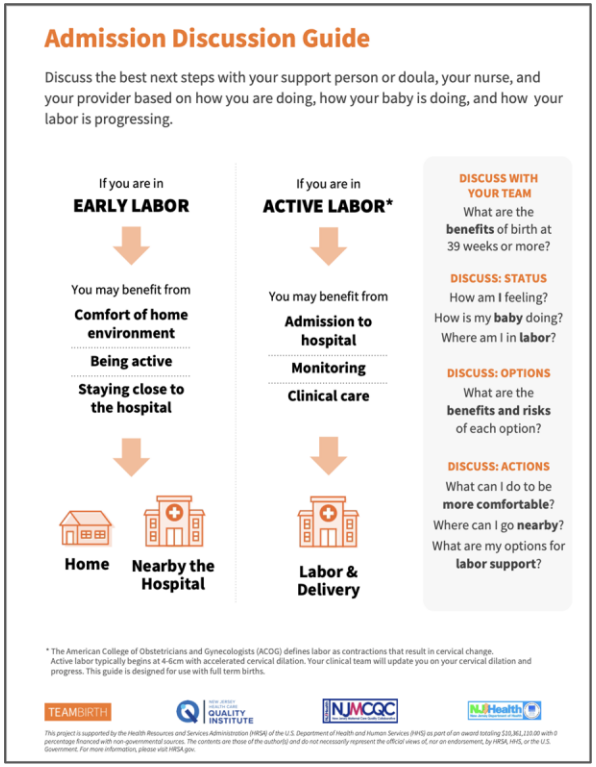
- NICU Observation/Transfer
- Supplemental Feeding Plans/ Hypoglycemia Management
- Hyperbilirubinemia/Phototherapy
- Opioid Withdrawal Syndrome/ Eat Sleep Console

ADD ON

ONGOING
PLANNED OR AS NEEDED

- Immediate Post-Birth
- Lactation
- Daily Rounds
- Discharge
- Provider Handoff
- Bedside Handoff
- Tuck-in (before bed to plan for night contingencies)

TeamBirth Discussion Guides



Admission Discussion Guide

Discuss the best next steps with your support person or doula, your nurse, and your provider based on how you are doing, how your baby is doing, and how your labor is progressing.

If you are in **EARLY LABOR**

You may benefit from

Comfort of home environment

Being active

Staying close to the hospital

Home **Nearby the Hospital**

If you are in **ACTIVE LABOR***

You may benefit from

Admission to hospital

Monitoring

Clinical care

Labor & Delivery

DISCUSS WITH YOUR TEAM

What are the **benefits** of birth at 39 weeks or more?

DISCUSS: STATUS

How am I feeling?
How is my **baby** doing?
Where am I in **labor**?

DISCUSS: OPTIONS

What are the **benefits and risks** of each option?

DISCUSS: ACTIONS

What can I do to be **more comfortable**?
Where can I go **nearby**?
What are my options for **labor support**?

* The American College of Obstetricians and Gynecologists (ACOG) defines labor as contractions that result in cervical change. Active labor typically begins at 4-6cm with accelerated cervical dilation. Your clinical team will update you on your cervical dilation and progress. This guide is designed for use with full term births.

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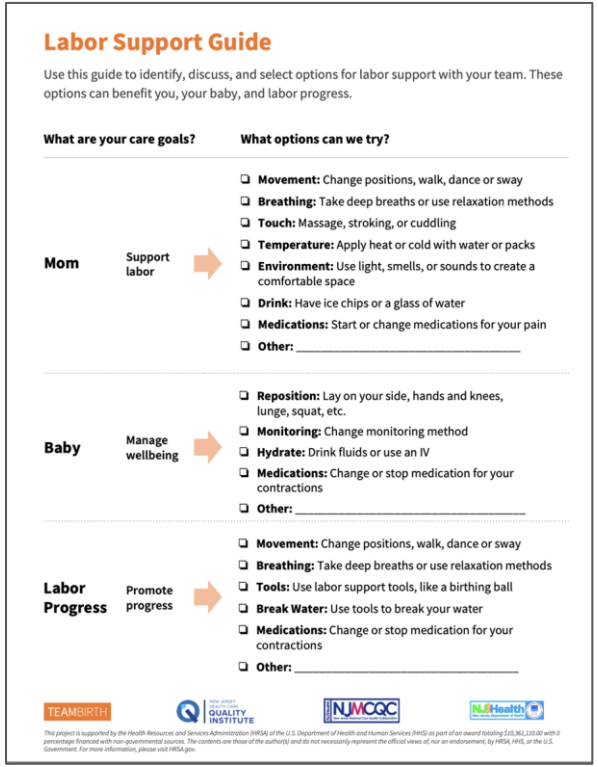

Labor Support Guide

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Labor Progress	**Promote progress**	❑ **Movement:** Change positions, walk, dance or sway ❑ **Breathing:** Take deep breaths or use relaxation methods ❑ **Tools:** Use labor support tools, like a birthing ball ❑ **Break Water:** Use tools to break your water ❑ **Medications:** Change or stop medication for your contractions ❑ **Other:** _____

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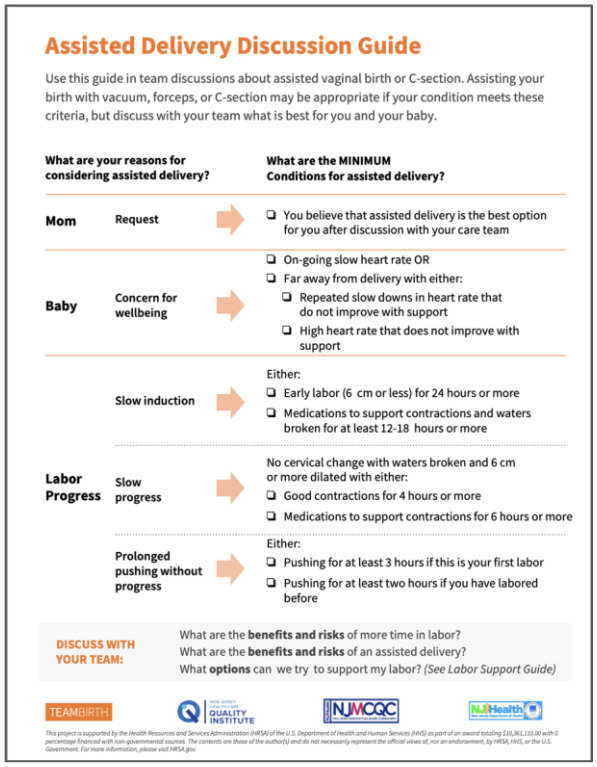

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DISCUSS WITH YOUR TEAM:

What are the **benefits and risks** of more time in labor?
What are the **benefits and risks** of an assisted delivery?
What **options** can we try to support my labor? *(See Labor Support Guide)*

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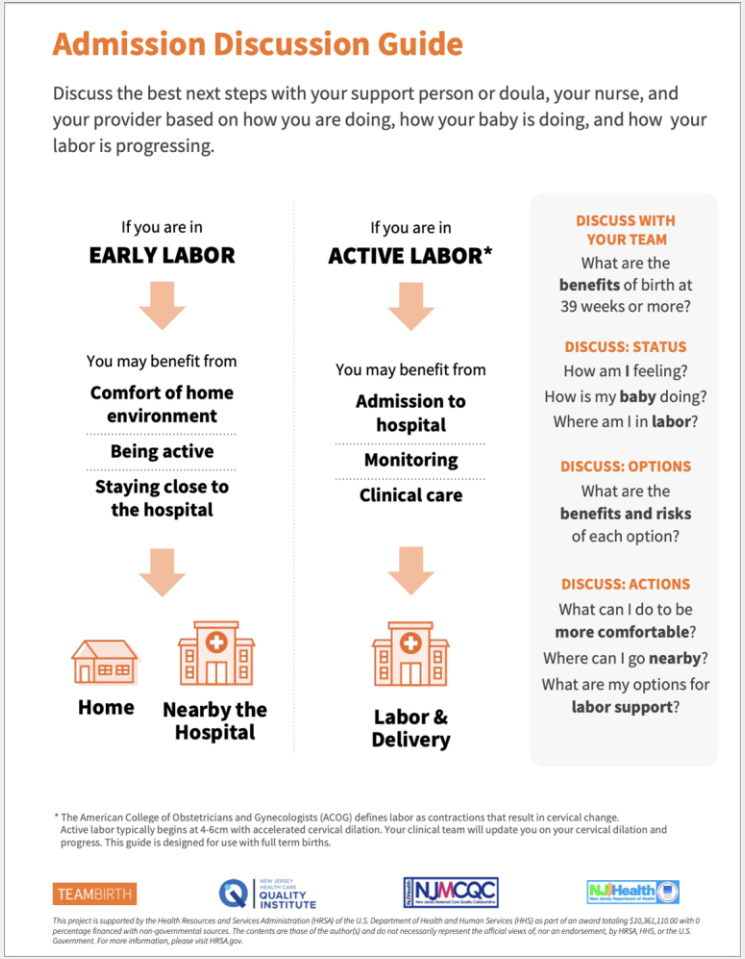

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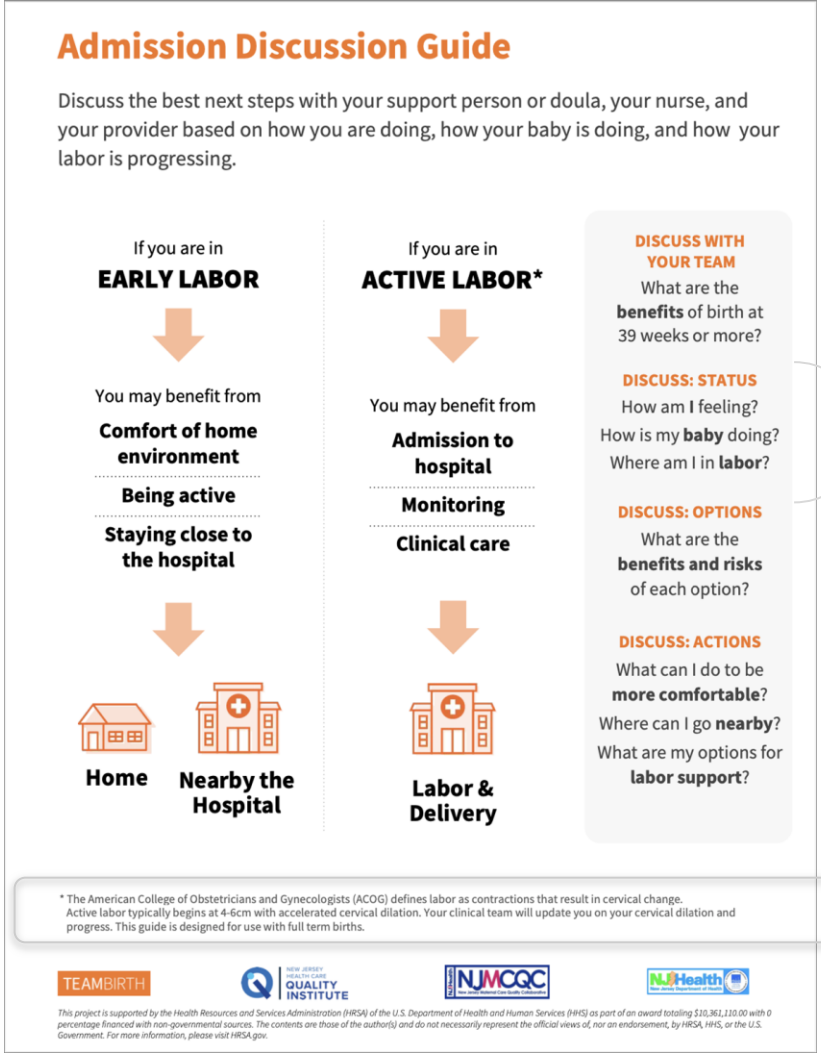


ACOG active labor definition

Using the Guide together:

- Facilitates shared admission decision making
- Minimizes implicit bias
- Supports transparency and respectful care

Clearly assess each to determine indicators for admission

PLAN FOR

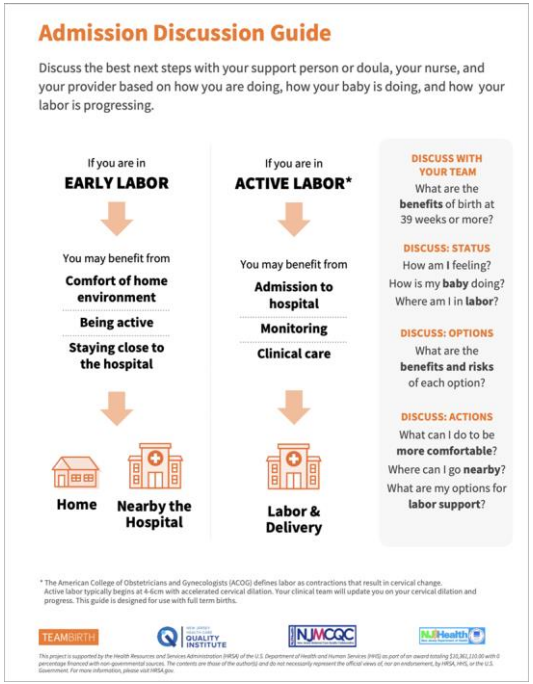
Me:

Baby:

Labor Progress:

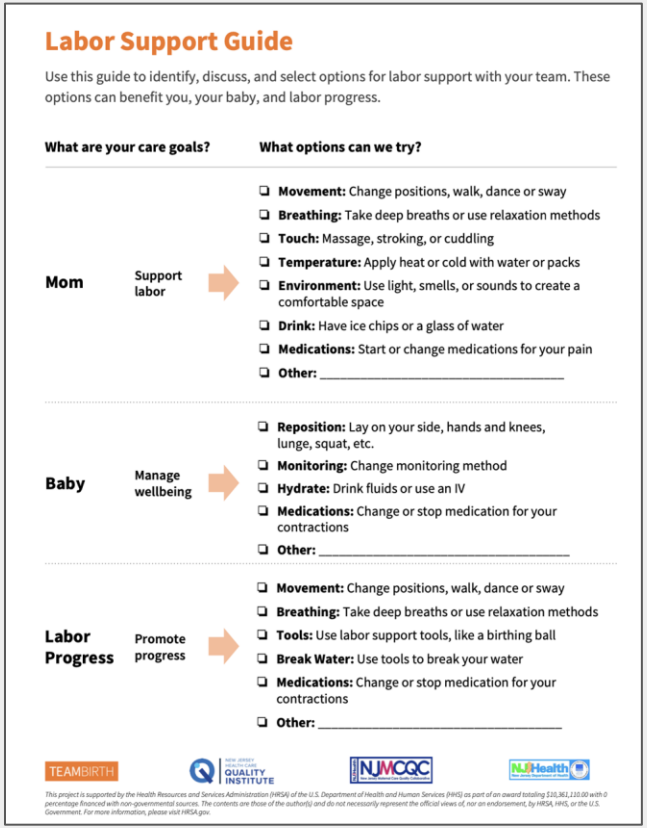
TeamBirth Huddle Considerations for Triage/OBED

- Introduce Admission Guide at onset of labor evaluation
  - Consistent use with every patient provides transparent, equitable decision-making
- Early messaging opportunity to patients and families about TeamBirth huddles
- Triage and OBED staff and providers may be coordinating the initial huddle, or commuting to the admitting staff and providers that an initial huddle is needed.



Any team member can request a huddle

Labor Support Guide



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Assisted Delivery Discussion Guide

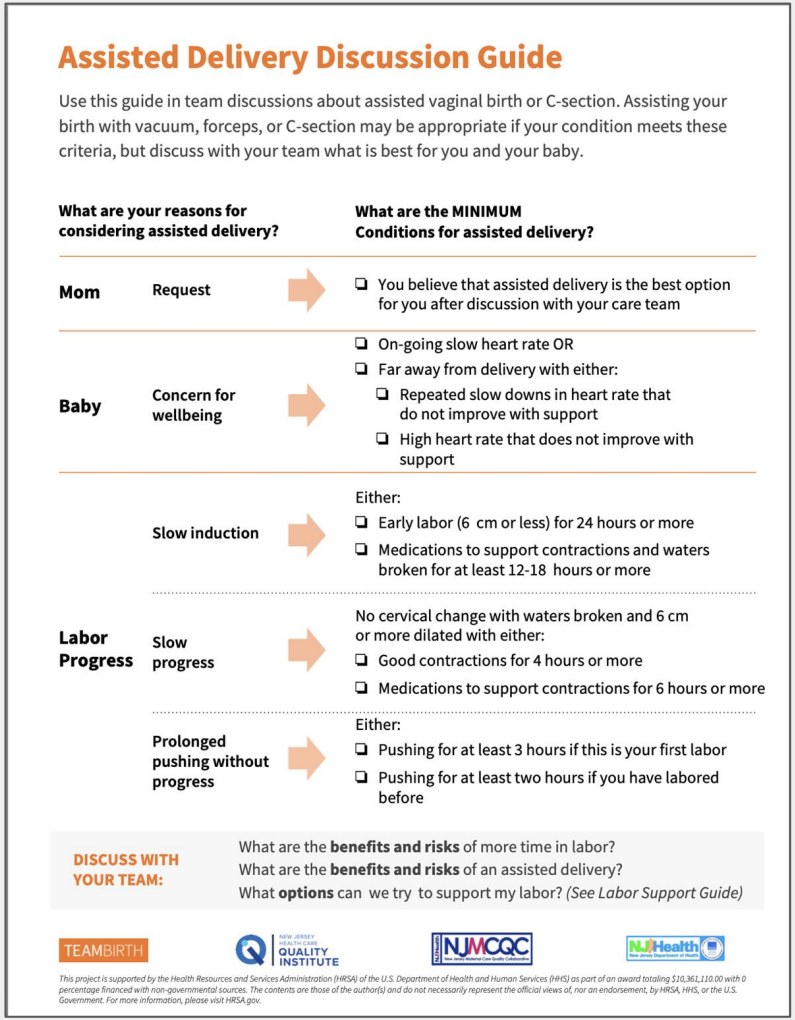

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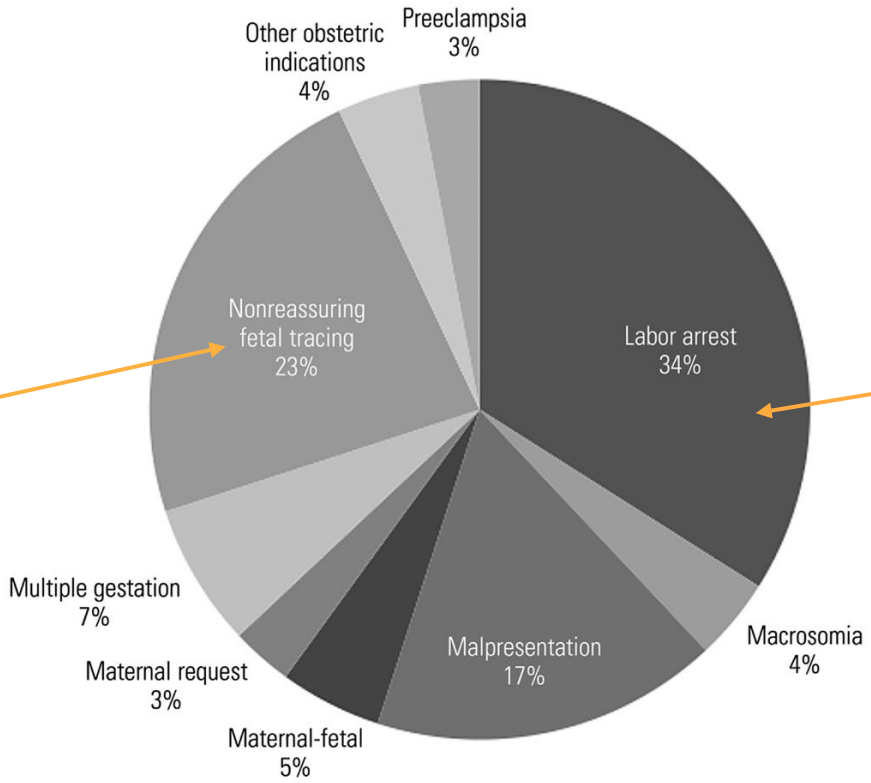
FIGURE 3
Indications for primary cesarean delivery



Baby:

Labor Progress:

Data from Barber et al.[16]

ACOG. Safe prevention of primary cesarean delivery. Am J Obstet Gynecol 2014.

When there is a concern, using the Guide:

- Facilitates shared decision making
- Minimizes implicit bias
- Supports transparency and respectful care

Provide structure to discussion of the MINIMUM conditions for assisted delivery

PLAN FOR

Me:

Baby:

Labor Progress:

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Labor Progress

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First stage of labor
A prolonged latent phase (eg, >20 h in nulliparous women and >14 h in multiparous women) should not be indication for cesarean delivery.
Slow but progressive labor in first stage of labor should not be indication for cesarean delivery.
Cervical dilation of 6 cm should be considered threshold for active phase of most women in labor. Thus, before 6 cm of dilation is achieved, standards of active-phase progress should not be applied.
Cesarean delivery for active-phase arrest in first stage of labor should be reserved for women ≥6 cm of dilation with ruptured membranes who fail to progress despite 4 h of adequate uterine activity, or at least 6 h of oxytocin administration with inadequate uterine activity and no cervical change.

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Baby	Concern for wellbeing	❑ On-going slow heart rate OR ❑ Far away from delivery with either: ❑ Repeated slow downs in heart rate that do not improve with support ❑ High heart rate that does not improve with support
Labor Progress	Slow induction	Either: ❑ Early labor (6 cm or less) for 24 hours or more ❑ Medications to support contractions and waters broken for at least 12-18 hours or more
		No cervical change with waters broken and 6 cm or more dilated with either:
	Prolonged pushing without progress	Either: ❑ Pushing for at least 3 hours if this is your first labor ❑ Pushing for at least two hours if you have labored before

DISCUSS WITH YOUR TEAM:

What are the **benefits and risks** of more time in labor?
What are the **benefits and risks** of an assisted delivery?
What **options** can we try to support my labor? *(See Labor Support Guide)*

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Before diagnosing arrest of labor in second stage, if maternal and fetal conditions permit, allow for following:

- At least 2 h of pushing in multiparous women (1B)
- At least 3 h of pushing in nulliparous women (1B)

Longer durations may be appropriate on individualized basis (eg, with use of epidural analgesia or with fetal malposition) as long as progress is being documented. (1B)

Baby

Management of Category II FHR

ACOG: Category II FHR tracings require **evaluation** and continued surveillance and **reevaluation**, taking into account the entire associated clinical circumstances.

Assisted Delivery Discussion Guide

Use this guide in team discussions about assisted vaginal birth or C-section. Assisting your birth with vacuum, forceps, or C-section may be appropriate if your condition meets these criteria, but discuss with your team what is best for you and your baby.

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	Slow progress	No cervical change with waters broken and 6 cm or more dilated with either: ❑ Good contractions for 4 hours or more ❑ Medications to support contractions for 6 hours or more
	Prolonged pushing without progress	Either: ❑ Pushing for at least 3 hours if this is your first labor ❑ Pushing for at least two hours if you have labored before

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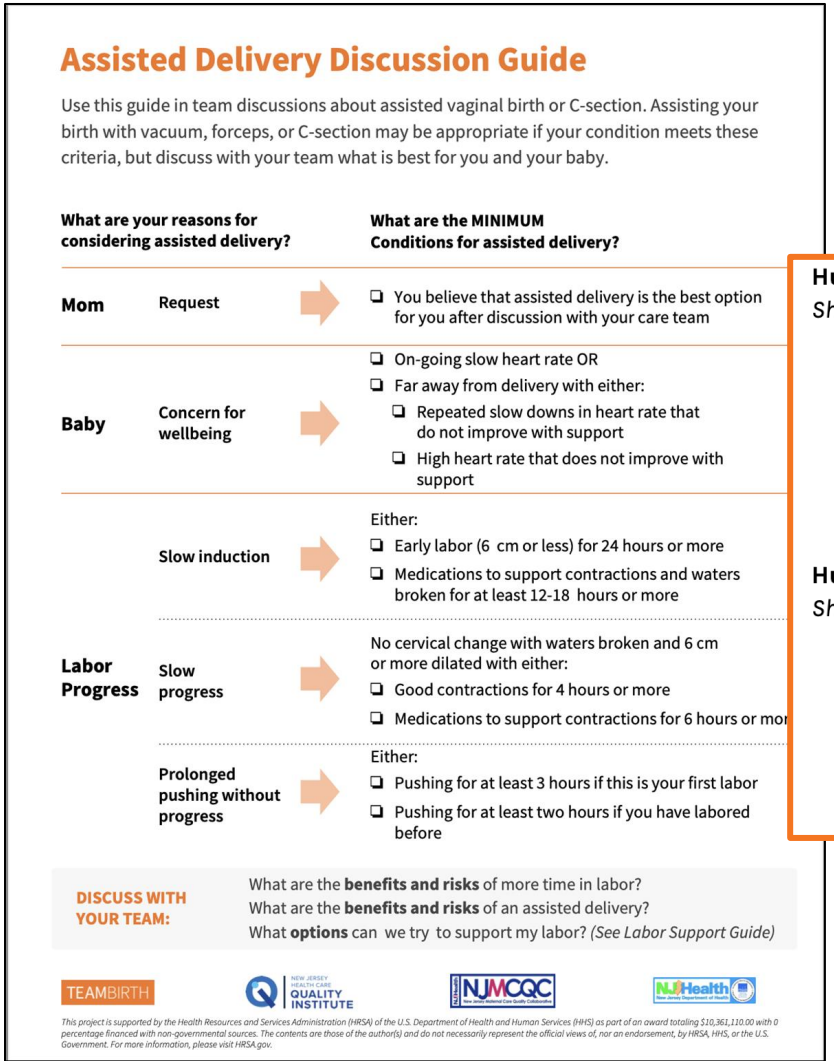

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Huddle 2

Shanell was recently admitted for labor; now getting comfortable with the epidural.

- FHR reassuring.
- Contractions are regular & palpate mod-strong.
- Copious clear fluid noted.
- Cervix was 4/100/0 on admission exam (has not been rechecked).
- On-call OB is expecting a speakerphone huddle now that Shanell is comfortable with the epidural.

Huddle 3

Shanell has been resting comfortably with the epidural since the last huddle.

- FHR has just recovered to baseline with minimal variability after a prolonged deceleration into the 60's for almost 3 minutes.
- Cervix was checked during the deceleration, now 9/100/+1.
- Meconium-stained fluid noted.
- On-call OB was paged during the intrauterine resuscitation and has just arrived. A huddle is appropriate at this time.

Team

Shanell & Taylor
Indigo - nurse til 7:30 am
Abagael - midwife
Dr. C - on call OB
Amana - charge nurse/baby nurse

Preferences

Lots of info about epidural

calm and quiet

Taylor wants to cut the cord (but might pass out!)

Plans for:

Me Naptime
Use epidural button, let Indigo know

Baby Watch Emory all the time

Labor Progress

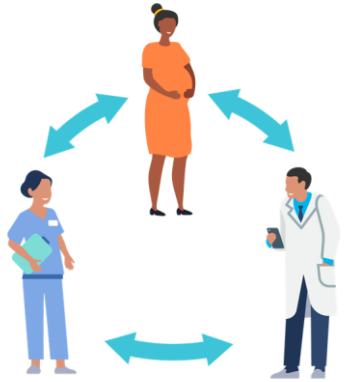
Go with the flow, peanut ball positions

Next Huddle

After next exam, can wait awhile (around 2am

Let’s Discuss: Weaving this together

- Gather champions → identify a huddle opportunity → guide a small test



- Remember to discuss your learnings as a team, and plan to test again!

Wrapping Up & Looking Ahead

Priorities & Action Items

Implementation Pathway	*Action Items*	*Details & Resources*
ATLAS STAFF SURVEY	❑ Final push of the Atlas survey across your department	Results in upcoming coaching calls
FINALIZE BOARDS	❑ Continue to progress toward finalizing boards	Aim to install in September
TESTING & TRAINING	❑ Upload TeamBirth Videos to your learning management system (LMS)	Assign videos based on roles NJHCQI Website
	❑ Gather champions → identify a huddle opportunity → guide a small test!	Try it out and then discuss learnings as a team, adjust, & try again
	❑ Plan for scenario based training with staff and providers	Look ahead for scheduling training
PATIENT SURVEY PROCESS	❑ Review Patient Survey Toolkit on Cohort 3 Resource page	www.njhcqi.org/teambirthnj-cohort3 ; password: Cohort32024!
	❑ Read the survey to get a sense of patient questions	What questions are most interesting to you? Share with staff and providers as a socialization tool!
	❑ Begin testing patient surveying workflow	

Looking ahead: Launch the project!
September 16th and 17th

Monday 9/16
JSUMC, Virtua Our Lady of Lourdes

Tuesday 9/17
HUMC, RWJ Jersey City

Next Cohort 3 Collab Learning Session

July 23rd @ 12-1pm ***(Fourth Tuesdays, monthly)***

Please reach out with any questions: aperez@njhcqi.org or achallenger@ariadnelabs.org

Share your feedback!

- Anonymous
- Short survey
- Tell us what you like
- Tell us how to improve