Doula Care

Section II of this toolkit gave a brief introduction to doulas and the care they provide. This section serves as a continuation and offers much more detail on what doulas do and how they benefit all patients, especially those from historically marginalized communities.

What Are Doulas?

Doulas have existed throughout history. A doula is a trained, non-medical professional who continuously supports the patient's physical, emotional, and informational needs during labor.[129,130,425,430,431] Many doulas are trained to provide more than labor and birth support. For example, a "full-spectrum" doula will provide emotional, physical, informational, and resource support during the prenatal and postpartum periods, during breastfeeding, for abortion care, and during miscarriage or stillbirth.[425,430] Some doulas even provide end-of-life support for families and patients.[432] For underrepresented and historically marginalized groups, the role of the doula as patient advocate is especially critical – particularly in the hospital setting where historical mistrust of the medical establishment persists after generational harm encountered in this setting through medical negligence, undertreatment, nonconsensual sterilization, and experimentation on Black and Brown bodies.[433] Indeed, studies confirm the positive impact of doula care is especially great for low-income people, the socially marginalized, and those with cultural barriers or language difficulties.[117,434]

Doulas provide support in various ways. In their labor and birth support role, they offer physical comfort care to promote pain relief and labor progress. Doulas also facilitate labor support by the patient's partner, family members, or friends. After the birth, they support and assist with breastfeeding and bonding.[129,130,425,430] Doulas help the patient articulate goals, preferences, needs, and fears.[130,430] Additionally, doulas help the patient understand and interpret what is happening to them and around them during labor and birth. When labor and birth occur in the hospital environment, the informational role of the doula may include interpretation of medical jargon and medical processes in real-time. In their role as patient advocate, the doula empowers the birthing person to make the best personal decisions for themselves, their labor, their own body, and their baby.[128] In this role, the doula acts, in a way, as a buffer for the patient against potential exclusion, discrimination, and loss of autonomy that is often reported by historically marginalized communities when they enter the medical system.[425]

Figure 20. The Role of Doulas During Labor and Birth[435]

What Doulas Do:	What Doulas Do Not Do:
• Prenatal teaching and childbirth education • Comfort care and physical support during labor • Culturally congruent advocacy and informational assistance (such as explaining medical jargon) during labor and birth • Preserve and support respectful care, dignity, and privacy for the patient • Support during epidural placement; comfort care and support if breakthrough pain occurs after epidural • Assistance with positioning the patient to assist fetal descent and rotation • Support for family members • Provide invaluable support for individuals who are alone or otherwise have limited support in labor • Support for bonding and lactation during the "Golden Hour" • Postpartum support for infant feeding, breastfeeding, daily infant care, and connecting the patient to local resources • Typically remain with the patient for the entirety of the labor and into the "Golden Hour" except for unusual cases where the labor is exceptionally long or where doula groups share patient care during labor	• Clinical care such as physical assessments or "catching" the baby • Nursing care such as fetal monitoring or medication administration • Diagnose conditions or give medical advice • Make decisions for the patient or pressure the patient into certain decisions

Doula Care Models

There are various models of doula care in the United States. These models include hospital-based programs, community-based programs, and private practice.[164] Hospital-based programs, such as those at UC San Diego Medical Center and Zuckerberg San Francisco General Hospital are generally grant-funded and volunteer-based. Hospital-based programs typically exist to bring doula care to those who would otherwise not have that opportunity. As the interest in providing doulas for marginalized communities increases, many community groups cannot yet meet the need. Hospital-based programs help to fill that gap while simultaneously normalizing the presence of doulas in the hospital setting.

Community-based programs, such as those provided through social service agencies, Federally Qualified Health Centers (FQHCs), or community-based nonprofit organizations, provide doulas who work in a similar capacity as community health workers and are typically from the communities they serve.[430] In this way, community doulas are intimately familiar with the culture, language, customs, and needs of their clients. This is particularly important for people of color in low-income areas where culturally congruent, culturally sensitive, and language-appropriate doula care will have the maximum benefit by ensuring that those who face the highest risk in pregnancy, birth, and postpartum receive the enhanced support they need.[131,166,430,436] Because of the potential to reduce birth disparities, community doula programs are rapidly growing, with many grantee project sites across the United States funded by the Health Resources and Services Administration (HRSA), state Medicaid programs, and private foundations.[166-168,437-440] Many community-based doula organizations structure their group to work together as a collective. In this model, doulas help each other, learn from each other, share care of the patient during labor, relieve each other for breaks and rest, or even "change shift" when a person's labor is exceptionally long.

Doulas also exist in private practice and can be independently hired by birthing people to assist during labor and postpartum. Given the hardship of paying for private practice doulas out-of-pocket, states are implementing innovative Medicaid coverage options. Such programs exist in Florida, Maryland, Minnesota, New Jersey, Oregon, Rhode Island, and – most recently – California.[168,430,436,439-441] Since 2019, California has also hosted the largest number of doula pilot projects. At the time of this writing, there are at least ten doula pilot projects focusing on the role of doulas in improving disparities for BIPOC patients and/or Medicaid recipients. These projects span multiple counties, and three are sponsored by Medicaid health plans.[440] The work of many community doula groups, birth advocates, and health care providers across California ultimately led to an expansion of Medicaid benefits. The California Department of Health Care Services will add doula services as a covered Medi-Cal benefit starting January 1, 2023.[442]

Two Support Models Serving California Communities to Improve Birth Outcomes

The AAIMM Doula Program
Los Angeles County

The Los Angeles County African American Infant and Maternal Mortality (AAIMM) Prevention Initiative is a large coalition of stakeholders including the Department of Public Health, First 5 LA, and a large partnership of community-based organizations, all working with one aim – to reduce the high rates of Black infant and maternal deaths in Los Angeles by addressing the root causes of racism-based disparities. The Initiative launched in 2018 and includes many distinct but coordinated projects that run the gamut of family-centered approaches to disparity reduction, including but not limited to the Perinatal Equity Initiative, group prenatal care, a fatherhood initiative, the Black Infant Health program, and the AAIMM Doula Program. The AAIMM Initiative has engaged a three-pronged strategy that focuses on (1) early intervention, (2) reducing social and environmental exposures that lead to poor health outcomes, and (3) using evidence-based approaches to block the physiologic pathway that converts social and environmental stress to actual physiologic stress.

Since its inception in 2019, the AAIMM Doula Program has provided free doula support to over 500 Black families. In 2020, with a financial award from the California Department of Public Health, the AAIMM Doula Program continues its work with a priority focus on the Antelope Valley, South Los Angeles, and South Bay. Approximately ten doulas work as a collective to assist patients with their informational, emotional, and physical support needs during pregnancy, birth, and postpartum. They provide crucial prenatal education, continuous labor support, breastfeeding support, and infant care and teaching during the first critical days and weeks postpartum. The AAIMM Doulas are often the first line of access to other social support needs the patient may have, such as referrals for mental health assessments. The program supports people who labor and birth in any setting, but often find their support services most vital for people birthing in the hospital setting to act as a communication bridge between patients and providers.

More information can be found here: *https://tinyurl.com/AAIMMDoulas*

Inquiries and referrals should be directed to AAIMMDoulas@ph.lacounty.gov or call (213) 639-6448

Hearts and Hands Volunteer Doula Program
UC San Diego Medical Center

The UCSD Hearts & Hands Volunteer Doula Program at UC San Diego Medical Center is a long-established program that began in late 1999. Anyone who births at UC San Diego may request a volunteer doula. Volunteer doulas work with both low-risk and high-risk patients, even those who birth by scheduled cesarean. Doulas work mainly "on call" and can be requested at any time, day or night. The doulas commit to remaining with the birthing person for the duration of the labor, no matter how long.

A smaller number of families are served through the client referral component of the program, which aims to provide support during pregnancies with special circumstances due to high medical or psychosocial stressors. Providers, social workers, or nursing staff may request a doula who will meet a pregnant person in advance and then attend the birth.

The doulas who participate in this program are highly trained and boast diverse backgrounds and experiences. Many doulas in the Hearts and Hands Program have additional training in childbirth education, breastfeeding, and other related areas. They are comfortable working to give non-clinical care alongside medical staff while functioning primarily as independent advocates for the families they serve.

Some doulas who volunteer at UCSD have been with the program for over 10 years and have achieved a next-level mastery in their field. Because of these committed volunteers, and a supportive hospital system, the Hearts and Hands Program has provided expert doula care at no charge to over 6,900 families who would not otherwise have had a doula. They serve an important role in filling the support gap that many patients have – either because they cannot afford a doula, do not know about doulas, or could not find a low-cost community-based doula in their area. The program was primarily funded through grants for the first five years until UC San Diego Health took over its financial support, creating sustainability for 17 more years and counting.

More information can be found here:
https://tinyurl.com/UCHeartsHands

Inquiries should be directed to Ann Fulcher, Program Manager, at afulcher@health.ucsd.edu

Benefits of Doula Care

Continuous labor support is associated with a significant reduction in cesarean deliveries, operative vaginal deliveries, and use of intrapartum oxytocin.[127,130,131,443] Studies continually replicate the finding of reduced cesareans specific to continuous labor support by doulas.[131,163,443] The ACOG/SMFM consensus statement states: "Published data indicate that one of the most effective tools to improve labor and delivery outcomes is the continuous presence of support personnel, such as a doula…Given that there are no associated measurable harms, this resource is probably underutilized."[3] Additionally, when doulas are utilized in a way that allows them to function appropriately in their unique and integral role, they can simultaneously advocate for birthing people while acting as helpful allies to nurses and providers.[164]

"In comparison with women receiving no continuous labor support, women with doula support were an impressive 39 percent less likely to have a cesarean birth"[444]

Figure 21. Benefits of Doula Care[131,443,445-447]

Less likely with a doula...	More likely with a doula...
• Cesarean birth • Operative vaginal birth • Need for oxytocin • Epidural anesthesia • Use of pain medication	• Spontaneous vaginal birth • Shorter labor • Higher APGAR scores • Breastfeeding initiation • Patient-centered care • Positive birth experience • Lower cost

Reasons for underutilization of doulas are varied but include knowledge deficit about what a doula is and does, objections from partners, geographic lack of access to a doula, and cost.[131] Also, while some nurses and providers fully understand a doula's multi-faceted role and see them as an experienced and valuable team member, others see doulas as an obstacle to care and may take an antagonistic or adversarial view of doulas.[13]

Table 45. Key Strategies for Integrating Doulas Into the Birth Care Team

1 Administrative Strategies

- Foster a departmental culture that values physiologic birth and reduced intervention for normal, low-risk birthing people
- Work together with local doula organizations to provide consistent, accessible support and resources to families
- Connect with community-based doula programs and show interest in supporting and welcoming community-based doulas at your facility
- Explore the feasibility of establishing a hospital-based doula program at your facility that prioritizes a doula workforce that reflects the community being served
- Even if your hospital already has a doula program, do not prevent or restrict the ability of patients to bring their own doula
- All doulas – whether community-based or hospital volunteers – should be empowered to remain independent champions for patients
- Hospital policies should reflect that doulas are not "visitors" in the traditional sense (specifically, they should not bound by time limits or other visitor rules that would restrict their ability to remain with the patient)

2 Clinical Strategies

- Intentionally cultivate a culture on the birthing unit that values physiologic birth through the standardization of clinical practices such as intermittent auscultation, mobility in labor, continuous labor support, and preserving the patient-baby dyad. Resources include:
  - Section II of this toolkit
  - ACNM's Pearls of Physiologic Birth[374]
  - ACOG's Approaches to Limit Intervention During Labor and Birth[377]
- Understand and value the doula's extensive knowledge of labor support techniques as a complement to technical and medical skill sets
- Establish expectations for how providers, nurses, and doulas interact and support each other, and consistently model collegial rapport and open communication
- Develop unit guidelines or educational materials that delineate a mutual understanding of roles and invite local doulas to help create these materials
  - Share these materials with nurses and providers and invite local community groups to share the materials widely with other doulas and patients
  - For facilities with hospital-based doula programs, posting this information at the bedside may help patients to understand the role of their doula
- Foster a culture of patient-centered care that values shared decision making and autonomy and the understanding that doulas are there to consistently advocate on behalf of the patient
- Engage in mutual learning at the time of clinical interaction. Doulas and nurses can learn an enormous amount from each other, and patients also benefit from this shared interaction
  - Some doulas desire to learn more about the medical and nursing aspects of labor
  - Doulas can teach evidence-based, culturally informed techniques that are not often taught in traditional medical and nursing training
- Update policies to include doulas as support people in the operating room if the patient desires

3 Educational Strategies

- Department educational opportunities should include a deeper dive into the components and strategies for successful team-based care that incorporate doulas as part of the team
- Create expanded opportunities for department-wide, interprofessional education that includes doulas from your community or a doula organization with whom you have a relationship
- Debrief about – and learn from – normal, physiologic birth where doula care was, or could have been, pivotal in the patient's progress and outcome
- Ensure that provider and nursing education includes racism-based disparities in maternity care, implicit bias, and an understanding of the role of doula care in curbing this trend

Beyond Labor and Birth: The Role of the Postpartum Doula

The postpartum period is an incredibly vulnerable time. For many, it is a beautiful and exciting experience, but for others, it is fraught with extreme fatigue, breastfeeding difficulties, feelings of anxiety and depression, other competing family responsibilities, and returning to work. The person must navigate all these issues while their body is simultaneously healing from labor, and – for some people – healing from major surgery. Postpartum depression is common, affecting about 15-20% of people during the perinatal period, and studies show that postpartum depression is more common in people of color and people with lower incomes. Postpartum doulas are an essential part of the postpartum team. Most people will not see their provider until at least 3 weeks postpartum, if not 6 weeks. For people experiencing postpartum depression, this time period is critical, and feelings of isolation are common, leading to worsening symptoms. During this time, doulas can provide emotional support, assistance with breastfeeding, meal preparation, light house cleaning, caring for the baby so the parent(s) can nap or shower, and providing resources for other postpartum services as needed. Importantly, they are trained to notice when a person may need an assessment by a trained health care provider for worsening symptoms of depression and anxiety. For many, access to this first-line support is vital in the initial postpartum period.

Table 46. Resources for Doula Integration

AAIMM Doula Project	***https://tinyurl.com/AAIMMPresentation***
March of Dimes – Position Statement on Doulas and Birth Outcomes	***https://tinyurl.com/MODDoula***
National Health Law Program (NHeLP) – California Doula Pilots –Lessons Learned	***https://healthlaw.org/cadoulapilots/***
UC Berkeley– Partnering with Community Doulas to Improve Maternal and Infant Health Equity in California	***https://www.share.berkeley.edu/communitydoulas***
National Partnership for Women & Families – Improving Our Maternity Care Now: Four Care Models Decisionmakers Must Implement for Healthier Moms and Babies (see Doula Care; page 43)	***https://tinyurl.com/NationalPartnership***

Part VI. Success Stories: Lessons Learned from California Hospitals

Table 47. Summary of Lessons Learned

External experts are helpful to initiate the project
Internal interprofessional champions (doctors, midwives, nurses) are critical to achieve improvement
Administrative support is important to establish institutional backing
Change may take time, but improvement can be rapid once a critical mass of early adopters "buys in." Late adopters do not prevent success. Stay the course!
Use feedback from end-users to reliably hard wire unit-level changes, such as with checklists and hard-stop policies
OB hospitalists retain core knowledge and skills, respond promptly, act as key consultants when cesarean birth is in question, and remove the time incentives for patients to give birth on any particular shift schedule
Collaborative practice between midwives and physicians creates an overall culture of care that values and accepts normal variations in labor, and the judicious use of interventions
Provider-level feedback about individual NTSV cesarean rates that is unblinded and shared for all to see, can have a significant and rapid effect on clinical practice—doctors don't like being outliers!
How the message is packaged (e.g. how the data is delivered) is critical!

The Pacific Business Group on Health / CMQCC Pilot Project for Cesarean Reduction

In 2014, the Pacific Business Group on Health (PBGH), working with the California Maternal Quality Care Collaborative, and funded by the Robert Wood Johnson Foundation, instituted a pilot program to reduce cesarean births at three hospitals in Southern California (Hoag Hospital in Newport Beach and two MemorialCare hospitals, Miller Children's and Women's Hospital in Long Beach and Saddleback Memorial Medical Center in Laguna Hills). These hospitals were selected because they exhibited the optimal conditions to initiate cesarean reduction programs, including high birth rates, higher than state average NTSV rates, strong leadership, readiness to engage in the project, and employer concerns about potentially unnecessary cesareans for the large number of employees receiving care at those particular facilities.[105] According to Allyson Brooks MD, Executive Medical Director at Hoag Women's Health Institute, the cesarean rate at Hoag had reached the point where major employers in the area, and individual patients, were voicing concern over the inordinate risk of cesarean at their institution. At MemorialCare, the rates had also reached a level that seemed unacceptable. According to David Lagrew MD, Chief Integration and Accountability Officer: "We had a long emphasis on keeping rates low but had seen a gradual rise to the point where we were seeing the negative outcomes in subsequent pregnancies, such as placenta accreta and massive maternal hemorrhage."

PBGH was successful in identifying major local employers and health plan partners who were interested in taking part in the project. The three institutions and their associated medical groups were matched with a major health plan partner and agreed to work together in a pilot payment reform program characterized by a "blended rate" for birth, for both providers and facilities respectively. As described in Part I of this toolkit, this method involves setting a benchmark cesarean rate and then reimbursing all births at a single rate regardless of mode of birth, essentially creating a "blend" of the proportion of vaginal to cesarean births. The resulting reimbursement rate was above the typical reimbursement rate for vaginal birth, but below typical reimbursement for cesarean. This change in payment signaled to the hospital systems that major payers

were actively reducing any financial incentives for cesareans, and also prompted senior administrative support at each facility. There were significant delays in renegotiating the contracts for the blended payment program and the actual change in payments did not occur until after 9 months into the project. Nonetheless, the three institutions and their respective providers were motivated by these proposed payment changes, employer concerns, and a commitment to improve quality of care.

All three institutions showed impressive improvement. Hoag Hospital started with a mean quarterly baseline NTSV cesarean rate of 32.6%. QI was initiated in January of 2014 and the NTSV cesarean rate dropped to 24.7% by the end of the first quarter of 2015 (a 24.2% reduction). Miller Children's and Women's Hospital showed a similar drop – from a mean baseline NTSV cesarean rate of 31.2%, to a rate of 24.3% during the initial QI period (a 22% reduction). Likewise, Saddleback Memorial decreased from a mean baseline NTSV rate of 27.2% to 21.9% in under a year (a 19.5% reduction). All three institutions started above the state average and dropped below the state average following the QI implementation, with an average decrease of over 20%, a remarkable accomplishment.

CMQCC assisted with implementation of the individual QI programs at each facility, providing mentorship and provider-level feedback data through the Maternal Data Center (MDC). According to Jennifer McNulty MD, the external expertise from Dr. Elliott Main and the CMQCC team helped to validate and legitimize the internal efforts. The hospital hosted Dr. Main for a system-wide kickoff lecture and many providers were motivated by the common sense approach and thoughtful data feedback presented. According to Dr. Marlin Mills from Hoag, the department-wide conversations facilitated by CMQCC demonstrated to bedside providers the importance of their work. Dr. Mills also felt that the individual provider-level cesarean rates, initially confidential but eventually unblinded and openly shared among all providers, strongly incentivized a good number of their staff. In addition, Dr. Brooks credits the hard stop policies for induction scheduling and staff education as key components. These views are echoed by Kim Mikes, Executive Nursing and Operations Director at Hoag Women's Health Institute, who encouraged strong staff support and education in an interprofessional fashion, and spearheaded a focus on the nurse's critical support role in supporting labor and preventing unnecessary cesarean. Similarly, Terri Deeds, Director of Women's and Children's Services at Saddleback Memorial, noted the success of these same improvement strategies, along with feedback from providers, and prioritizing such discussions at department meetings. At Miller Children's and Women's Hospital, Dr. Kenneth Chan and Janet Trial, EdD, CNM are expanding the QI efforts to include a clinical checklist utilizing the newer definitions for arrest of labor and second stage management. The checklist, which is completed by the health care team prior to proceeding with cesarean birth in cases of failure to progress, thus far seems to be the single most effective intervention in decreasing the NTSV cesarean birth rate. According to Dr. McNulty, the MemorialCare Women's Best Practice Team is spearheading efforts to automate the electronic record system to provide detailed clinical feedback to MemorialCare providers. Finally, OB hospitalists were utilized. Two of the hospitals (Hoag and Saddleback) already had active full-time OB hospitalist (laborist) services at the time. Of the two, the Saddleback program sought out more direct engagement of the hospitalist by allowing nursing staff to routinely seek their involvement in all labors. The hospitalist presence allowed on-call physicians to more easily meet professional and personal off-site duties while their patients labored, gave more immediate attention to all laboring women and decreased potential time or financial incentives to prematurely end labors.

According to these leaders, while the majority of doctors and nurses have supported these efforts and the hospitals are continuing to work on lowering rates, change is still not universal and not all providers are fully committed to the program. The combination of payment reform, unit policy changes, overall cultural change on the labor and delivery unit, and continued provider-level feedback should continue the trend in cesarean reduction. Nonetheless, persistence and commitment will be essential to sustained success.

John Muir Medical Center

In 2014, John Muir Medical Center had approximately 2800 births, and an NTSV cesarean rate of 17.4%. Approximately 25 private obstetricians, 2 perinatologists, and 4 midwives (making up a total of 15 practice groups) have delivery privileges at this facility. While most delivering patients experience a traditional private practice model, where the prenatal provider (or someone from that particular provider group) attends to their own patients at the time of birth, John Muir has also created a 24/7 quasi-hospitalist approach, where a rotating schedule determines the physician who is assigned to cover emergencies, precipitous births, and other events not otherwise covered by the private practice groups.

According to Jamie Vincent, Clinical Nurse Specialist with John Muir for 26 years, a turning point came with one of the first quality improvement initiatives related directly to cesarean, that of improving VBAC rates and offering TOLAC

to more eligible women. John Muir now boasts a VBAC success rate above 80%. While not intentional, it seems this philosophy of care, or one that Jamie Vincent describes as "a culture that says vaginal birth is important" now informs the care practices and overall attitude of supporting intended vaginal birth for every patient.

The practices now embedded in the culture of care at John Muir include patience with the length of labor as long as the fetus and mother are doing well, external cephalic version for women with a singleton breech fetus, skilled providers who attend to vaginal breech deliveries in the rare cases that present, a safe use of oxytocin policy, a push toward eliminating non-medically indicated induction of labor, encouragement of ambulation during labor, intermittent monitoring for low-risk patients (and telemetry units available for women who need to be continuously monitored but who desire freedom of movement), delayed pushing (passive descent) in the second stage, and a commitment to providing a "low intervention birth experience" for women who desire a hospital birth but wish to have a birth experience where interventions are based upon need rather than convenience and routine use. Furthermore, a philosophy of patience permeates the culture at John Muir. For example, when patients are brought to the operating room, it is not a forgone conclusion that a cesarean will occur. The providers and nurses are willing to assess the situation further while there and, in many cases, return to the patient's room to continue labor when fetal and maternal statuses permit. This host of policies, practices, and beliefs – along with nurses and providers who care deeply about quality of care – has led to an embedded philosophy of support for intended vaginal birth.

Feedback is important. Cesarean rates and quality measures from other improvement projects are openly shared. Nurses and providers are curious and informed. They request timely data and are not shy in questioning the data to ensure accuracy. The members of the inter-professional Perinatal Quality and Safety Committee form the foundation of a stable leadership team that researches and implements most improvement activities. Like many high performing organizations, teamwork and interdisciplinary communication is a work in progress. Understanding the relationship between teamwork and the ability to consistently perform well in both emergencies and day to day operations, John Muir continues to make this a priority, engaging in High Reliability Organization trainings and consistently prioritizing teamwork and better communication.

Kaiser Permanente Roseville Medical Center

The Kaiser Permanente Roseville Medical Center opened in 2009 with a Level III NICU and high-risk expertise in maternity care. Kaiser Roseville's 2014 NTSV cesarean rate was 16.9%, despite its many high-risk patients and a total birth rate of approximately 5,000 per year.

While there has always been a "quasi-hospitalist" model at Kaiser (in the sense that providers worked shifts on the labor and delivery unit as opposed to being called in for births), Kaiser Roseville recently created a specific OB hospitalist position. Now, in addition to the other physicians who work in shifts on the labor and delivery unit but who may also attend to multiple other clinical obligations, the unit is staffed 24/7 by an OB hospitalist whose main priority is the management of laboring patients. According to Dr. Belinda Perez, OB hospitalist, this creates a sense of continuity and smooth transition between providers, and an understanding that patients are not on a timeline based upon any particular shift. Furthermore, according to Dr. Carolyn Odell, Maternity Subchief, the OB hospitalist is a resource to the other physicians when complicated cases arise. The hospitalists are expected to develop and retain skills in operative vaginal delivery, manual rotation, external cephalic version, and breech extraction of the second twin. Even if another physician is managing a patient, the hospitalist is available as a "second pair of eyes" for consultation, or to help as needed.

Kaiser Roseville also has 15 midwives. Just as there is always an OB hospitalist, there is also a midwife on the unit around-the-clock. The midwife attends low-risk births and, as appropriate, co-manages higher risk patients who need physician oversight but prefer a midwifery approach to labor management. The midwifery group has positively influenced both physician and nursing practice in terms of how normal labor is managed. These influences include accepting that there are normal variations in the length of labor, encouraging ambulation, using alternative methods of pain relief, and judiciously using interventions such as oxytocin and continuous monitoring. For women meeting low-risk criteria, intermittent monitoring is the standard of practice.

Holly Champagne, Clinical Nurse Specialist, notes that Kaiser Roseville, like many Kaiser facilities, maintains a culture of quality improvement, adherence to evidence based practice, and a strong interprofessional leadership team that enforces a constant culture of safety and

attention to quality. For example, when Spong and colleagues published *Preventing the First Cesarean Delivery* in 2012,[85] the Perinatal Patient Safety Committee quickly took the lead in reframing for providers and nurses the parameters for normal labor duration and, ultimately, succeeded in letting go of the Friedman curve. Dr. Perez notes that doing so reduced the overall number of cesareans for failure to progress. Furthermore, chart reviews indicate that there are now rarely cases of "failure to progress" that do not meet the new definitions. While it did take some time for all providers to "digest" and accept this new information, leadership by the OB hospitalists and expertise of the midwives in normal birth helped to further solidify this new concept into the culture of care.

Dr. Perez and Susan Stone, CNM (previous Chief Nurse-Midwife) agree that gatekeeping, or hard-stop policies, are also an important component of keeping cesarean rates low. For example, Kaiser Roseville has a policy of no inductions without medical indication before 40 weeks, and providers are strongly encouraged to schedule postdates inductions at or after 41 weeks. This is enforced through a method of online scheduling that requires a medical indication. When there is no medical indication for induction, review by the OB hospitalist and nurse manager is required.

Other ongoing quality improvement activities and patient safety initiatives at Kaiser Roseville may also directly impact cesarean rates, including the recent institution of a safe usage of oxytocin policy and checklist, interdisciplinary team trainings for critical events, and instituting algorithms and decision making tools for Category II fetal tracings.

Holly Champagne notes that the labor and delivery nurses at Kaiser Roseville are absolutely integral to the quality improvement process, and are exceptional in both support to the patient and technical aptitude. Nonetheless, she states there is an expectation of constant improvement, noting the recent midwife-led trainings for labor support and recent emphasis on alternative coping methods, such as use of TENS and the upcoming integration of nitrous oxide into the labor and delivery suites.

Finally, data is important. Dr. Odell notes that cesarean rates are routinely discussed and remain a priority topic at monthly Perinatal Patient Safety Committee meetings. Also, providers and nurses are given feedback and provided with timely data to show the success of each quality improvement effort. Holly Champagne agrees wholeheartedly that interdisciplinary leadership and buy-in is critical to this process, but also notes that the stable leadership team at Kaiser Roseville is adept at packaging the information appropriately for each member of the labor and delivery team. She states that while the nurses, doctors, and midwives all care deeply about patients and quality, each discipline benefits from unique, tailored "messaging" that aligns data feedback and policy change. Although subtle, these differences in messaging are critical to the acceptance of change and identifying potential points of resistance.