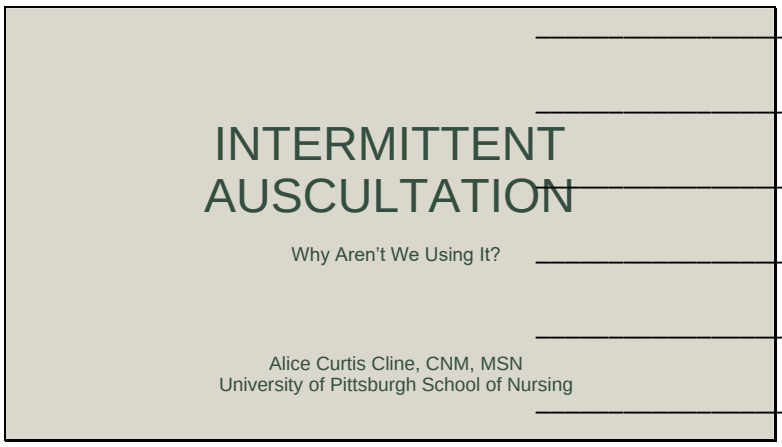
Slide 1



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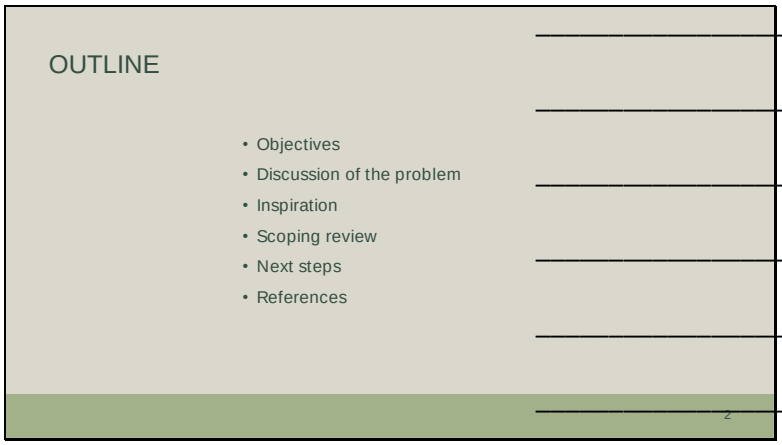

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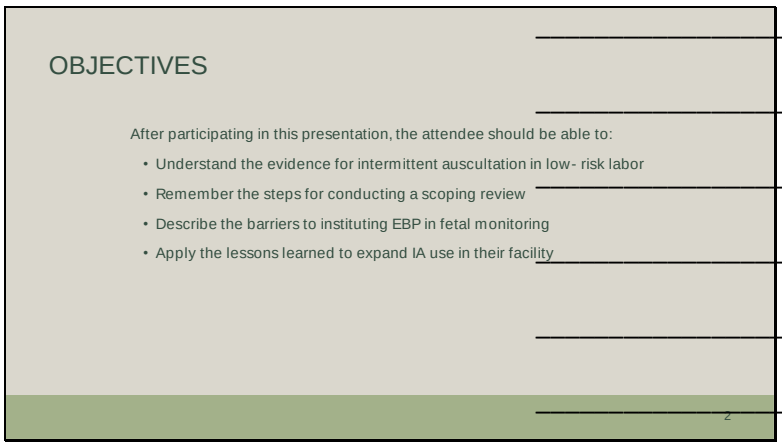

Slide 4

Bio

- PhD student
  - University of Pittsburgh School of Nursing
- Certified Nursing Midwife
  - UPMC Magee Women's Hospital
- MSN in Midwifery
  - Frontier Nursing University
- Labor & Delivery Nurse
  - Washington, DC
- Accelerated 2nd degree BSN
  - Georgetown University
- BA
  - University of Chicago

Disclosures

- No financial disclosures
- Research supported by internal SON research awards, scholarships

Acknowledgements

- Faculty mentor Dr. Sandra Founds, PhD, CNM
- Collaborator Dr. Abigail Slocum, DNP, CNM
- Librarian Ms. Rebekah Miller, MLIS

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THE PROBLEM

- Why do we routinely use CEFM when we know AI is recommended for low-risk labor?
- What are the barriers to using IA?
- What could facilitate the use of EBP fetal monitoring modalities?
- How do we improve the quality and safety of healthcare in labor?

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THE EVIDENCE

Original RCTs

- Starting in 1975; Haverkamp et al., 1975; Kelso et al., 1977; Niswander et al., 1984; MacDonald et al., 1985; Garcia et al., 1985; Vintzileos et al., 1993
- CEFM decreases risk of neonatal seizures, no other improvements. Increases cesarean risk
- One study showed improvements in fetal/ neonatal death (Vintzileos et al., 2013)

Reviews

- Cochrane: Alfirevic et al., 2017; Devane et al., 2017; Martis et al., 2017; Shepherd et al., 2017; East et al., 2014
- Systematic reviews and meta-analyses: Al Wattar et al., 2021; Vintzileos et al., 1995; many others

Guidelines

- Professional organizations: ACOG, 2017; SMFM, ACNM, 2015; AWHONN, 2018
- National: NICHD, 2008; NICE, 2017; SOGC, 2018
- International: WHO, FIGO

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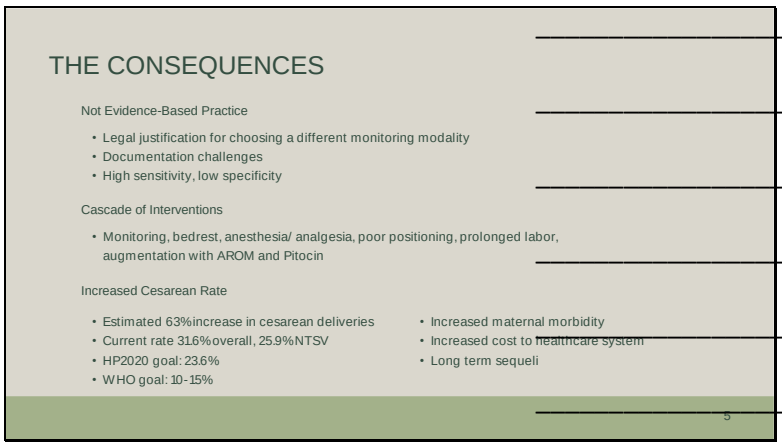

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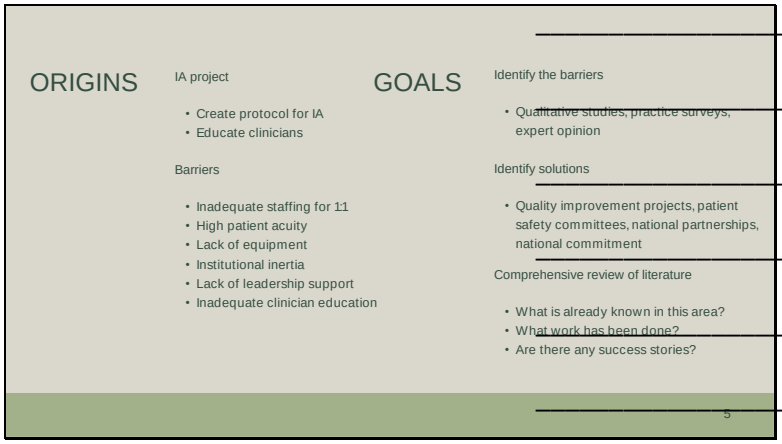

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