Driving Obstetrical Excellence Through a Council Structure

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Learning Objectives

• Describe how implementation of a multidisciplinary OB Quality Council may enable health systems to improve patient safety and quality

• Discuss how a quality dashboard may be used to identify system wide opportunities for improvement and standardization of care

• Describe how simulation and education may be used to facilitate the rollout of patient safety initiatives across a health system
Hartford HealthCare

- 5 general hospitals
- 2 psychiatric hospitals
- 80 ambulatory sites
- 17 behavioral health locations
- Outpatient rehabilitation locations
- Home Care
- 7 skilled nursing and assisted living facilities
- 2800 Physicians
- >500 Employed Physicians
- Clinically Integrated Network
- Revenue: $2.5 billion
- Inpatient discharges: 90,000
- Emergency Room visits: 382,000
Mothers-to-be know best:

• In 2015, we delivered 7,485 babies.
The Challenge: We are a Young Healthcare System Experiencing Rapid Growth

The question:
How do you move a large organization to eliminate unnecessary variation, achieve clinical consensus and reduce cost?
Our Promise: *The Five Ones*
*We Began the Council Structure to Realize this Goal*

1. Registration
   Health Record
2. Standard of Excellence
3. Bill
4. Relationship
Councils 1.0: We Began this Work Four Years Ago

- Began in clinical areas with good relations and hospital based
- Expanded council to include representation across the continuum of care
- Enhanced the inter-council relationship and support
- First effort to drive clinical performance within our system
- Second focus was standardization to reduce cost
- System-wide programs with defined clinical scope and the associated management structure to coordinate care, improve quality and act as a vehicle for growth
Council Structure

- The OB departments of Hartford Healthcare (HHC):
  - Five hospital system
    - Notable variability among cultures, policies, protocols, processes, standardization of care and best practices.

- Goal:
  - Develop system standards and best practice guidelines to mitigate risk, improve patient outcomes and decrease cost
Establishing a Council

• Council leaders demonstrate ability to develop and support consensus

• Identification of team members and accountabilities

• Letter of invite sets the stage

• Charter drives the focus
Clinical Councils 2.0: *Driving Change from the System Level to Hospitals*

- All councils have an Executive Sponsor
- Requires attention to “clinical governance”
- System policies/procedures/guidelines
- Hospital Medical Executive Committees adopt work of Councils – work becomes a “consent agenda” approval
- Increased efficiency and decreased “time to market” for new policies and procedures

*The work of the councils is no longer optional*
Obstetrics Network Quality Council Instituted to Drive Quality Improvement

- Formed in January 2014
- Multidisciplinary team (includes MFM and Neonatology Services)
- Dashboard helped to identify practice gaps
  Development of standard quality metrics
- Driving improvements through identification of standard best practices
- Sharing of successful projects and then deploying system-wide
- Identification of lessons learned from events and development of strategies to mitigate risks
Setting the Council’s Strategic Agenda

- Prioritized our focus
  - Accomplished through brainstorming sessions

- Consensus priorities:
  - Clinical Standardization
  - EPIC Order Sets & Readiness
  - Risk Management & Simulation Education
  - Supply Reduction

YOU CAN DO ANYTHING, BUT NOT EVERYTHING.

-David Allen
We don’t know what we don’t know.

What key metrics will drive patient outcomes?

What are best practices nationally?

How do we stand as a system and as individual facilities?

To Drive Improvement, a Baseline Assessment is Required
Identifying Gaps
Developing Consensus
Implementing Standardized Approaches
Tracking Outcomes
Identifying our Gaps – Where did we start?

NATIONAL ASSESSMENT

Rising rates of maternal morbidity and mortality

- One of the few developed nations with increasing maternal mortality rate
- Estimated maternal mortality rate per 100k live births for 48 states and Wash DC increased by 27% 2000-2014
- 23.8/100k (excluding TX and CA)

SELF ASSESSMENT

- 5 Oxytocin protocols
- 5 VTE assessment standards
- 2/5 PPH response plans
- 2/5 Severe htn guidelines
- 1/5 Maternal early warning standard
- 1/5 Standardized shoulder dystocia documentation
- Individualized labor and Cat II management
- Individualized order sets
- 3 Fetal monitoring platforms

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• Oxytocin Policy and Checklists
• Severe Hypertension Guidelines
• Hemorrhage Response Guidelines
• VTE Assessment and Prophylaxis Guidelines
• System Wide Epic Order sets
• Single fetal monitoring system
Developing Consensus: An opportunity...

CareConnect
A system-wide initiative of Hartford HealthCare, transforming the way we provide patient care.

Registration
Health Record
Standard of Excellence
Bill
Relationship
Developing Consensus – Maternal Safety Bundles

**RECOGNITION & PREVENTION**

**Every Patient**
- Assessment of hemoglobin risk (prevalence, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (oral, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

**RECOGNITION & PREVENTION**

**Every Patient**
- Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
- Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CRP, with platelets, ASI, and ALT)
- Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia

**Response**

**Every Unit**
- Use standardized tool to identify appropriate for thromboprophylaxis
- Provide patient education
- Provide all healthcare providers education regarding risk assessment tools and recommended thromboprophylaxis

**Reporting/Systems Learning**

**Every Unit**
- Review all thromboprophylaxis events for systems issues and compliance with protocols
- Monitor process metrics and outcomes in a standardized fashion
- Assess for complications of pharmacologic thromboprophylaxis

**Readyness**

**Every Unit**
- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (both post-drill debrief)
- Process for timely response and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas
- Rapid access to medications used for severe hypertension and/or eclampsia
- Medications should be stocked and immediately available on L&D and in other areas where patients may be treated
- Include brief guide for administration and dosage
- System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

**Obstetric Hemorrhage**

**Every Unit**
- Hemorrhage cart with supplies, checklists, and instruction cards for intravenous balloons and compression devices
- Immediate access to hemorrhage medications (kit or equivalent)
- Establishment of a response team who will call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish and maintain emergency drill protocols (type O negative, uncrossmatched)
- Unit education on protocols, unit-based drills (both post-drill debrief)

**Reporting/Systems Learning**

**Every Unit**
- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in maternal quality improvement (QI) committee

**Maternal Venous Thromboembolism Prevention**

**Every Patient**
- Use a standardized thromboprophylaxis risk assessment tool for VTE during:
  - Outpatient prenatal care
  - Antepartum hospitalization
  - Hospitalization after cesarean or vaginal deliveries
  - Postpartum period (up to 6 weeks after delivery)

The Council on Patient Safety in Women’s Health Care is a broad coalition of organizations across the spectrum of women’s health for the promotion of safe health care for every woman.

For more information visit the Council’s website at www.councilonsafety.org

May 2015
Developing Consensus

HHC Culture

H3W Leadership Behaviors
A Commitment to Continuous Improvement

1. Be in the moment
2. Be authentic and humanistic
3. Volunteer discretionary effort constantly
4. Model high performance – desired behaviors that drive desired results
5. Respect and leverage separate realities
6. Be curious vs. judgmental
7. Look in the mirror first – be accountable
8. Have courageous conversations
9. Provide timely, clear and specific performance expectations and feedback
10. Teach, coach and mentor – spend at least half of your time developing others

Remember, “It’s about progress, not perfection!”
Center for Education, Simulation and Innovation
Implementing standardized care – HHC Safety and Quality Culture

- **Infrastructure**
  - CESI (Center for Education, Simulation and Innovation)

- **Education**
  - Wide spectrum of task, cognitive and communication programs focused on safety and quality initiatives

- **Partnership**
  - Medical Risk Management and CESI
Medical Risk Management and Simulation Education

• Collaborated with a MRM company to standardize risk-reduction curriculum

• Highly-engaging risk education programs which include live sessions, videos, and content specialty-specific based on actual malpractice cases.

• All education is managed through a cloud-based technology platform with measured results and post-program evaluation
Post-Partum Hemorrhage: Improving maternal outcomes with multidisciplinary collaboration

- Identification of opportunities
- HHC Guidelines based on national best practice recommendations
- Leveraged education/simulation to support implementation
Identifying Gaps

• Rising rates of maternal morbidity and mortality
  – PPH is one of the most preventable causes of maternal mortality
    • Avoid Delay and Denial

• No system standards for recognition or management of hemorrhage
  – Vulnerability = Failure to rescue

• Variability in resources at each hospital
  – Tertiary care center vs community hospitals
Implementing a standardized approach – PPH Education

- Curriculum designed by a multidisciplinary team of nurse and physician members of the OB Council
  - Representation from each hospital in system

- Risk management education:
  - Failure to Rescue
  - Proactive communication with patients about risk of PPH across the care continuum
  - Documentation of informed consent or informed refusal discussions and decisions

- PPH curriculum/goals for all participants:
  - Demonstrate effective team response to PPH
  - Recognize stages of hemorrhage and mobilize response teams
  - Utilize checklists to improve team response
  - Facilitate directed team debriefing post event
PPH Education Timeline

- **October 2015**
  - Pre-Test Survey

- **December 2015**
  - Risk Rounds

- **February 2016**
  - RiskByte
  - TBD Simulation Training

- **April 2016**
  - Spotlight

- **July 2016**
  - RiskByte

- **August 2016**
  - Post-Test Survey

Adult Learning Theory:
- Interactive
- Multiple Modalities and Exposures
- Focus on outcomes considered important to providers
RESULTS
PPH/Communication Compliance

Pre-Test: 73% Providers, 88% Nurses
Risk Rounds: 87% Providers, 98% Nurses
Simulation: 67% Providers, 86% Nurses
Web Module (Spotlight): 57% Providers, 94% Nurses
RiskByte 1: 60% Providers, 98% Nurses
RiskByte 2: 44% Providers, 91% Nurses
Post-Test: 39% Providers, 73% Nurses
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<td>Hemorrhage Med Kit</td>
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<td>Stage Based Response Team</td>
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<td>MTP or emergency release protocol</td>
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<td>Unit Education on response plan</td>
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<td>Huddle for high risk and post event debriefs</td>
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<td><strong>Report</strong></td>
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<td>Multidisciplinary review of serious PPH</td>
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<tr>
<td>Monitor outcomes in QI improvement committee</td>
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Next steps

- Creation of system wide hemorrhage dashboard
  - Review outcomes, system and process metrics over time
  - Review at council and hospital level
- Hard wiring
  - Hemorrhage risk assessment built into EHR
  - Develop culture of debriefing after serious events and sharing findings on a system level
  - Collaboration on development of patient and family resources after serious obstetric events
  - Collaboration regarding cumulative assessment of QBL for all deliveries
Identifying Gaps, Developing Consensus, Implementing Standardized Care

Tracking Outcomes

AIM Data Reporting Measures v1.5

Obstetric Hemorrhage

Outcomes Measures (D): State

- O2: Severe Maternal Morbidity
  - Universal AIM Data Measure
- O3: Severe Maternal Morbidity (excluding transfusions)
- O4: Severe Maternal Morbidity among Hemorrhage Cases
  - Numerator: Cases with a SMM code (see SMM Indicator Codes by Categories)
  - Denominator: All mothers during their birth admission, exclude ectopics and miscarriages, with one of the following codes:
    - Abruption, Previas or Antepartum hemorrhage: 641.20, 642.21, 641.23
    - Transfusion: 99.00, 99.03, 99.04 (exclude transfusion codes for women with Sickle Cell Disease: 282.84)
    - Postpartum hemorrhage: 686.xx

Process Measures (P): Birth Facility

- P1: Unit Drills
  - Universal AIM Data Measure
- P2: Provider Education
  - What cumulative proportion of obstetric physicians and midwives have completed an education program on hemorrhage (within the last 2 years) that includes teaching on the Hemorrhage bundle and the unit-standard protocol?
  - Report estimate in 10% increments
- P3: Nursing Education
  - What cumulative proportion of OB nurses have completed an education program on hemorrhage (within the last 2 years) that includes teaching on the Hemorrhage bundle and the unit-standard protocol?
  - Report estimate in 10% increments
- P4: Risk Assessment
  - What proportion of women who gave birth during this quarter had a hemorrhage risk assessment recorded in the medical record prior to them giving birth?
  - Report estimate in 10% increments
- P5: Quantified Blood Loss
  - What proportion of women who gave birth had formal measurement of cumulative blood loss from the time they gave birth through the recovery period recorded in the medical record during this quarter?
  - Report estimate in 10% increments

Structure Measures (S): Birth Facility

- S1: Patient, Family, & Staff Support
  - Universal AIM Data Measure
- S2: Debriefs
  - Universal AIM Data Measure
- S3: Multidisciplinary Case Reviews
  - Universal AIM Data Measure
- S4: Hemorrhage Supplies
  - Does your hospital have OB hemorrhage supplies readily available?
  - Report completion date
- S5: Unit Policy and Procedure
  - Does your hospital have an up-to-date OB hemorrhage policy and procedure (reviewed and updated in the last 2-3 years) that:
    - Provides a unit-standard approach using a stage-based management plan with checklists
    - Ensures availability to OB hemorrhage supplies at all times
  - Report completion date
- S6: EHR Integration
  - Were the recommended OB hemorrhage bundle processes (i.e. order sets, tracking tools) integrated into your hospital’s Electronic Health Record system?
  - Report completion date
The Council Development is Key to Success

- Strong leadership
- Team members from across the healthcare system
- Accountability of the council to decrease variation and drive improvement
- Celebration of success