January 5, 2023
3:00 PM ET

AIM TAP WEBINAR:

Safe Reduction of Primary Cesarean Birth: Keys to Implementation Success

with Dr. Stephanie Radke, MD, MPH, FACOG

ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

The Alliance for Innovation on Maternal Health is a national, cross-sector commitment designed to support best practices that make birth safer, improve maternal health outcomes, and save lives.

This program is supported by a cooperative agreement with the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UC4MC28042, Alliance for Innovation on Maternal Health. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Before we get started

AIM TAP Webinars are recorded

Resources discussed are not vetted or endorsed by AIM or ACOG and are provided for your convenience

Resources should be used at your discretion

If you need help during the call, please chat an AIM staff member

Safe Reduction of Primary Cesarean Birth: Keys to Implementation Success

Dr. Stephanie Radke
MD, MPH, FACOG

Safe Reduction of
Primary Cesarean Birth

AIM TAP Webinar:

Safe Reduction of Primary Cesarean Birth, Pearls from Iowa

Stephanie Radke, MD, MPH, FACOG

January 5, 2023

IOWA Maternal Quality Care Collaborative

STATE OF IOWA DEPARTMENT OF Health AND Human SERVICES

AIM ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Support acknowledgement:
HRSA State Maternal Health Innovation Program &
ACOG Alliance for Innovation on Maternal Health Program

This presentation was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

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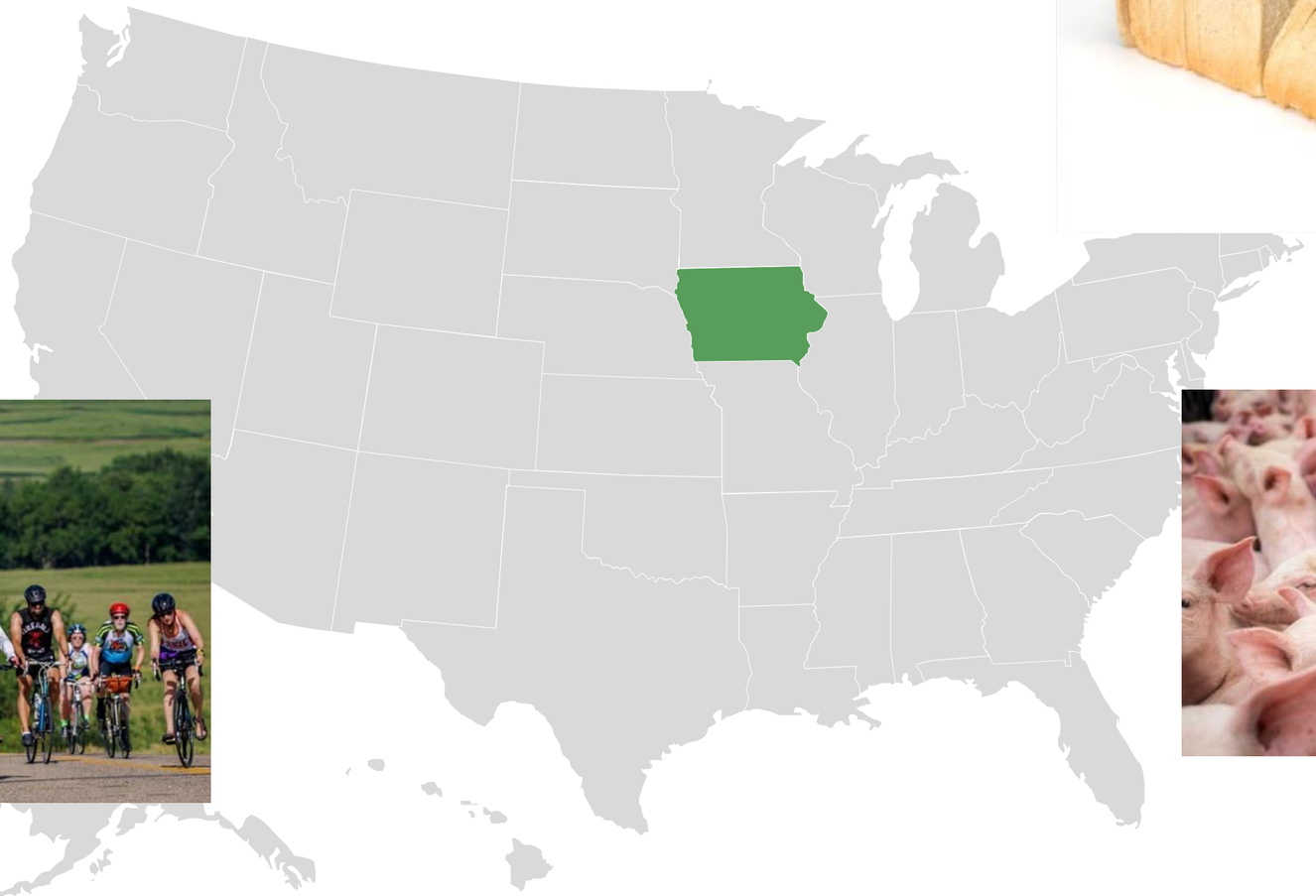
My background and perspectives

- Academic General OB/GYN at the University of Iowa Hospitals & Clinics
- Direct the AIM program in Iowa
- Led my own facility's effort to reduce our NTSV CS rate from 28% to under 23%
- Trained in collaborative improvement and improvement coaching by IHI
- Experience in community private practice prior to moving to academic medicine
- Exclusively trained and worked in multidisciplinary obstetrical practices with midwives, family physicians, and obstetrician-gynecologists

Here is Iowa



Intended Audience

- State AIM leaders
- Facility leaders and QI champions
- Maternal health stakeholders
- Patient partners

A Disclaimer from the WHO

Cesarean sections are effective in saving maternal and infant lives when required for medically-indicated reasons

Every effort should be made to provide cesarean sections to people in need, rather than striving to achieve a specific rate

WHO Statement on Caesarean section Rates. Department of Reproductive Health and Research, World Health Organization. 2015. Retrieved from: https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/

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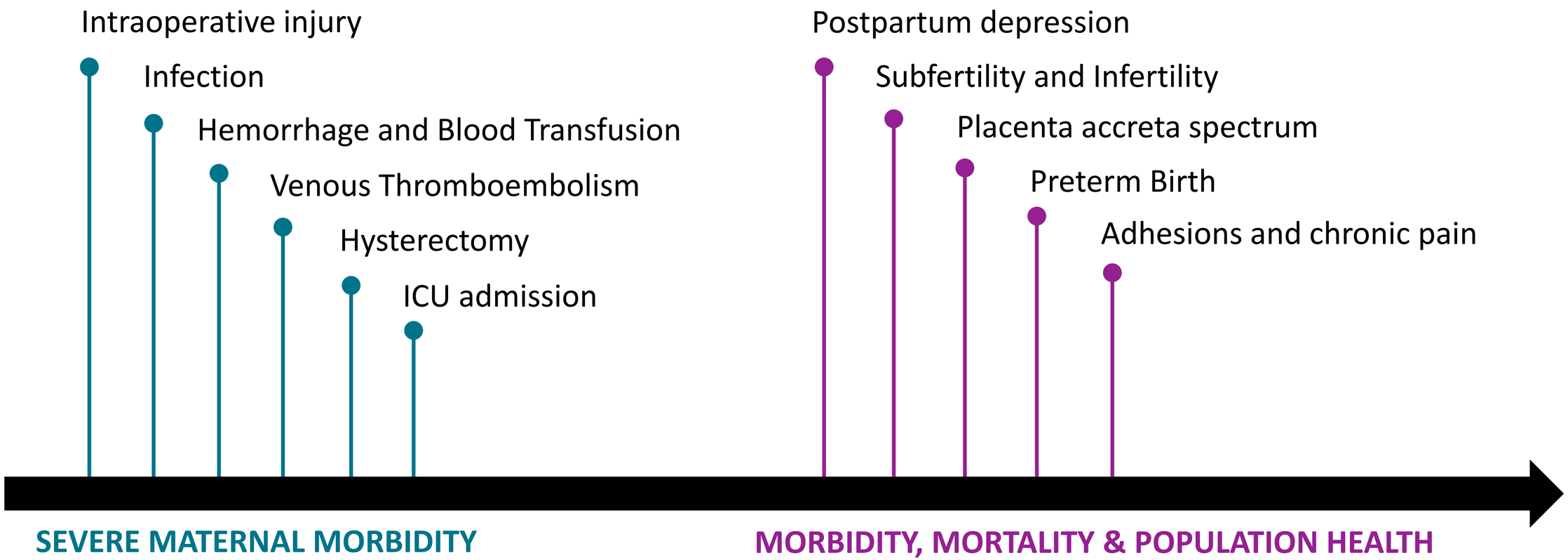
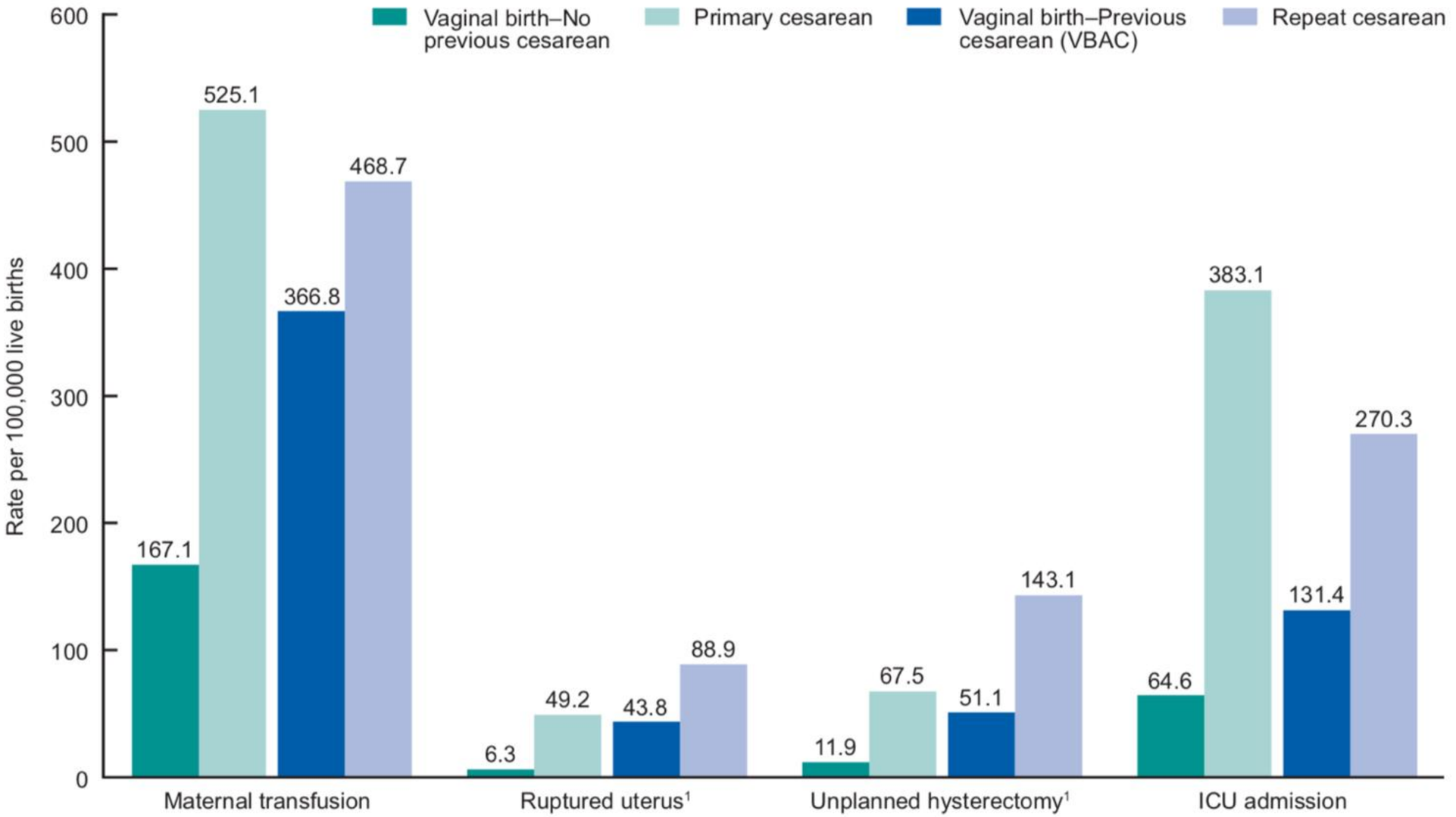
What is the population impact of excess cesarean delivery?



Nisenblat V, Barak S, Griness OB, Degani S, Ohel G, Gonen R. Maternal complications associated with multiple cesarean deliveries. Obstet Gynecol. 2006;108(1):21-26.
Clark EA, Silver RM. Long-term maternal morbidity associated with repeat cesarean delivery. Am J Obstet Gynecol. 2011;205(6 Suppl):S2-S10.
Xu H, Ding Y, Ma Y, Xin X, Zhang D. Cesarean section and risk of postpartum depression: A meta-analysis. J Psychosom Res. 2017;97:118-126.



[1]Difference in rates between primary cesarean and VBAC is not statistically significant.
NOTES: The birth certificate reporting area represented 90% of all U.S. births in 2013. ICU is intensive care unit.
SOURCE: CDC/NCHS, National Vital Statistics System.

Severe Maternal Morbidity (SMM) by delivery type:
There is greater morbidity associated with all deliveries after a primary cesarean

https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_04.pdf

Identifying an Optimal Population Cesarean Rate

2005-2012 Cesarean delivery rates for 194 WHO member states

- Relationship between Cesarean delivery rate, maternal mortality ratio and neonatal mortality rates
- Adjusted for per-capita health expenditure, population, % urban, fertility rate, and region

Cesarean delivery rate of approximately 19% was associated with the lowest maternal and neonatal mortality rates

Molina G, Weiser TG, Lipsitz SR, et al. Relationship Between Cesarean Delivery Rate and Maternal and Neonatal Mortality. JAMA. 2015;314(21):2263-2270. doi:10.1001/jama.2015.15553

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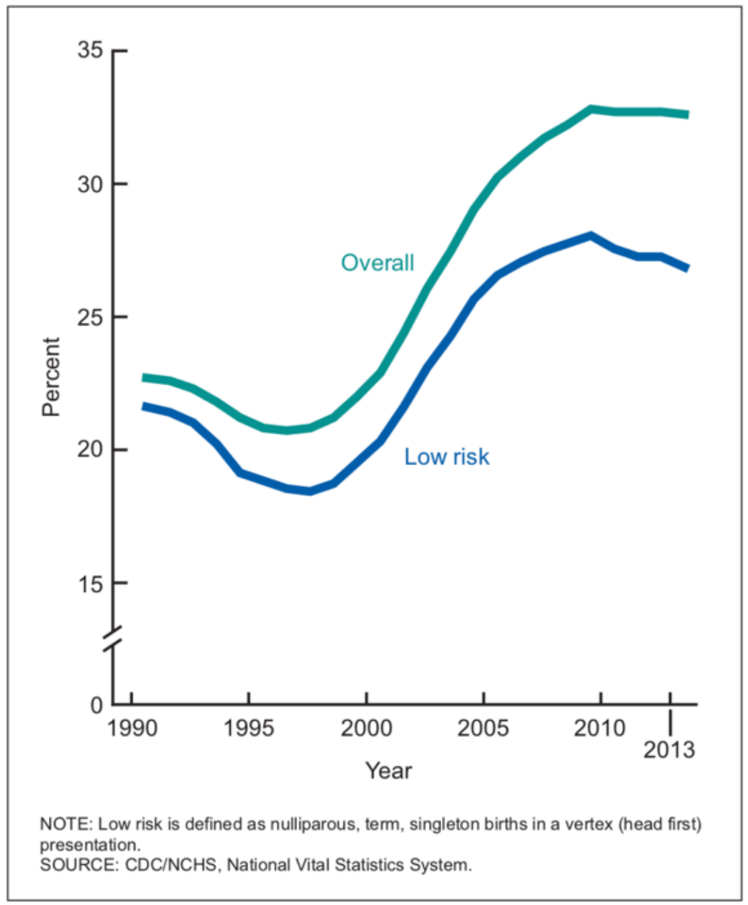
What is the best measure of cesareans for improvement work?



NOTE: Low risk is defined as nulliparous, term, singleton births in a vertex (head first) presentation.
SOURCE: CDC/NCHS, National Vital Statistics System.

Figure 1. Overall cesarean delivery and low-risk cesarean delivery: United States, final 1990–2012 and preliminary 2013

Nulliparous
Term
Singleton
Vertex
Cesarean Rate

- First birth
- Focus on generally low-risk pregnancies

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Population Targets for NTSV CS:

15%

24.7%

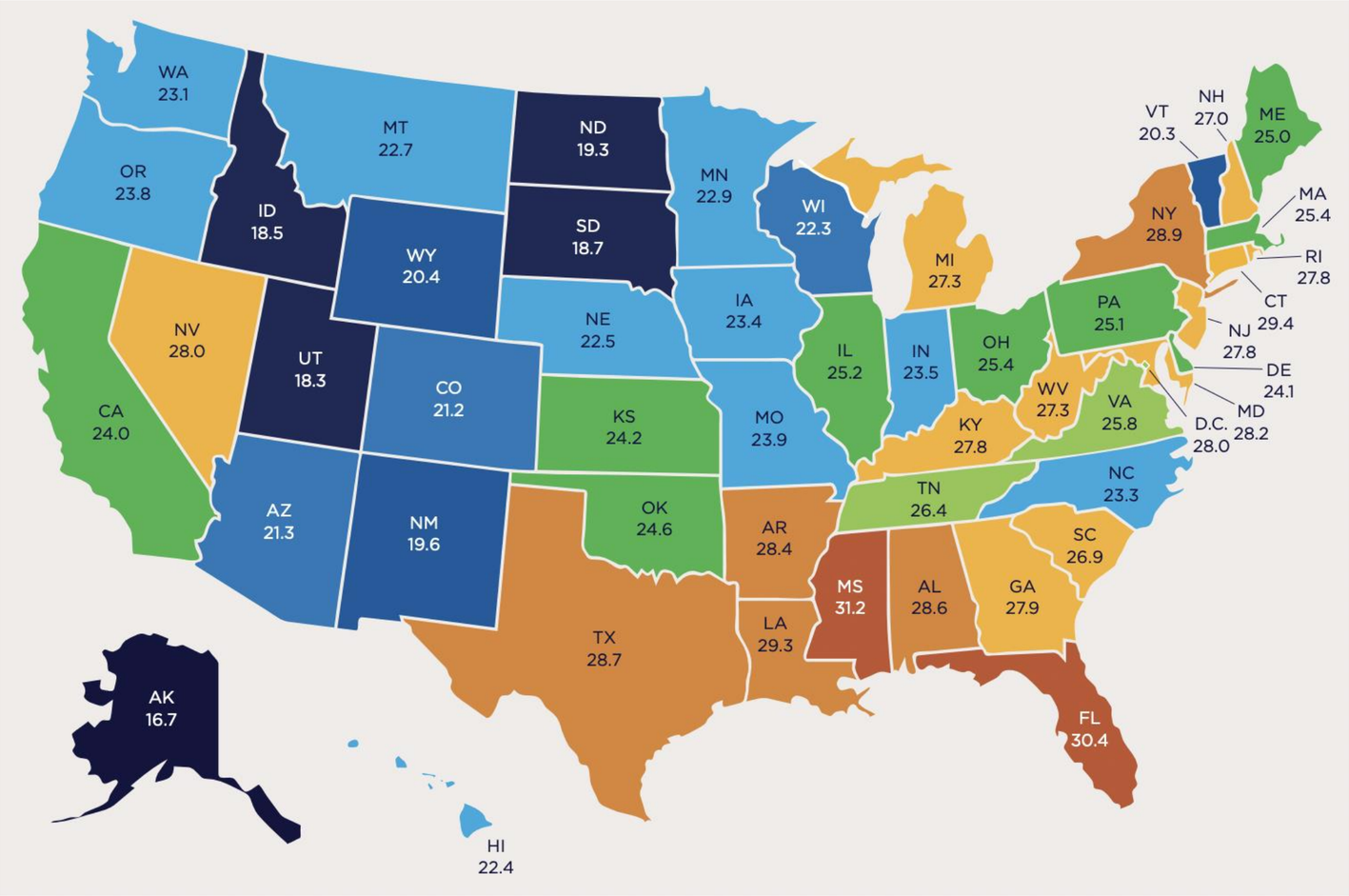
(10% reduction from 2007 rate)

23.6%

(10% reduction from 2018 rate)

https://www.healthypeople.gov/node/4900/data_details
https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-cesarean-births-among-low-risk-women-no-prior-births-mich-06

Cesarean rates (NTSV) by state demonstrate significant regional variation



https://aspe.hhs.gov/sites/default/files/private/aspe-files/264076/hhs-maternal-health-action-plan-summary.pdf

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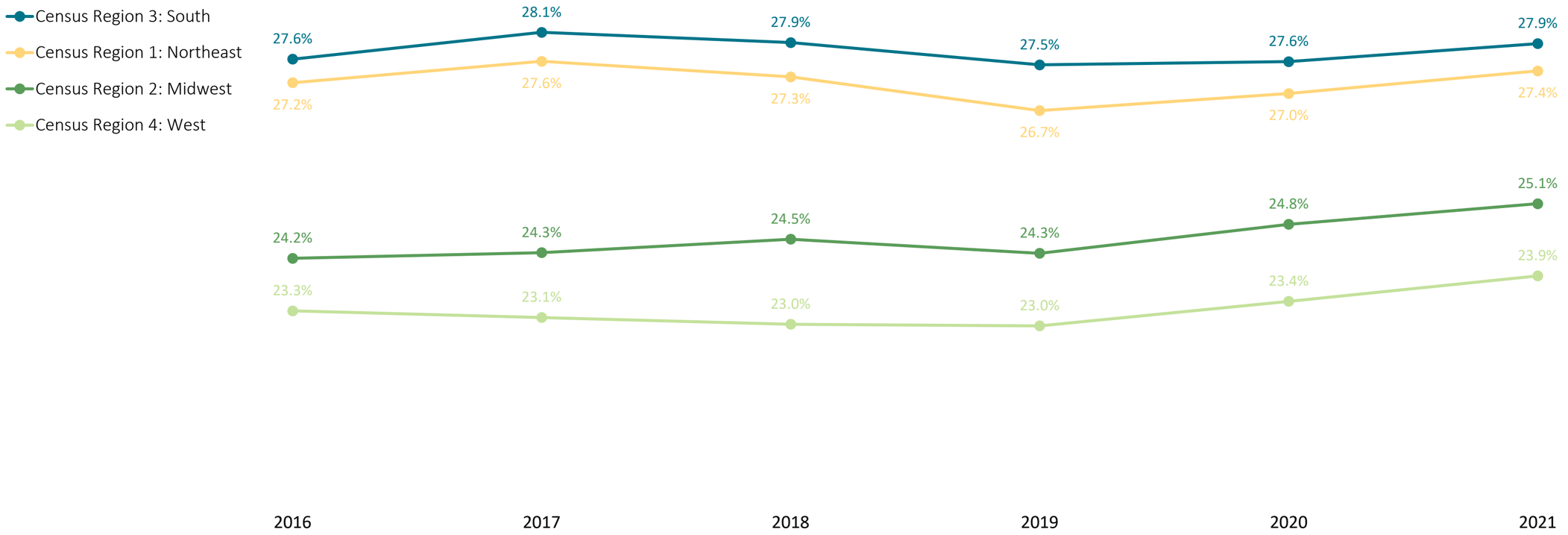
Trends over time show regional variation and recently increasing NTSV CS rates (%)



Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/natality-expanded-current.html on Dec 29, 2022 1:12:08 PM

Structure of an AIM bundle

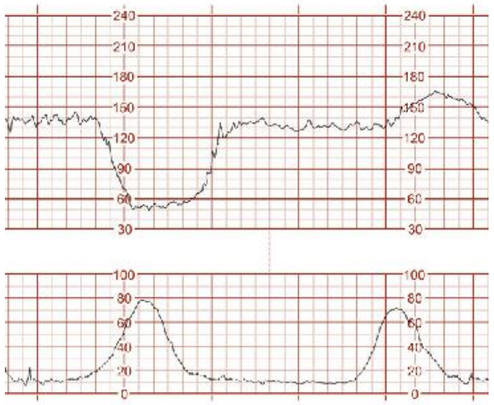
Safe Reduction of
Primary Cesarean Birth

- **Readiness:** every unit, every team
- **Recognition:** every patient
- **Response:** every event
- **Reporting:** every unit
- **Respectful care:** integrated

How to improve:
Outline for the rest of the session

READINESS

Building systems to support physiologic birth: everyone has a role to play



RECOGNITION & RESPONSE

Important opportunities:
Labor inductions, equivocal FHR patterns, and slow labor

REPORTING

Using data to guide improvement efforts

RESOURCES

Available resources from AIM and others

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How to improve:
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Payors and policy solutions

- Fee for service model favors more interventions, including cesareans
- Value-based payment programs that reward by quality metrics will motivate systems to improve
- Coverage for doula services
- Public reporting of facility cesarean rates
- Incentivization of facility participation in quality collaboratives

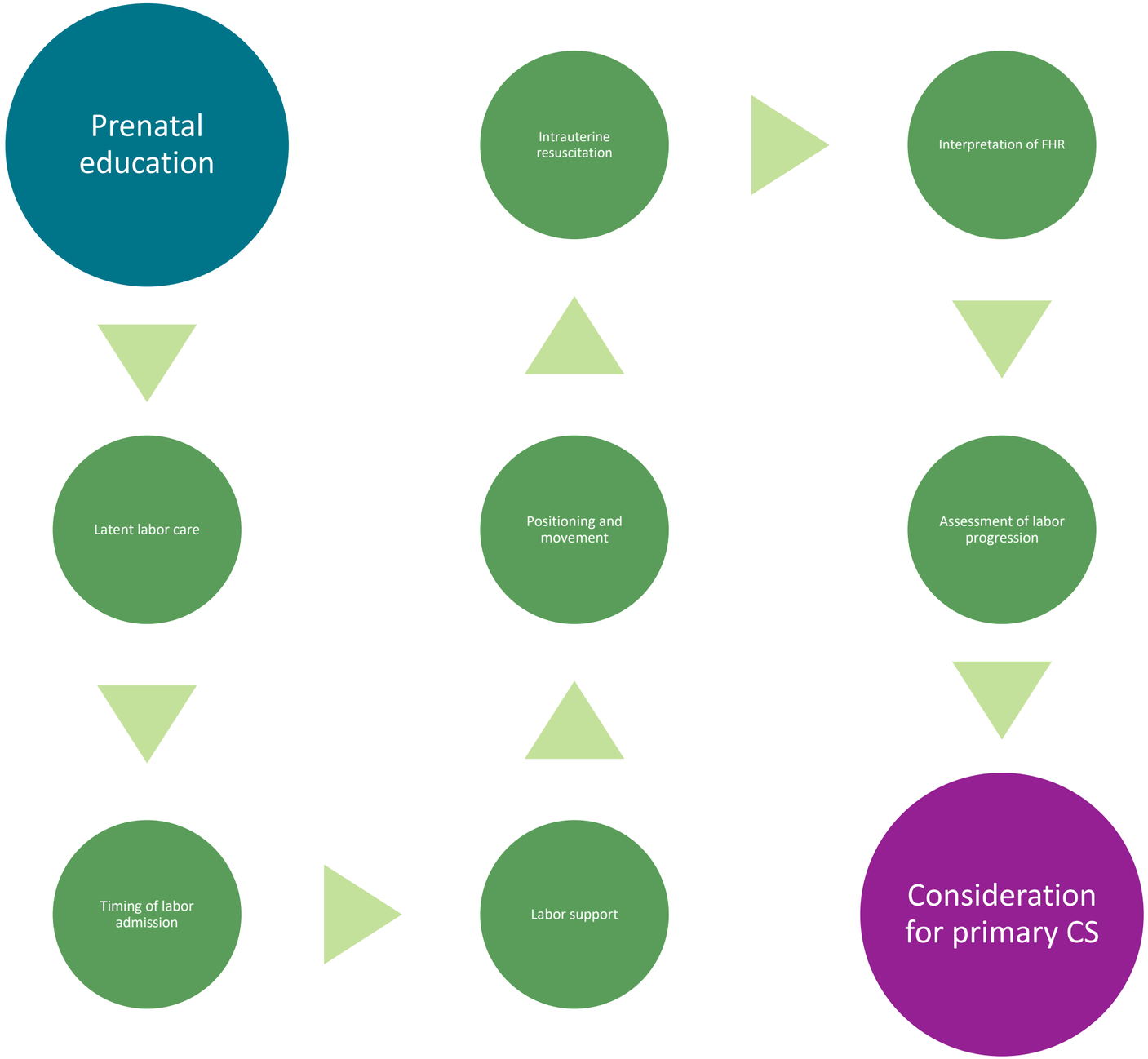
Community resources

- Normalization of physiologic birth
- Community support and connection to resources to promote health before, during, and after pregnancy
- Group prenatal care
- Prenatal education
- Doula services

Unit culture

- Hire midwives
- Collaborative practice models (shared RVUs, cross-coverage)
- Shift-based coverage vs solo practitioner (avoid the 5pm CS)
- Ask: do nurses and providers value physiologic birth?
  - Knowledge
  - Attitudes
  - Beliefs

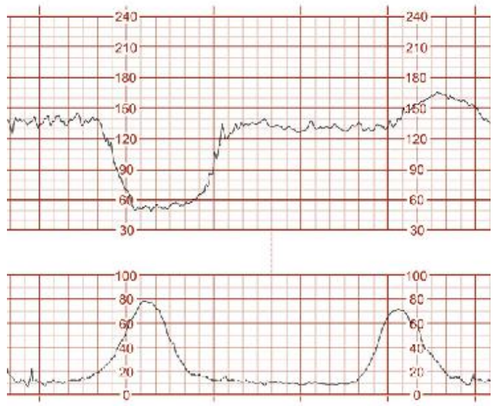
Provider concerns: Is this all just about when to “call it”?


Prenatal education
Latent labor care
Timing of labor admission
Labor support
Positioning and movement
Intrauterine resuscitation
Interpretation of FHR
Assessment of labor progression
Consideration for primary CS

How to improve:
Outline for the rest of the session

READINESS

Building systems to support physiologic birth: everyone has a role to play



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Labor induction

- Is labor induction a standardized process or is there variation based on individual provider or group preferences?
- Is there a standard assessment of Bishop score and protocol to perform cervical ripening if unfavorable?
- Is there a process to consider abandoning an induction if cervical ripening is unsuccessful?
- Consider the impact the ARRIVE trial may have had on your facility.
- How are patients counseled about planned labor inductions?

Medically-Indicated Late Preterm and Early Term Deliveries

- Comprehensive recommendations for delivery timing by maternal and fetal indications
- Definitions:
  - Late preterm = 34w0d-36w6d
  - Early term = 37w0d-38w6d
  - Full term = 39w0d-40w6d

INTERIM UPDATE

ACOG
The American College of Obstetricians and Gynecologists

Society for Maternal-Fetal Medicine

ACOG COMMITTEE OPINION

Number 831

(Replaces Committee Opinion Number 818, February 2021)

Committee on Obstetric Practice
Society for Maternal-Fetal Medicine

This Committee Opinion was developed by the Committee on Obstetric Practice in collaboration with Society for Maternal-Fetal Medicine liaison member Cynthia Gyamfi-Bannerman, MD, MS, committee members Angela B. Gantt, MD, MPH and Russell S. Miller, MD, and the Society for Maternal-Fetal Medicine.

INTERIM UPDATE: The content in this Committee Opinion has been updated as highlighted (or removed as necessary) to reflect a limited, focused change in delivery timing recommendations around preterm prelabor rupture of membranes.

Medically Indicated Late-Preterm and Early-Term Deliveries

American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, Society for Maternal-Fetal Medicine. Medically Indicated Late-Preterm and Early-Term Deliveries: ACOG Committee Opinion, Number 831. *Obstet Gynecol*. 2021;138(1):e35-e39.

NTSV Elective Labor Induction in 39th Week:
Revising the ARRIVE Trial

	Primary Outcome: Neonatal death or composite morbidity	Secondary Outcome: Cesarean delivery rate	Hypertensive Disorder	Length of stay on L&D
Intervention group: **eIOL 39w0d-39w4d** (n=3062)	*4.3%*	18.6%	9.1%	20 hours
Expectant group: **no eIOL until 40w5d** (n=3044)	*5.4%*	22.2%	14.1%	14 hours

- Intention to treat analysis (144 in intervention group and 135 in expectant group did not adhere to protocol)
- Expectant group protocol included medically-indicated IOL prior to 40w5d ("usual care")
- Mean age 23-24 years (<5% were >35)
- Mean BMI at enrollment (38w) 30
- Median Bishop score of 4 (over 60% with Bishop <5)

Grobman WA, Rice MM, Reddy UM, et al. Labor Induction versus Expectant Management in Low-Risk Nulliparous Women. *N Engl J Med.* 2018;379(6):513-523.

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National trends in practice and outcomes post-ARRIVE

- Population-based retrospective cohort study of low-risk NTSV patients who delivered at 39w or greater
  - Pre-ARRIVE cohort delivered between January 1, 2015 – December 31, 2017 (n=1,966,870)
  - Post-ARRIVE cohort delivered between January 1, 2019 – December 31, 2019 (n=609,322)
- Adjusted for differences in age, race, BMI, marital status, infertility treatment, and smoking status

Gilroy LC, Al-Kouatly HB, Minkoff HL, McLaren RA Jr. Changes in obstetrical practices and pregnancy outcomes following the ARRIVE trial. *Am J Obstet Gynecol*. 2022;226(5):716.e1-716.e12.

National trends in practice and outcomes post-ARRIVE trial

	Post-ARRIVE compared to Pre-ARRIVE
Labor induction	More likely (36.1% vs 30.2%, aOR 1.36)
Deliver by 39w6d	More likely (42.8% vs 39.9%, aOR 1.14)
Cesarean delivery	Less likely (27.3% vs 27.9%, aOR 0.94)
Receive a blood transfusion	More likely (0.4% vs 0.3%, aOR 1.43)
Require ICU admission	More likely (0.09% vs 0.08%, aOR 1.20)
Baby needs assisted ventilation	More likely (3.5% vs 2.8%, aOR 1.28)
Baby has low 5-minute APGAR	More likely (0.4% vs 0.3%, aOR 0.9)
Baby is admitted to NICU	No difference

ARRIVE trial eIOL NTSV CS rate = 18.6% vs 22.2% in non-induction group

Gilroy LC, Al-Kouatly HB, Minkoff HL, McLaren RA Jr. Changes in obstetrical practices and pregnancy outcomes following the ARRIVE trial. *Am J Obstet Gynecol*. 2022;226(5):716.e1-716.e12.

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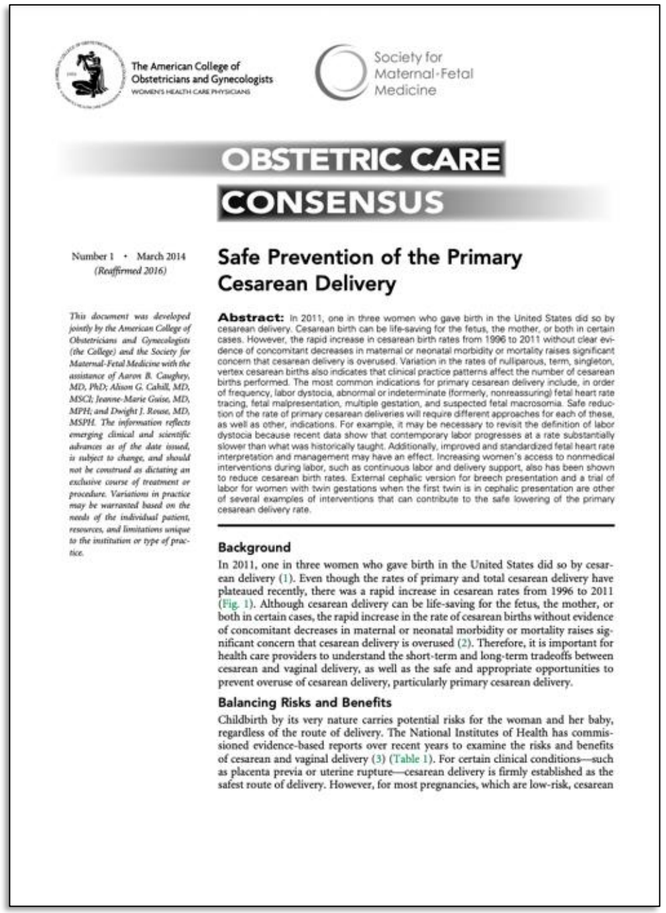
Defining slow or absent labor progress: ACOG/SMFM OB Care Consensus



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

Number 1 • March 2014
(Reaffirmed 2016)

Safe Prevention of the Primary Cesarean Delivery

This document was developed jointly by the American College of Obstetricians and Gynecologists (the College) and the Society for Maternal-Fetal Medicine with the assistance of Aaron B. Caughey, MD, PhD; Alison G. Cahill, MD, MSCE; Jeanne-Marie Guise, MD, MPH; and Dwight J. Rouse, MD, MSPH. The information reflects emerging clinical and scientific advances as of the date issued, is subject to change, and should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Abstract: In 2011, one in three women who gave birth in the United States did so by cesarean delivery. Cesarean birth can be life-saving for the fetus, the mother, or both in certain cases. However, the rapid increase in cesarean birth rates from 1996 to 2011 without clear evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused. Variation in the rates of nulliparous, term, singleton, vertex cesarean births also indicates that clinical practice patterns affect the number of cesarean births performed. The most common indications for primary cesarean delivery include, in order of frequency, labor dystocia, abnormal or indeterminate (formerly, nonreassuring) fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia. Safe reduction of the rate of primary cesarean deliveries will require different approaches for each of these, as well as other, indications. For example, it may be necessary to revisit the definition of labor dystocia because recent data show that contemporary labor progresses at a rate substantially slower than what was historically taught. Additionally, improved and standardized fetal heart rate interpretation and management may have an effect. Increasing women's access to nonmedical interventions during labor, such as continuous labor and delivery support, also has been shown to reduce cesarean birth rates. External cephalic version for breech presentation and a trial of labor for women with twin gestations when the first twin is in cephalic presentation are other of several examples of interventions that can contribute to the safe lowering of the primary cesarean delivery rate.

Background

In 2011, one in three women who gave birth in the United States did so by cesarean delivery (1). Even though the rates of primary and total cesarean delivery have plateaued recently, there was a rapid increase in cesarean rates from 1996 to 2011 (Fig. 1). Although cesarean delivery can be life-saving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused (2). Therefore, it is important for health care providers to understand the short-term and long-term tradeoffs between cesarean and vaginal delivery, as well as the safe and appropriate opportunities to prevent overuse of cesarean delivery, particularly primary cesarean delivery.

Balancing Risks and Benefits

Childbirth by its very nature carries potential risks for the woman and her baby, regardless of the route of delivery. The National Institutes of Health has commissioned evidence-based reports over recent years to examine the risks and benefits of cesarean and vaginal delivery (3) (Table 1). For certain clinical conditions—such as placenta previa or uterine rupture—cesarean delivery is firmly established as the safest route of delivery. However, for most pregnancies, which are low-risk, cesarean

- Classification of the phase and stage of labor
  - First stage – latent: less than 6cm
  - First stage – active: 6cm or greater
  - Second stage: 10cm
- Standard criteria for diagnosing an arrest of labor in each of the three groups

American College of Obstetricians and Gynecologists (College); Society for Maternal-Fetal Medicine, Caughey AB, Cahill AG, Guise JM, Rouse DJ. Safe prevention of the primary cesarean delivery. *Am J Obstet Gynecol*. 2014;210(3):179-193. doi:10.1016/j.ajog.2014.01.026

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Arrest of labor per ACOG/SMFM

Failed Induction of Labor (or arrest of latent phase labor):

- ☐ Current dilation is <6cm
- ☐ Membranes ruptured
- ☐ Oxytocin administered for at least 12-18 hours *after* membrane rupture, or longer if maternal and fetal status allow

Arrest of Dilation:

- ☐ Current dilation is 6cm or greater
- ☐ Oxytocin administration
- ☐ At least 4 hours of adequate uterine contractions (200 MVUs / strong to palpation) *or* at least 6 hours of inadequate uterine contractions (<200 MVUs)

Arrest of Descent:

- ☐ Full cervical dilation achieved (10cm)
- ☐ Membranes ruptured
- ☐ Active maternal pushing *nulliparas* for 4 hours with an epidural *or* 3 hours without an epidural. Active maternal pushing *multiparas* 3 hours with an epidural *or* 2 hours without an epidural
- ☐ Assessed or attempted operative vaginal delivery (if fetal station is +2 or lower)

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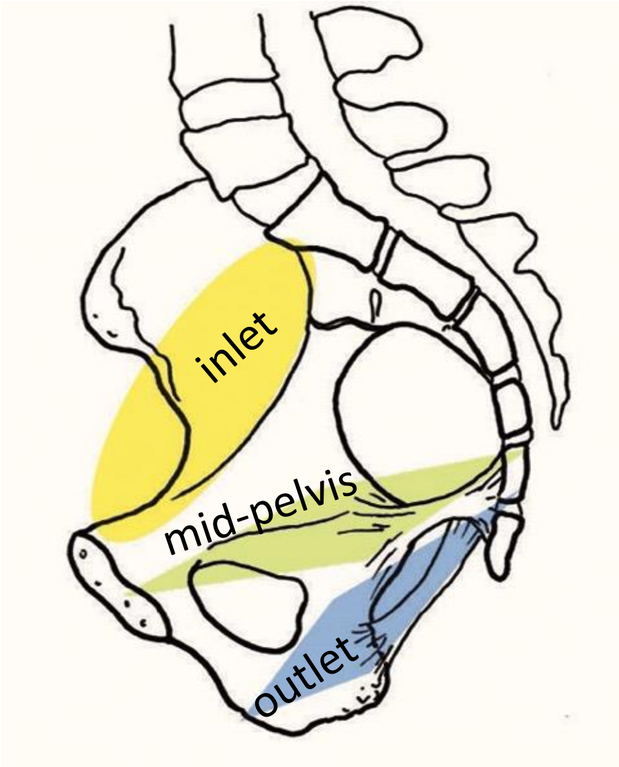
Approach to slow labor: positioning

- Power, position, pelvis
- Utilize maternal positions that align with where baby is in the pelvis
- Resources:
  - Peanut balls and staff education on use
  - Spinning Babies education
  - Bundle Birth position guides



https://mandyirby.com/peanut-balls-labor/

https://www.spinningbabies.com/solutions-for-dystocia-in-the-levels-of-the-pelvis/

https://www.bundlebirth.com/product-page/bundle-birth-position-guide

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Non-reassuring fetal status / fetal intolerance to labor

Consistency across and between providers and nurses in EFM description, interpretation, and response is the goal.

- NICHD standards
  - Baseline
  - Variability
  - Presence or absence of accelerations
  - Presence or absence of decelerations and type, if present
- Standardize and broaden the description of variable and late decelerations
  - Length (onset to return to baseline)
  - Depth (BPM at nadir and difference between baseline and nadir)
  - Frequency (ie. with 100%, 50%, 30%, 10% of contractions)

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Utilize an algorithm to approach equivocal EFM patterns (Category II)

- Initial algorithm by Clark et al offered response to decelerations in the presence of moderate variability
- Shields et al expanded on this by offering an expert consensus on response to decelerations in the presence of minimal or absent variability
  - Developed and implemented this algorithm across the Dignity Health network of hospitals in California and Arizona
  - Goal was not to reduce cesareans, but to reduce unexpected term newborn outcomes
  - In Iowa, we have found success in reduction of cesareans using this tool as a strategy to avoid over treatment of equivocal tracings

Clark SL, Nageotte MP, Garite TJ, et al. Intrapartum management of category II fetal heart rate tracings: towards standardization of care. *Am J Obstet Gynecol*. 2013;209(2):89-97. doi:10.1016/j.ajog.2013.04.030

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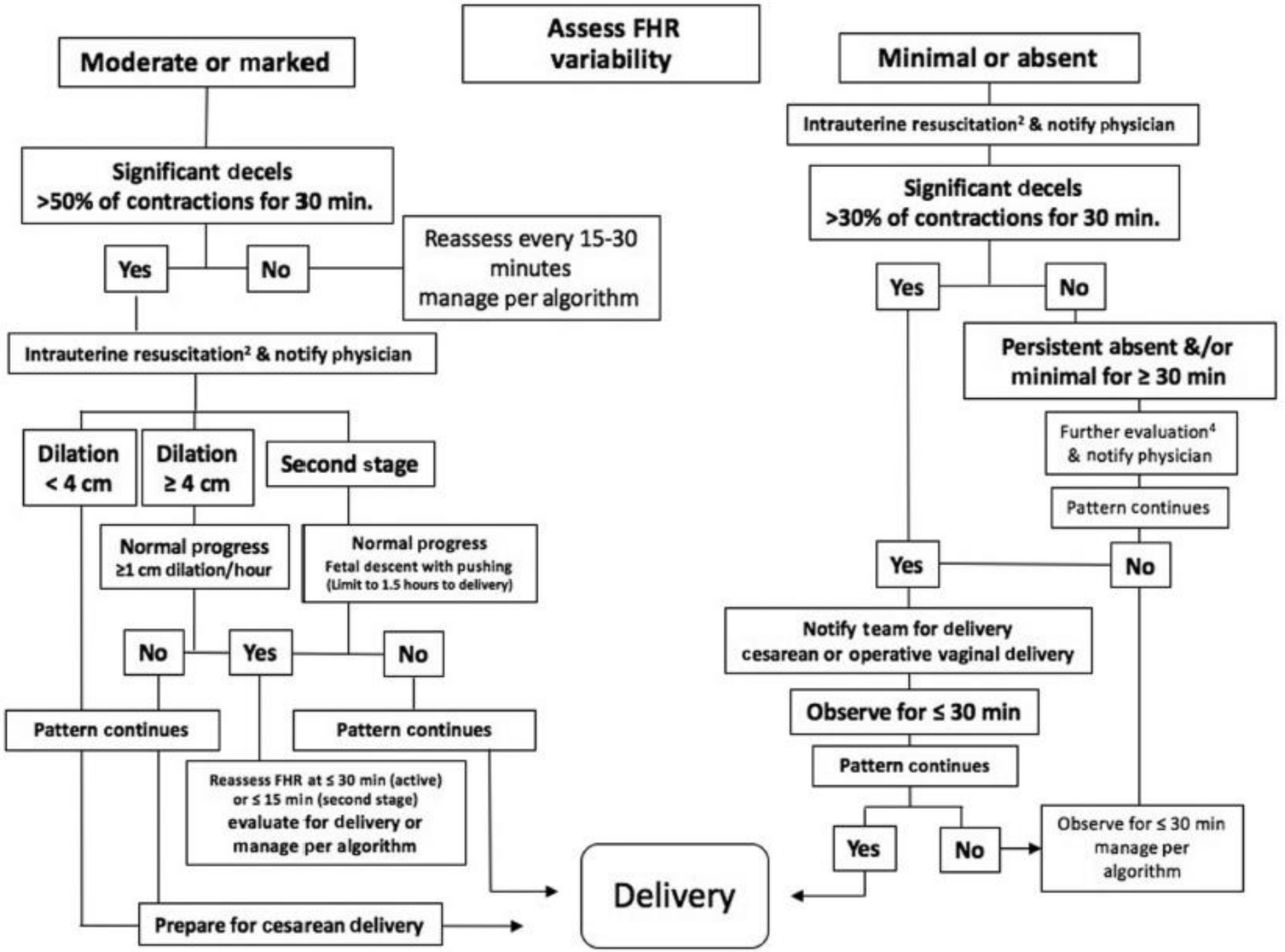

Fig. 1 Management outline for patients with Category II fetal heart rates associated with "significant decelerations" and normal fetal heart rate variability (moderate or marked) and abnormal variability (minimal or absent). FHR, fetal heart rate. Notes: 1. Resuscitative Measures may include: repositioning, O_2 (10L via mask), IV bolus, correction of hypotension. 2. Additional Interventions: consider amnioinfusion for variable decels. 3. Scalp stimulation and/or vibroacoustic stimulation.

Shields LE, Wiesner S, Klein C, Pelletreau B, Hedriana HL. A Standardized Approach for Category II Fetal Heart Rate with Significant Decelerations: Maternal and Neonatal Outcomes. *Am J Perinatol*. 2018;35(14):1405-1410. doi:10.1055/s-0038-1660459

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Decelerations: what is significant?

- Prolonged decelerations
- Late decelerations
- Severe variable decelerations
  - 60 seconds long
  - 60 beats below baseline
  - 60 BMP at the nadir

When a cesarean is needed, optimize the experience

- Some cesareans will always be needed.
- Including the pregnant person and their support people in the labor decision-making process may ease potential feelings of disappointment and improve their understanding of the rationale.
- Taking steps to promote family bonding during and after cesarean birth will improve satisfaction, reduce perceptions of pain, and improve breastfeeding.

How to improve:
Outline for the rest of the session

READINESS

Building systems to support physiologic birth: everyone has a role to play

RECOGNITION & RESPONSE

Important opportunities: Labor inductions, equivocal FHR patterns, and slow labor

REPORTING

Using data to guide improvement efforts

RESOURCES

Available resources from AIM and others

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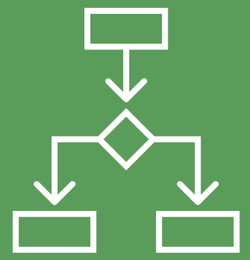
A Family of Measures for Improvement

Outcome



Process

Balancing

Structure

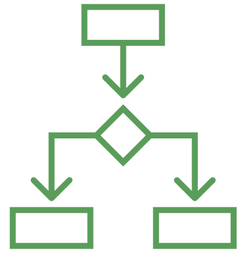
Outcome Measures

The clinical outcome of interest for the initiative

- Overall cesarean rate
- Primary cesarean rate
- NTSV cesarean rate
- NTSV cesarean rate following labor induction

- Measures can be easily captured using vital records, billing, and EHR data sources

Process Measures

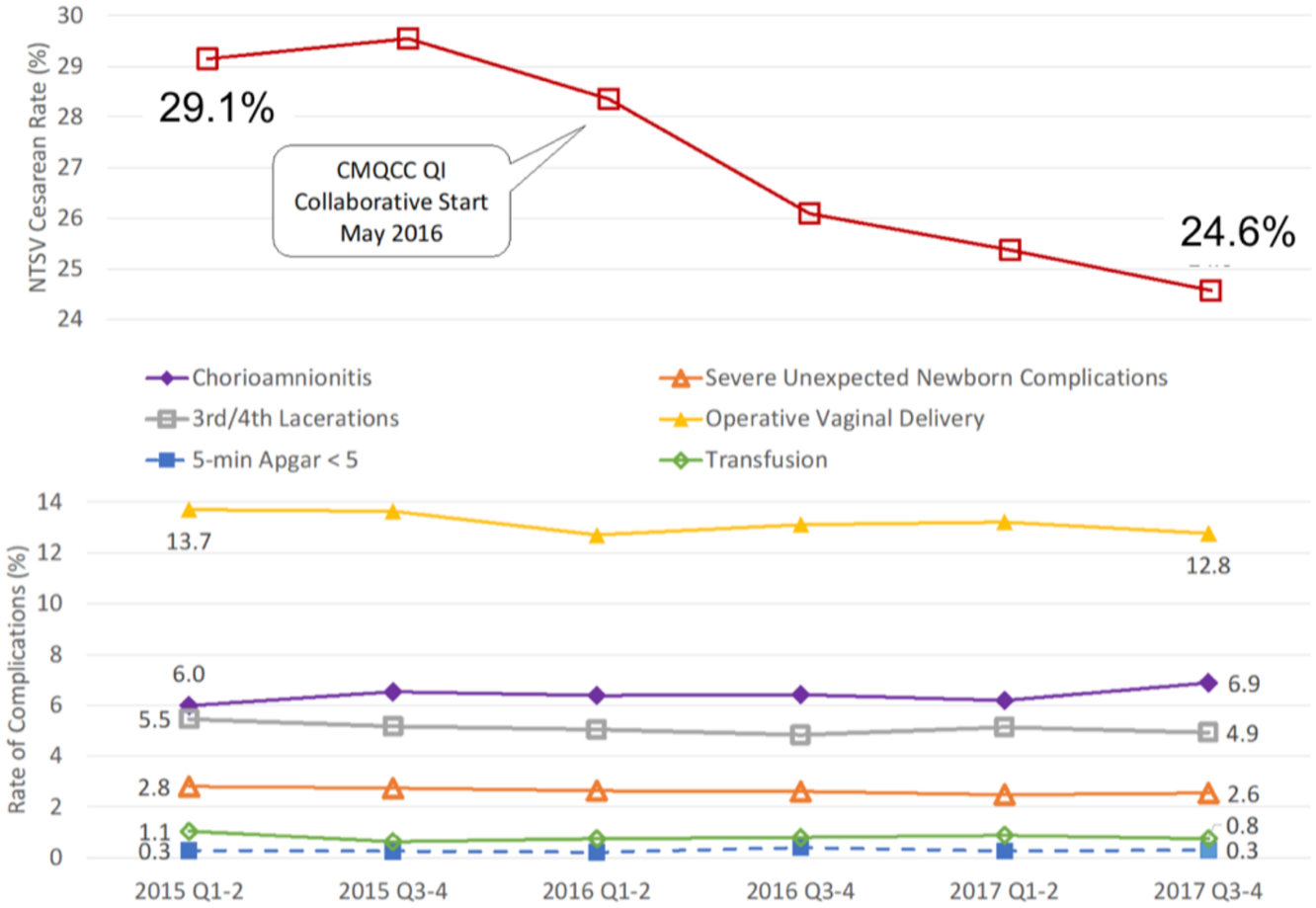


Measuring the quality of the care provided

- Portion of **term primary cesareans for non-progressive labor** that met current national consensus guidelines
- Portion of **term primary cesareans for fetal concerns** that met current expert guidelines

- These values are important to understand, at a facility and maybe even provider level, where your improvement opportunities lie

Balancing Measures



Will doing fewer cesareans result in harm in other ways?

Balancing measures are important for:

- Safety
- Staff buy-in

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California Maternal Quality Care Collaborative

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Main EK, Chang SC, Cape V, Sakowski C, Smith H, Vasher J. Safety Assessment of a Large-Scale Improvement Collaborative to Reduce Nulliparous Cesarean Delivery Rates. *Obstet Gynecol*. 2019;133(4):613-623.

A word about examining provider-level cesarean rates

- Recognition of outliers in practice is an important part of improvement.
- Those with the best outcomes should be studied to learn keys to success.
- Those with suboptimal outcomes should be offered support to adjust practices.
- Calculation of rates must account for practice type (ie coverage of non-operative obstetrical providers) and be over enough time for trends to be stable (6-month time periods or more).

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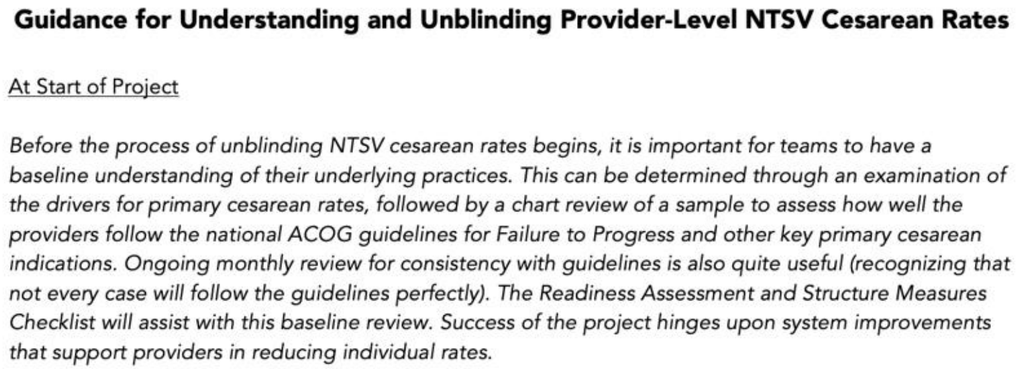
California Maternal Quality Care Collaborative



Guidance for Understanding and Unblinding Provider-Level NTSV Cesarean Rates

At Start of Project

Before the process of unblinding NTSV cesarean rates begins, it is important for teams to have a baseline understanding of their underlying practices. This can be determined through an examination of the drivers for primary cesarean rates, followed by a chart review of a sample to assess how well the providers follow the national ACOG guidelines for Failure to Progress and other key primary cesarean indications. Ongoing monthly review for consistency with guidelines is also quite useful (recognizing that not every case will follow the guidelines perfectly). The Readiness Assessment and Structure Measures Checklist will assist with this baseline review. Success of the project hinges upon system improvements that support providers in reducing individual rates.

https://www.cmqcc.org/content/guidance-understanding-and-unblinding-provider-level-ntsv-cesarean-rates

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How to improve:
Outline for the rest of the session

READINESS

Building systems to support physiologic birth: everyone has a role to play

RECOGNITION & RESPONSE

Important opportunities:
Labor inductions, equivocal FHR patterns, and slow labor

REPORTING

Using data to guide improvement efforts

RESOURCES

Available resources from AIM and others

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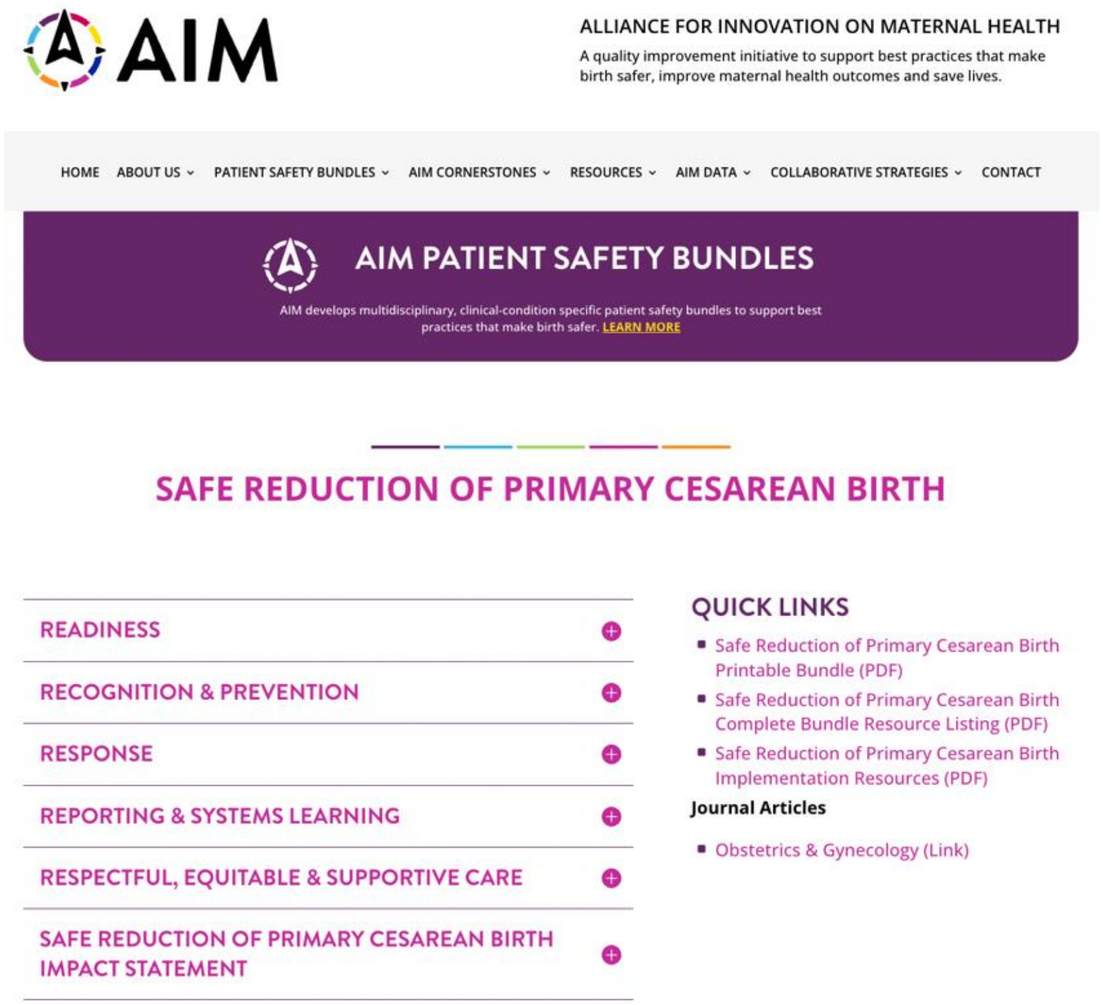
Resources from AIM

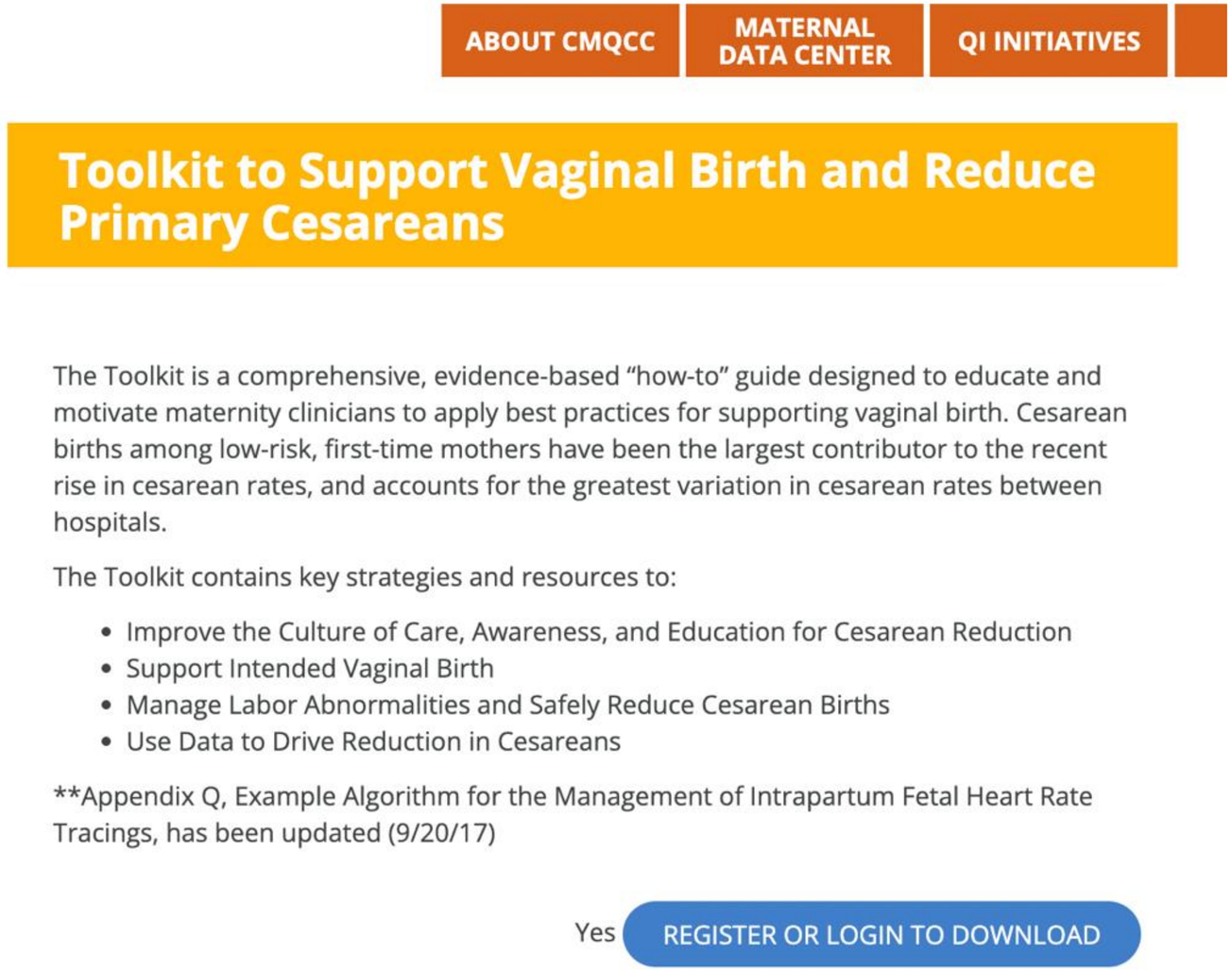
- Bundle is under revision and new version with additional resources expected in early 2023



https://saferbirth.org/psbs/safe-reduction-of-primary-cesarean-birth/

Resources from CMQCC

- Toolkit from CMQCC outlines specific practices and resources in detail, complementary to the AIM bundle.
- Free on their website, just need to register



https://www.cmqcc.org/VBirthToolkitResource

Conclusions

- Rates of cesarean birth are too high in the U.S. and contribute to morbidity and mortality. Regional, facility, and provider-level variation demonstrate the potential for improvement.
- Strategies exist to support physiologic birth at the policy, community, facility, and individual provider and nurse levels. Everyone has a part to play.
- The first step for a state, community, facility, or individual looking to lower cesarean rates is to examine historical data to identify improvement opportunities.
- Unit culture heavily influences cesareans – investing in training and resources to support labor progress is an important way to promote a culture of support for physiologic birth.
- Partnering with pregnant people and their families throughout care, including during labor, may ease emotions if a cesarean becomes necessary. Taking deliberate steps to promote family bonding following cesarean birth also optimizes the experience and outcomes.

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Questions or discussion?
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How did you find us?








Upcoming TAP Webinars

Register at saferbirth.org under Resources > Events

Implementing a Clinician and Staff Peer Support Program

January 19th at 3 PM ET

Linda Kenney & Jackie Ewuoso, MPH

Patient Support

February 9th at 3 PM ET

Coming Soon!

Thank you!

The recording will be emailed to all attendees once ready

AIM will also post the recording on our website, saferbirth.org

Any questions about this webinar or the series can be sent to AIM@acog.org

Remember to register for upcoming webinars!