

# OBI & Labor Management for the Practicing Clinician

OBI Webinar Series | February 25, 2025

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# Disclosures

Support for OBI is provided by Blue Cross Blue Shield of Michigan and Blue Care Network as part of the BCBSM Value Partnerships program.

Although Blue Cross Blue Shield of Michigan and OBI work collaboratively, the opinions, beliefs, and viewpoints expressed by the author do not necessarily reflect the opinions, beliefs, and viewpoints of BCBSM or any of its employees.

Jourdie Triebwasser MD and Lisa Kane Low PhD CNM had salary support during the time of this project as members of the OBI program as well as from the National Institutes of Health, Michigan Department of Public Health

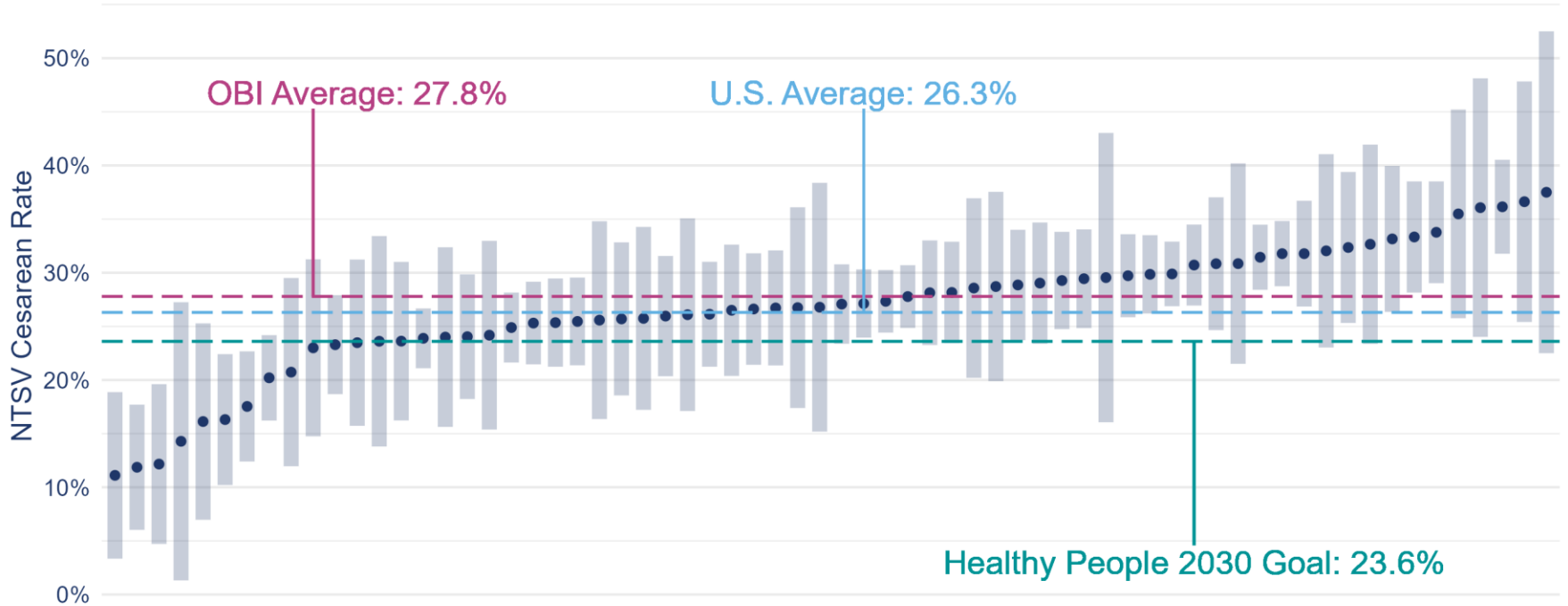


# Objectives

At the conclusion of this webinar participants will be able to:

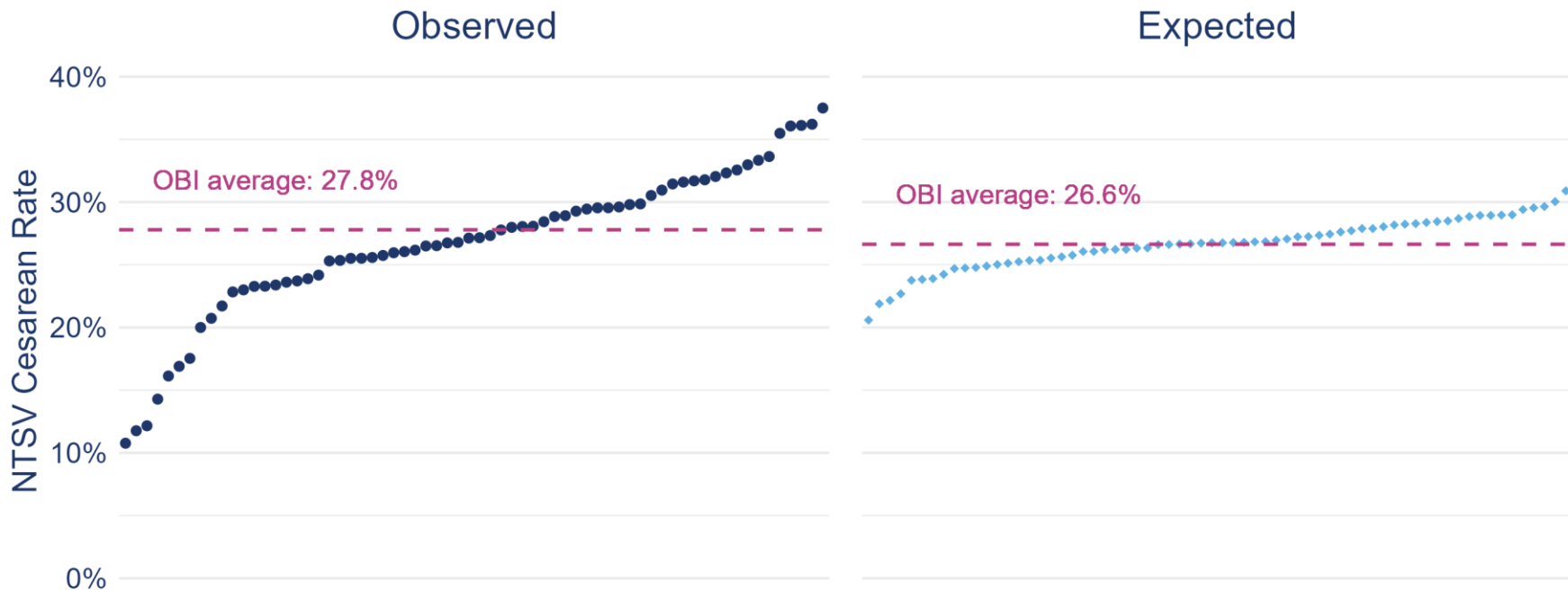
- Accurately identify the criteria for differing types of labor dystocia and options for documentation of it.
- Discuss strategies for management of labor dystocia and potential for prevention of it.
- Identify opportunities to engage all maternity care team members in strategies to increase compliance with use of dystocia criteria in alignment with the Obstetric Initiative.

# We continue to observe clinically unwarranted wide variation in the NTSV cesarean rate in MI



Includes complete cases 01/01/2024 - 09/29/2024

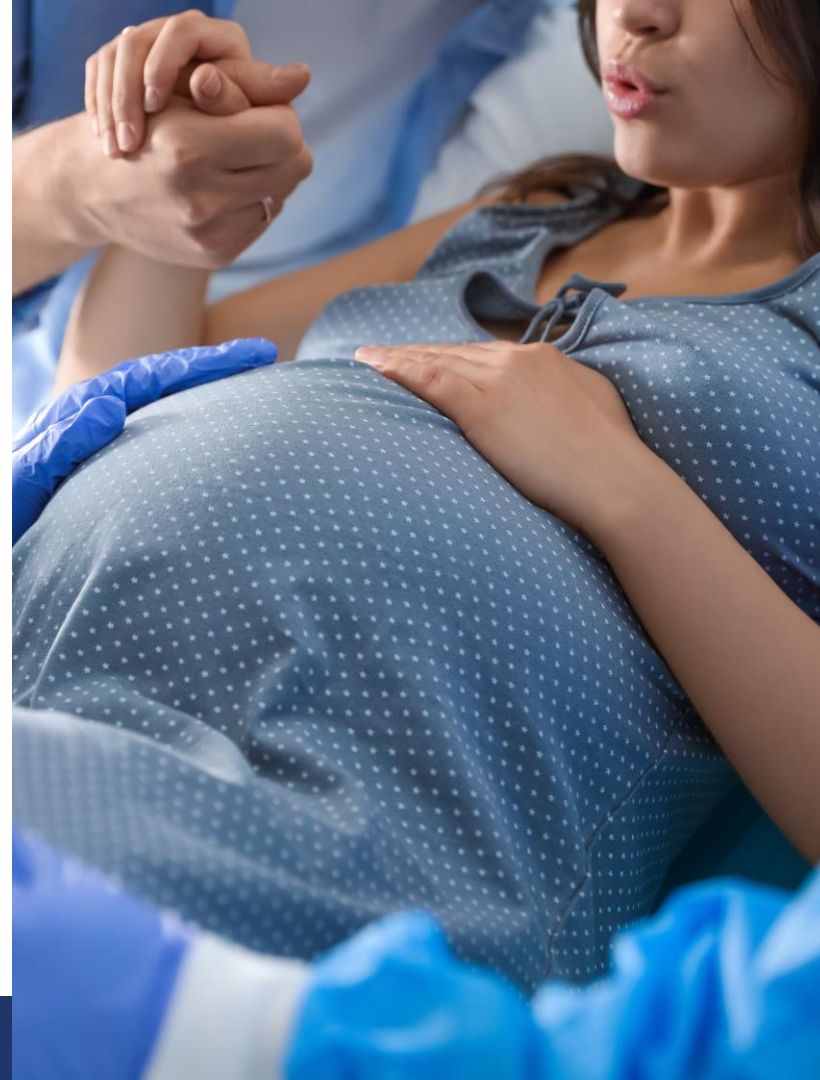
# Observed variation is not explained by common medical & social risk factors



Predictions are based on data from 01/01/2024 - 09/30/2024

# 22 yo G1 presents for induction (IOL) for preeclampsia

- Initial exam 1/long/high
- Received 3 doses of misoprostol and foley balloon
- Exam 3/50/-2 over 12 hours while on pitocin
- Do you recommend a cesarean now?





## 28 yo G1 presents with painful contractions

- Initial exam 3/50/-2
- Admitted
- Next exam 4 hours later 4/50/-2
- 3 subsequent exams over 12 hours: 5/50/-1
- Do you recommend a cesarean now?

# 30 yo G1 presents with painful contractions

- Initial exam 3/50/-2
- Admitted
- Next exam 4 hours later 6/75/-1
- SRM to clear fluid soon after exam
- Next exam 4 hours later 6/75/-1
- Do you recommend a cesarean now?







## 35 yo G2P0 presented in active labor

- Received epidural at 8 cm
- Began pushing 3 hours ago, efforts more effective recently
- Do you recommend a cesarean now?



**All four scenarios represent questions for management of dystocia and whether it meets criteria for performance of a Cesarean**

# Ten Years Ago: New Paradigm for 1st Stage

Prolonged latent phase >24 hours not an indication for CD

Latent phase includes 4 - 6cm of cervical dilation

*No difference between nulliparas and multiparas*

**OBSTETRIC CARE**

**CONSENSUS**

Safe Prevention of the Primary  
Cesarean Delivery

**6cm - the threshold for active phase**

**3 hours for Nulliparous and 2 hours for Multiparous Second Stage**

Time intervals for meeting criteria for dystocia: Active Phase Arrest, Failed Induction of Labor, Second Stage: Failure to Descend.

# ACOG 2024

- General management of “normal labor” and diagnosis of dystocia
- Reinforces the “New” Paradigm



## CLINICAL PRACTICE GUIDELINE

NUMBER 8

JANUARY 2024

(REPLACES OBSTETRIC CARE CONSENSUS 1, MARCH 2014)

### First and Second Stage Labor Management

**Committee on Clinical Practice Guidelines—Obstetrics.** This Clinical Practice Guideline was developed by the ACOG Committee on Clinical Practice Guidelines—Obstetrics in collaboration with Alison G. Cahill, MD, MSCI; Nandini Raghuraman, MD, MSCI; and Manisha Gandhi, MD; with consultation from Anjali J. Kaimal, MD, MAS. The Society for Maternal-Fetal Medicine (SMFM) supports this document.

**PURPOSE:** The purpose of this document is to define labor and labor arrest and provide recommendations for the management of dystocia in the first and second stage of labor and labor arrest.

**TARGET POPULATION:** Pregnant individuals in the first or second stage of labor.

**METHODS:** This guideline was developed using an a priori protocol in conjunction with a writing team consisting of one maternal-fetal medicine subspecialist appointed by the ACOG Committee on Clinical Practice Guidelines—Obstetrics and two external subject matter experts. ACOG medical librarians completed a comprehensive literature search for primary literature within Cochrane Library, Cochrane Collaboration Registry of Controlled Trials, EMBASE, PubMed, and MEDLINE. Studies that moved forward to the full-text screening stage were assessed by the writing team based on standardized inclusion and exclusion criteria. Included studies underwent quality assessment, and a modified GRADE (Grading of Recommendations Assessment, Development, and Evaluation) evidence-to-decision framework was applied to interpret and translate the evidence into recommendation statements.

**RECOMMENDATIONS:** This Clinical Practice Guideline includes definitions of labor and labor arrest, along with recommendations for the management of dystocia in the first and second stages of labor and labor arrest. Recommendations are classified by strength and evidence quality. Ungraded Good Practice Points are included to provide guidance when a formal recommendation could not be made because of inadequate or nonexistent evidence.

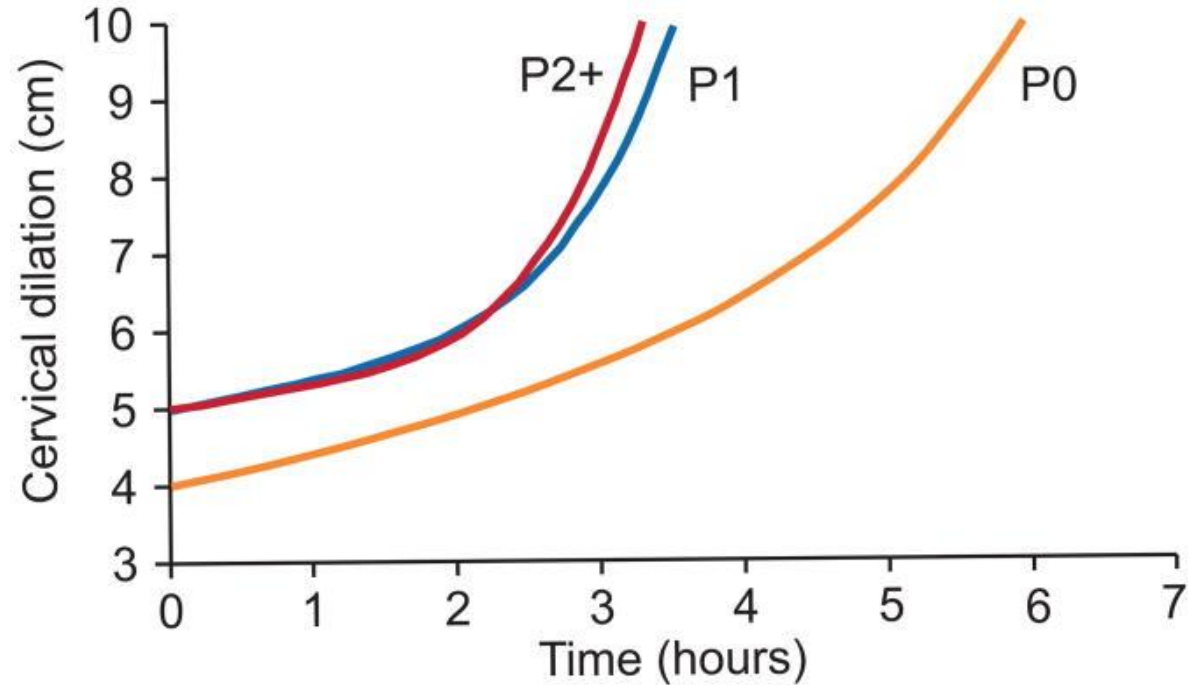
# First and Second Stage Labor Recommendations 2024

## Reaffirms:

- No specific definition of latent phase labor\*
- Recommendation of 6 cm as start of active phase
- Suggests active phase arrest definition is unchanged
- Recommends definition of prolonged second stage of labor is defined as more than 3 hours of pushing in nulliparous individuals and 2 hours of pushing in multiparous individuals.
- Tailored counseling if moving beyond 2 or 3 hours second stage labor



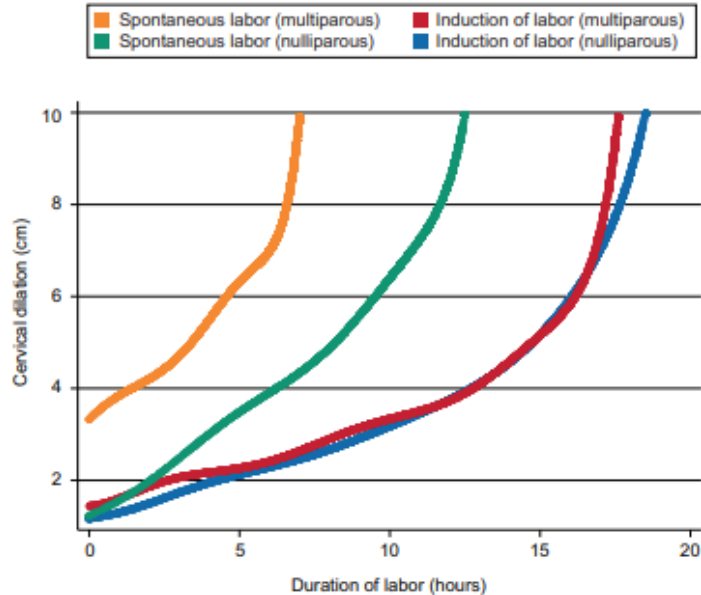
# Normal Labor Progress



# Six is the New Four

Cervical Dilation (cm)	Parity=0 Median (95 <sup>th</sup> percentile) N=25624	Parity=1 Median (95 <sup>th</sup> percentile) N=16755	Parity=2+ Median (95 <sup>th</sup> percentile) N=16219
3-4	1.8 (8.1)	--	--
4-5	1.3 (6.4)	1.4 (7.3)	1.4 (7.0)
5-6	0.8 (3.2)	0.8 (3.4)	0.8 (3.4)
6-7	0.6 (2.2)	0.5 (1.9)	0.5 (1.8)
7-8	0.5 (1.6)	0.4 (1.3)	0.4 (1.2)
8-9	0.5 (1.4)	0.3 (1.0)	0.3 (0.9)
9-10	0.5 (1.8)	0.3 (0.9)	0.3 (0.8)
2 <sup>nd</sup> stage with epidural analgesia	1.1 (3.6)	0.4 (2.0)	0.3 (1.6)
2 <sup>nd</sup> stage without epidural analgesia	0.6 (2.8)	0.2 (1.3)	0.1 (1.1)

# What about Induction of Labor?



**Fig. 1.** Average labor curves stratified by parity and type of labor onset.

- Latent phase is slower with IOL
- Active phase at 6 cm
- Active phase slope similar to spontaneous labor



# ACOG Guideline Summary Continued

## For Spontaneous Labor:

- Continue to support admission in active labor (> 6 cm), considering discharge home if not in active labor upon presentation at hospital
- Once admitted promote labor progress through support techniques including mobility, position changes and comfort measures
- Select appropriate fetal assessment strategy
- Promote continuity of care and labor support and engage Doula or Family support
- Encourage pushing once complete, and consider a variety of positions as indicated, while continuing to assess fetal rotation and descent



# **Lessons from the Literature & OBI**

**Does following the ACOG Labor Guidelines Matter?**

# Implementing Dystocia Criteria (Site 1)

**OBSTETRIC CARE**

**CONSENSUS**

Safe Prevention of the Primary  
Cesarean Delivery



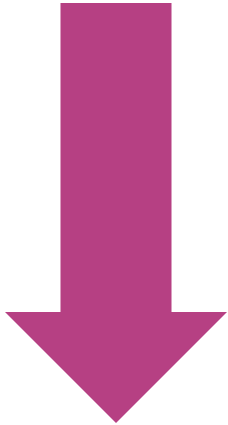
*Original Research*

## Reduction in the Cesarean Delivery Rate After Obstetric Care Consensus Guideline Implementation

*Jonas G. Wilson-Leedy, MD, Alexis J. DiSilvestro, MD, John T. Repke, MD, and Jaimey M. Pauli, MD*

# Dystocia Guidelines Reduced Cesarean

NSTV cesarean after  
IOL (36% to 25%)



NSTV cesarean  
(27% to 19%)



Maternal  
Morbidity



What  
changed?


Reduction in latent  
phase arrest and  
failed induction

# Implementing Dystocia Criteria (Site 2)

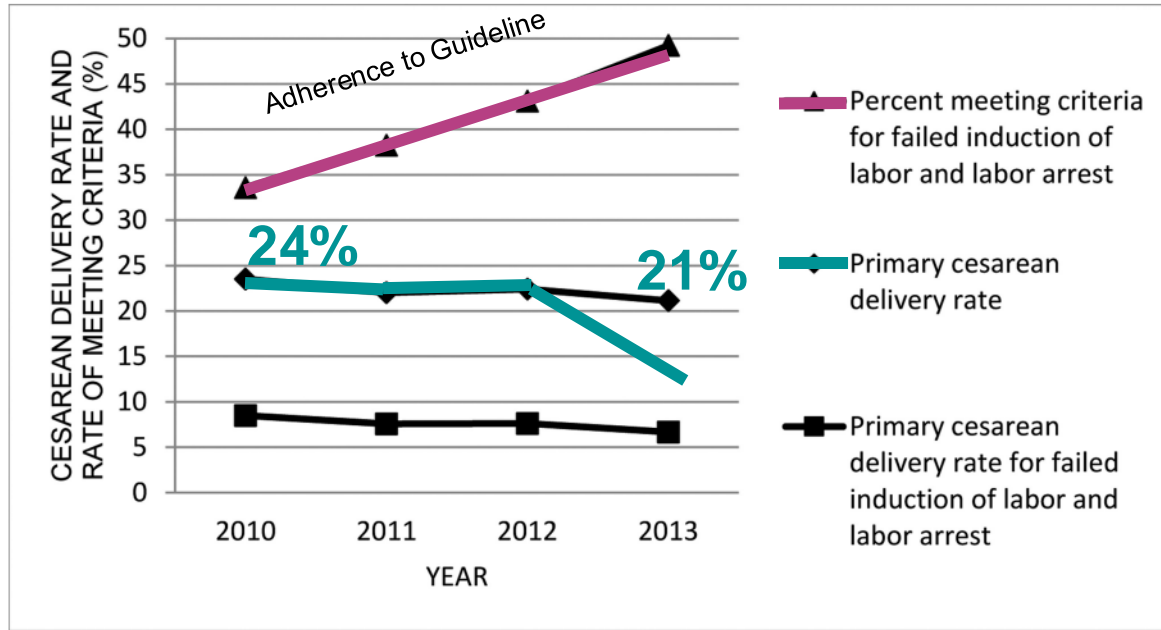
2012 NICHD  
“Preventing the First  
Cesarean Delivery”



## Adherence to Definitions of Labor Arrest Influence on Primary Cesarean Delivery Rate

Jessica T. Greenberg, MD<sup>1,2</sup>  Sarah N. Cross, MD<sup>1,3</sup> Cheryl A. Raab, MSN<sup>4</sup> Christian M. Pettker, MD<sup>1</sup>  
Jessica L. Illuzzi, MD<sup>1</sup>

# Dystocia Guidelines Reduced Cesareans



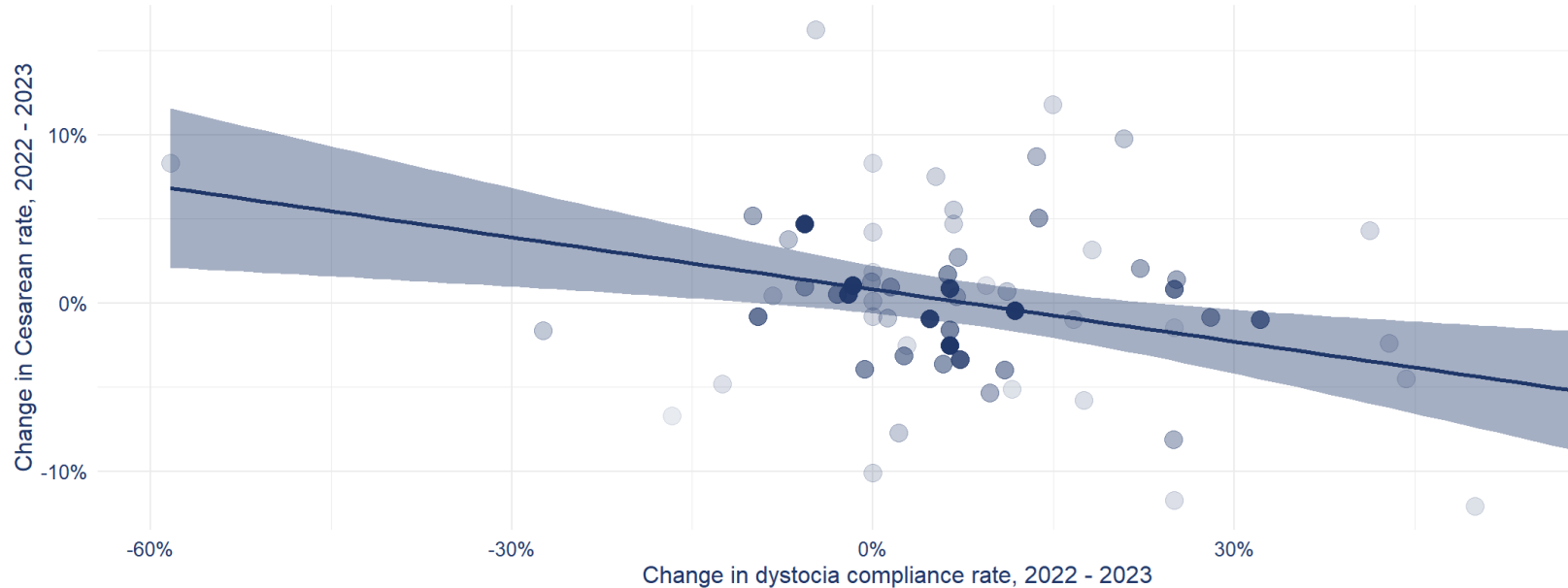
What changed?

Reduction in latent phase arrest and failed induction

# OBI's Experience Promoting Dystocia Compliance

There is a significant, negative relationship between dystocia compliance change and unplanned Cesarean rate change, 2022 - 2023 ( $p = 0.003$ )

Unadjusted linear regression. Darker points represent hospitals with a larger NTSV delivery volume



# Doing the Dance with Dystocia: The Steps

- ✓ Prevention
- ✓ Early identification
- ✓ Diagnosis
- ✓ Response or Treatment
  - Levels of Treatment





# Keeping Labor Normal

- Be a constant presence
- Create a positive, respectful atmosphere
- Arrange the room for patient's comfort
- Give support, comfort, reassurance
- Use touch, massage, physical support as desired and consented to by the patient
- Promote being upright and moving
- Promote comfort consistent with the patient's desires and preferences
- Assess for progress over time and identify opportunities to encourage the labor process

# Specific Practices to Prevent Dystocia

- Childbirth preparation classes
- Continuous labor support by RN, midwife, doula\* or family
- Walking, movement
- Hydrotherapy\* (active labor)
- Position changes
- Intermittent FH auscultation when eligible
- Use of wireless EFM when continuous monitoring indicated
- Spinning babies\*
- Use of peanut balls\*
- Comfort assessment and management



# The Use of “Magical” Balls

Expert Review

ajog.org

## Birthing balls to decrease labor pain and peanut balls to decrease length of labor: what is the evidence?



Jessica M. Grenvik, MD; Laniece A. Coleman, DNP, CNM; Vincenzo Berghella, MD

- A recent systematic review and meta-analysis found that the use of the peanut ball compared with no peanut ball is associated with a significantly decreased first stage of labor (mean difference, 87.42 minutes; 95% confidence interval, 94.49 to 80.34) and an 11% higher relative risk of vaginal delivery (relative risk, 1.11; 95% confidence interval, 1.02e1.22; n 669).
- More Randomized Controlled Trials are needed: ACOG no recommendation

# Adequate Nurse Staffing

Nursing Outlook 73 (2025) 102346



Contents lists available at ScienceDirect

Nursing Outlook

journal homepage: [www.nursingoutlook.org](http://www.nursingoutlook.org)



## Relationship between nurse staffing during labor and cesarean birth rates in U.S. hospitals



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### ARTICLE INFO

#### Article history:

Received 7 September 2024

Received in revised form 20 December 2024

Accepted 29 December 2024

Available online xxx

#### Keywords:

Nursing staff

Hospital

Personnel staffing

Hospitals

Pregnancy

Maternal health services

Workforce

Inpatients

Obstetric nursing

Cesarean section

Vaginal birth after cesarean

### ABSTRACT

**Background:** Cesarean birth increases risk of maternal morbidity and mortality.

**Purpose:** Examine the relationship between labor and delivery staffing and hospital cesarean and vaginal birth after cesarean (VBAC) rates.

**Methods:** Survey of U.S. labor nurses in 2018 and 2019 on adherence to AWHONN nurse staffing standards with data linked to American Hospital Association Survey data, patient discharge data, and cesarean birth and VBAC rates.

**Findings:** In total, 2,786 nurses from 193 hospitals in 23 states were included. Mean cesarean rate was 27.3% (SD 5.9, range 11.7%–47.2%); median VBAC rate 11.1% (IQR 1.78%–20.2%; range 0%–40.1%). There was relatively high adherence to staffing standards (mean, 3.12 of possible 1–4 score). After adjusting for hospital characteristics, nurse staffing was an independent predictor of hospital-level cesarean and VBAC rates (IRR 0.89, 95% CI 0.84–0.95 and IRR 1.58, 95% CI 1.25–1.99, respectively).

**Discussion:** Better nurse staffing predicted lower cesarean birth rates and higher VBAC rates.

**Conclusion:** Hospitals should be accountable for providing adequate nurse staffing during childbirth.  
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# Moving our Mamas (MOMs) Labor Support Training

- Labor Support Tip Sheets
- Posters with Photos



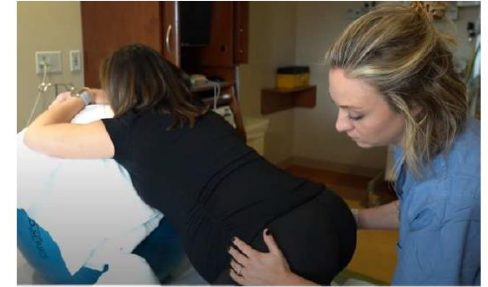
## Counter Pressure

- Counter-pressure consists of steady, strong force applied to one spot on the lower back during contractions using the heel of the hand, or pressure on the side of each hip using both hands.
- Counter-pressure helps alleviate back pain during labor, especially in those women experiencing “back labor.”



## Hip Squeeze

- The hip squeeze pushes the pelvis back into a relaxed position, which both relieves the pressure of the stretch and causes the pelvis to flare out slightly, allowing the baby room to move around and down.



FIFTH EDITION



SIMKIN'S  
**LABOR**  
PROGRESS  
HANDBOOK

**EARLY INTERVENTIONS  
TO PREVENT AND  
TREAT DYSTOCIA**

EDITED BY  
**LISA HANSON  
EMILY MALLOY  
PENNY SIMKIN**

- “More time” does not mean not doing anything during that time
- Identifying opportunities to promote labor progress
- Again: Being there makes a difference
- Role of continuous labor support
- Doulas
- Nursing Staffing



# Diagnosis of Dystocia

<b>Active Phase Arrest <math>\geq 6</math>cm</b>	<p>No improvement in cervical dilation with rupture of membranes &amp;:</p> <ul style="list-style-type: none"><li>◦ <math>\geq 4</math> hrs of adequate uterine contractions</li><li>◦ Or <math>\geq 6</math> hrs of oxytocin administration with inadequate uterine contractions</li></ul>
<b>Arrest of Descent</b>	<p>Second stage of labor with rupture of membranes &amp; <math>\geq 3</math> hrs of pushing</p>
<b>Failed Induction</b>	<p>Cervical dilation of <math>&lt; 6</math> cm &amp; oxytocin administration for <math>\geq 12-18</math> hrs after rupture of membranes</p>



# What happened to Latent Phase Labor?

- Prior use of CMQCC Definition
  - Cervical dilation <6cm and moderate or strong contractions on palpation were present for at least 12 hours without improvement in cervical dilation
- Smallest frequency of dystocia diagnosis leading to cesarean
- Requires management of latent phase labor
  - Decision to move to augmentation of labor
  - Decision to move to discharge home post comfort care management
- 2025 Diagnosis of Latent Phase Labor for Cesarean is non-compliant



## 28 yo G1 presents with painful contractions

- Initial exam 3/50/-2
- Admitted
- Next exam 4 hours later 4/50/-2
- 3 subsequent exams over 12 hours: 5/50/-1
- Do you recommend a cesarean now?

# Latent Phase Labor

- Patient education regarding labor progress, active labor definitions and strategies to support delayed admission until active labor
- For birthing person in latent labor options include delayed admission, support at home, use of Doula, “walking paths” and promotion of comfort measures
- If prolonged latent labor is being experienced after admission (greater than 16 hours or 95%tile for admission to active labor time in Spong et. al) consider induction/augmentation and follow induction of labor management or discharge home

# 22 yo G1 presents for induction (IOL) for preeclampsia

- Initial exam 1/long/high
- Received 3 doses of misoprostol and foley balloon
- Exam 3/50/-2 over 12 hours while on pitocin
- Do you recommend a cesarean now?



# Induction of Labor & Dystocia

- Interval from initiation of the induction process and < 6cm
  - Oxytocin administration at least 12-18 hours after membranes are ruptured
- If >6 cm dilated, follow the criteria for arrest of active phase
  - Arrest of Active Phase Labor: Membranes ruptures and:
    - *At least 4 hours of adequate contractions without change or*
    - *At least 6 hours of oxytocin use with inadequate contractions and no change*



## Labor Induction Process (or latent labor not progressing)

- Refer to Best Practice Guidance for Induction Agents: High or Low Dose Oxytocin is appropriate
- Early amniotomy is strongly recommended (high quality evidence)
- Failed Induction of Labor is when Oxytocin administration is at least 12-18 hours after membranes are ruptured
- Follow criteria for dystocia management of spontaneous labor once in active labor (>6cm)

# 30 yo G1 presents with painful contractions

- Initial exam 3/50/-2
- Admitted
- Next exam 4 hours later 6/75/-1
- SROM to clear fluid soon after exam
- Next exam 4 hours later 6/75/-1
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## ACOG Recommendations for Spontaneous Labor

- Continue to support admission in active labor (> 6 cm), considering discharge home if not in active labor upon presentation at hospital
- Once admitted promote labor progress through support techniques including mobility, position changes and comfort measures
- Select appropriate fetal assessment strategy
- Promote continuity of care and labor support and engage Doula or Family support

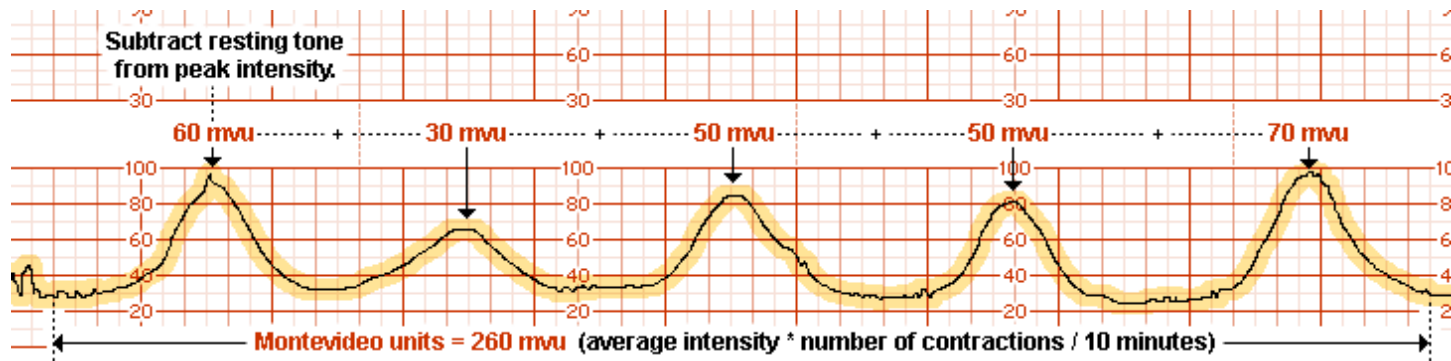


# 2024 Updates: Management of Dystocia in First Stage Labor Recommendations

- Recommends amniotomy for patients undergoing augmentation or induction of labor to reduce the duration of labor.
- Recommends either low-dose or high-dose oxytocin strategies as reasonable approaches to the active management of labor to reduce operative deliveries.
- Using intrauterine pressure catheters among patients with ruptured membranes to determine adequacy of uterine contractions in those with protracted active labor or when contractions cannot be accurately externally monitored.

# 2024 Updates: Management of Dystocia in First Stage Labor Recommendations

- The only direct measure of uterine quality is with an internal pressure catheter
- Strength of contractions measured with Montevideo units (mvu)
  - 200 mvu generally considered “adequate”



# Management of Active Phase Labor Arrest/Dystocia

- Recommends performing a Cesarean in patients with active phase arrest
- Suggests assessment for operative vaginal delivery before performing a cesarean for second stage arrest





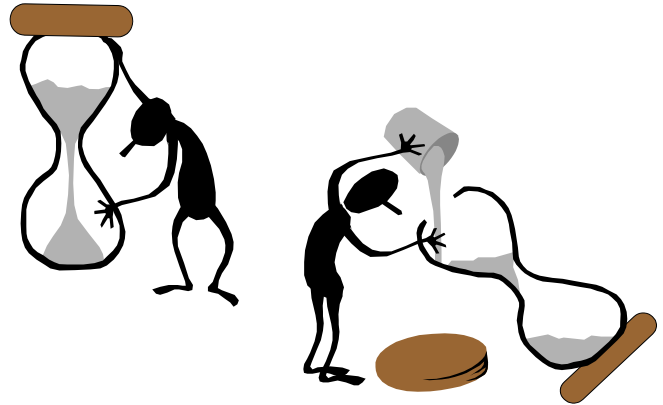
## 35 yo G2P0 presented in active labor

- Received epidural at 8 cm
- Began pushing 3 hours ago, efforts more effective recently
- Do you recommend a cesarean now?

# Consensus Statement

## 2nd Stage Duration

- At least 2 hours for multiparous women
- At least 3 hours active pushing for nulliparous birthing people
- Longer durations may be appropriate on an individualized basis...e.g., epidural, fetal malposition



# Second Stage Labor Pushing to Manage (Prevent) Dystocia

**New  
Recommendation:**

Pushing commence when complete cervical dilation is achieved

# Normal Second Stage

Cervical Dilation (cm)	Spontaneous Labor		Induced or Augmented Labor		P
	n	Median Station (95% CI) (n=1,796)	n	Median Station (95% CI) (n=2,822)	
0	3	-3 (-3 to -3)	162	-3 (-3 to -2)	.62
1	22	-2.5 (-3 to 0)	471	-3 (-3 to -1)	<.01
2	70	-2 (-3 to 0)	654	-3 (-3 to -1)	.03
3	231	-2 (-3 to 0)	1,222	-2 (-3 to -1)	<.01
4	428	-2 (-3 to 0)	1,520	-2 (-3 to 0)	.95
5	520	-1 (-3 to 0)	1,281	-1 (-3 to 0)	.47
6	511	-1 (-3 to 1)	951	-1 (-3 to 1)	.31
7	469	0 (-3 to 1)	695	0 (-2 to 1)	.02
8	520	0 (-2 to 1)	661	0 (-2 to 1)	.03
9	432	0 (-2 to 2)	614	1 (-1 to 2)	.02
10	1,770	2 (0-2)	2,772	2 (0-3)	.59

CI, confidence interval.

Median station adjusted for parity, maternal body mass index, and birth weight greater than 4,000 g.

Most patients will be at least 0 station at complete, even in setting of IOL (Median is +2)

Fetal Station	Spontaneous Labor (n=1,796)	Induced or Augmented Labor (n=2,822)	P
-2 to -1	0.3 (0.03-2.1)	1.2 (0.2-9.9)	<.01
-1 to 0	0.2 (0.03-2.2)	0.6 (0.1-5.4)	<.01
0 to +1	0.2 (0.03-2.1)	0.4 (0.04-3.3)	<.01
+1 to +2	0.1 (0.02-0.8)	0.2 (0.02-1.1)	<.01
+2 to +3	0.05 (0.01-0.2)	0.1 (0.02-0.4)	.03

Data are median hours (95% confidence interval) unless otherwise specified.

Median times adjusted for parity, maternal body mass index, and birth weight greater than 4,000 g. No adjustment for maternal age, diabetes, or regional anesthesia, which were not significant in the final model.

# Second Stage Management

Longer second stage = higher risk of maternal and neonatal morbidity

- Consistent data across multiple large observational cohorts

Outcomes	Immediate (n=1200)	Delayed (n=1204)	RR (95% CI)
SVD	1031 (85.9%)	1041 (86.5%)	0.99 (0.96-1.03)
PPH	27 (2.3%)	48 (4.0%)	<b>0.60 (0.3-0.9)</b>
Chorio	80 (6.7%)	110 (9.1%)	<b>0.70 (0.66-0.9)</b>

Delayed pushing in nulliparous patients with epidural

- No benefit, + Harm
- OMSS trial stopped early due to futility (for SVD) and harm signal
- pH <7.1 and suspected neonatal sepsis also increased with delayed pushing
- No impact on pelvic floor morbidity

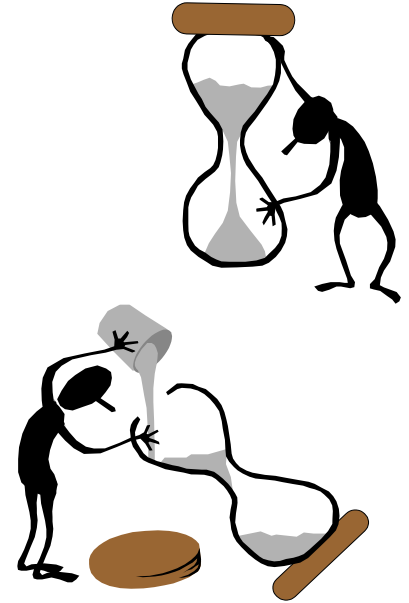


# Evidence-Based Management of Second Stage Labor

- **Laboring down with an Epidural no Longer Encouraged (Cahill et al)**
- **Open Glottis, Self Directed Pushing not Coached (may be tailored)**
- **Upright Positions, Freedom of Movement to Change Positions**
- **Evaluate progress in descent and ROTATION**
- **Assess for Need to Change Process: Fetal Position, Presentation**
- **Close Fetal AND MATERNAL Assessment**

# Updated ACOG Statement: Second Stage

- **New:** Individualized decision making when making no progress prior to 2 hours in a multiparous individual and 3 hours in a nulliparous individual (strong evidence)
- “Arrest in the second stage can be identified earlier if there is lack of fetal rotation or descent despite adequate contractions, pushing efforts, and time. (GOOD PRACTICE POINT)”\*



# New OBI Labor Dystocia Compliance Measure Specifications

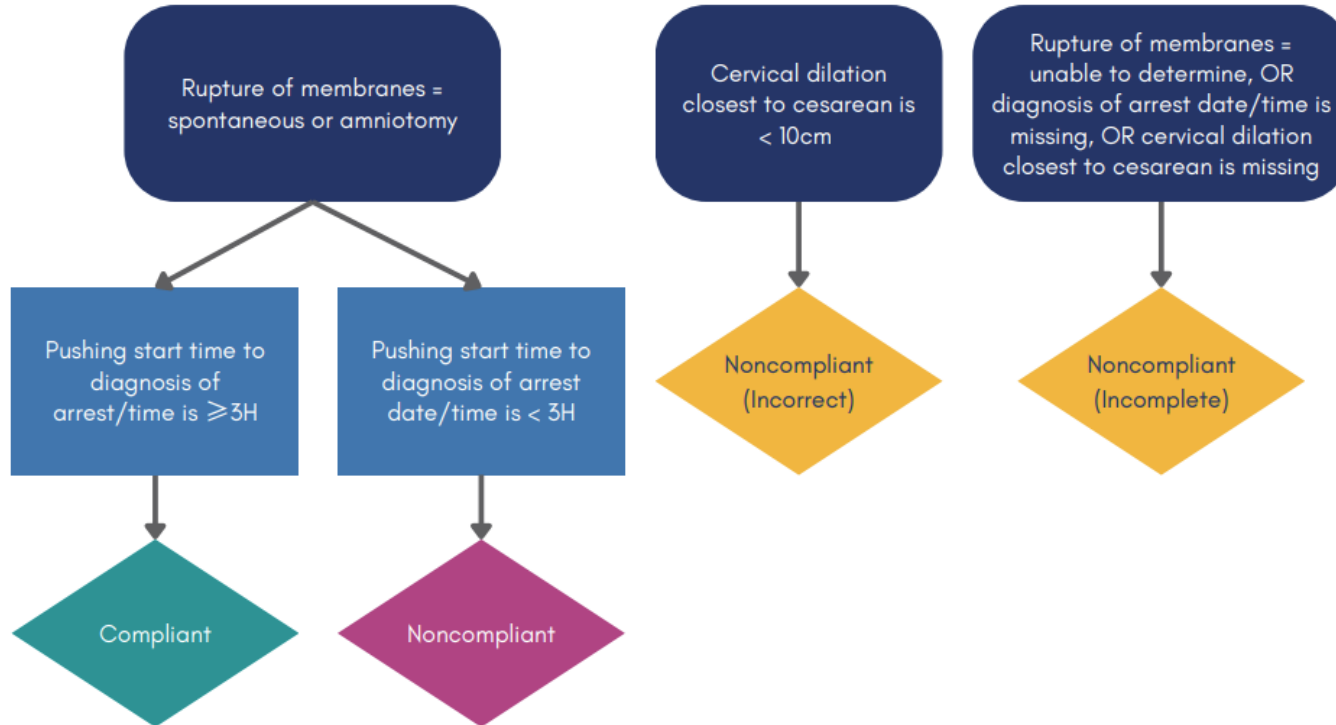
Scan the QR Code

or visit

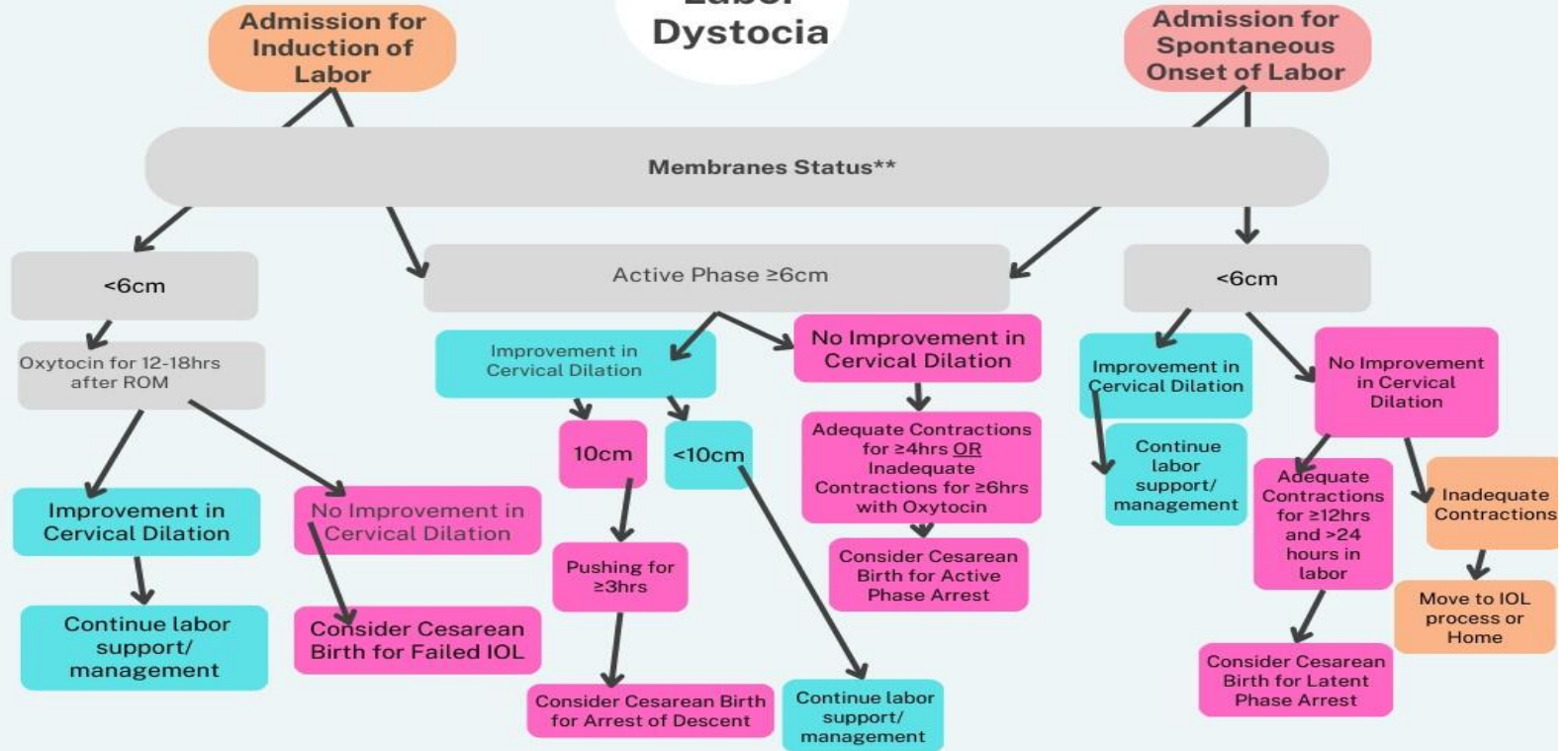
<https://tinyurl.com/2025Dystocia>



## Primary Indication for Cesarean Delivery: Arrest of Descent



# Labor Dystocia



ROM, Rupture of membranes; IOL, induction of labor

# Strategies to Improve Dystocia Compliance

- Multidisciplinary Education
- ACOG/SMFM Guidelines Posted, Badge Buddies
- Use of Checklists, EMR, Dot Phrases
- Patient Centered Huddles, Team Review, CS Review
- Non-Compliant Cases or Fall Out Case Reviews

# OBI Safely Averting NTSV Cesarean Births Toolkit



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## Safely Averting NTSV Cesarean Births



# OBI Safely Averting NTSV Cesarean Births Toolkit



obstetricsinitiative.org

## Clinician Engagement

### OBI Criteria Badge Buddy

A [two-sided, 4"x 3" inch badge buddy](#) that can be used as a fast reference reminder for Labor Dystocia compliance criteria and Category II FHR monitoring interventions.

Consider printing these for all members of your clinical team!

### Training Slide Deck Template

### Moving our Mamas (MOMs) Labor Support Training

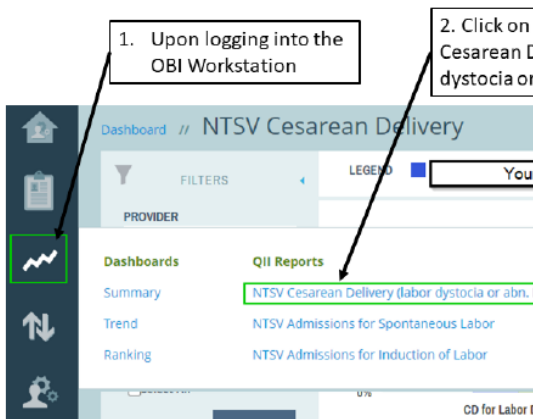
## ACOG/SMFM Labor Dystocia Criteria

<b>Active Phase Arrest <math>\geq 6</math>cm</b>	No improvement in cervical dilation with rupture of membranes &: <ul style="list-style-type: none"><li>◦ <math>\geq 4</math> hrs of adequate uterine contractions</li><li>◦ Or <math>\geq 6</math> hrs of oxytocin administration with inadequate uterine contractions</li></ul>
<b>Arrest of Descent</b>	Second stage of labor with rupture of membranes & $\geq 3$ hrs of pushing
<b>Failed Induction</b>	Cervical dilation of $< 6$ cm & oxytocin administration for $\geq 12-18$ hrs after rupture of membranes



# NTSV Performance Report

## SAMPLE REPORT



### About this report

- This report is limited to Nulliparous, Term, Singleton, Vertex (NTSV) births
- This report contains data on the most recent 12 months of cases abstracted within the OBI registry. The delivery date is between 03-31-2022 and 03-31-2023, unless otherwise specified.
- Please note that results for 2023 are preliminary and subject to change as additional quarters of data are reported.

### Information about your site

#### Staffing

Midwives: 18; L&D Nurses: 130; OBs: 134; Family Physician: 0

#### QII Choices

- 2023: Management of Category II Fetal Tracings
- 2022: Management of Category II Fetal Heart Rate Tracings
- 2021: Early Labor Admission Screening Checklist

#### Hospital

NICU: Yes; Teaching: Yes; 2022 Singleton Delivery Volume: 6538

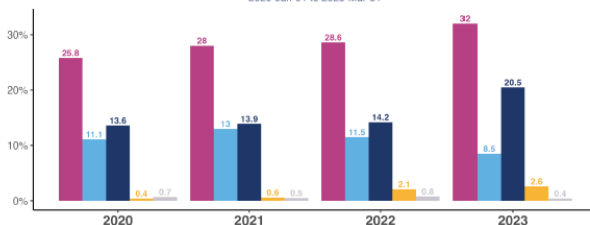
Note: Staffing and QII choices are from OBI declaration form; Hospital information is from the American Association (NICU and Teaching status) and Michigan Birth Certificate data (Delivery Volume)

### Indications for Unplanned Cesarean Among NTSV Patients Over Time

#### QII Insights

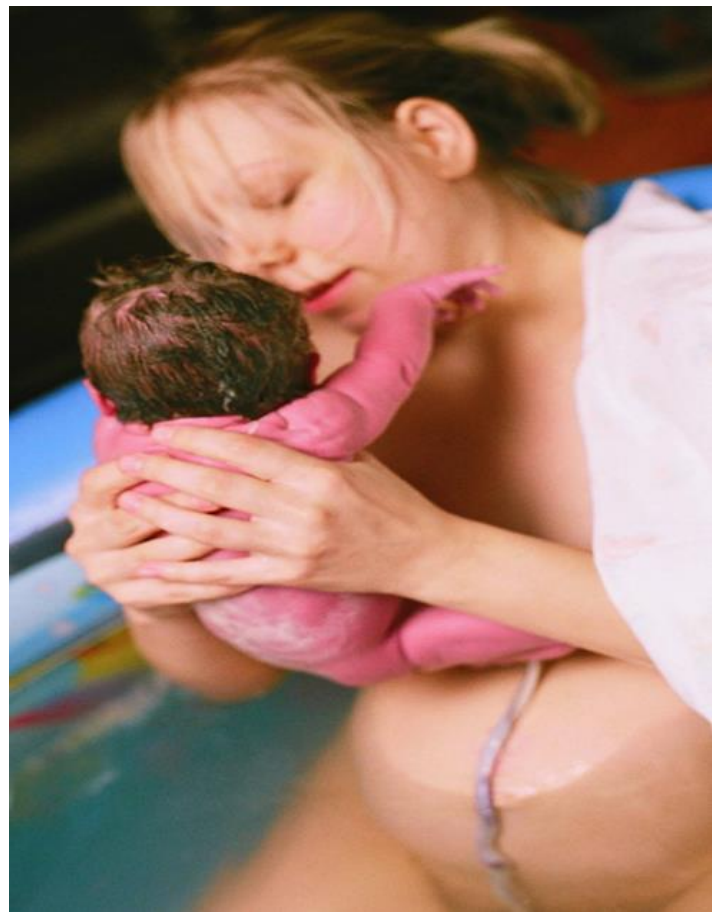
- At the top performance sites, the overall unplanned cesarean rate among NTSV patients was 22.4%. Among unplanned cesareans, the dystocia rate was 9.7%, the abnormal FHT rate was 10.8%, the maternal request rate was 1.0%, and the other rate was 0.9%.
- Top Performer sites were defined as those with the lowest quartile NTSV Cesarean rates (median 25%) in the most recent 12 months, and a delivery volume >1000/yr (to ensure reliable Cesarean rate estimate).

Indications for Unplanned Cesarean Among NTSV Patients: Your Site Over Time  
2020-Jan-01 to 2023-Mar-31





KEEP  
CALM  
AND  
BIRTH  
ON



# Thank You!

## Questions?



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